Managing patients' expectations in telephone complaints in Scotland

(chapter for *Identity Struggles: Evidence from Workplaces around the World*)

Bethan Benwell and May McCreaddie

Abstract

In this Conversation Analytical study we examine telephone complaints to the NHS which address a variety of issues raised by patients or their families. One area of 'identity struggle' for the patient caller is located in the difficult moral work that often needs to accompany the act of complaining. Complaints are an accountable activity, and legitimacy is 'built into' the complaint through a variety of means including invocations of the 'right' to complain, emotion discourse and constructions of the self as a 'good' or 'reasonable' patient. Similarly, identity conflicts arise for complaints handlers when the ideal forms of rapport involved in complaining sequences sometimes come into conflict with the institutionality of the event.

It is hoped that a detailed and discursive exploration of this key stage of the patient experience will lead to productive observations about effective communicative strategies for addressing complaints in ways that successfully manage the patient's expectations.

Keywords: complaints, affiliation, CA, telephone conversations, NHS

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Introduction

In this study we examine telephone complaints to the UK National Health Service (NHS) in a particular Scottish Health Authority, which address a variety of issues raised by patients or their families. The Patient Relations and Complaints department is the first point of contact for patients wishing to register a formal complaint. We are interested in the work that is accomplished by *both* sides (complainer and complainee) in order to manage potential conflict, communicate objectives clearly and meet the patient's expectations. One area of 'identity struggle' for the patient caller is located in the difficult moral work that often needs to accompany the act of complaining. Complaints are an accountable activity, and legitimacy is 'built into' the complaint through a variety of means including invocations of the 'right' to complain, emotion discourse and constructions of the self as a 'good' or 'reasonable' patient (McCreaddie and Wiggins 2009).

Our observations of how patients' expectations are most successfully met focus upon the ways in which this issue of 'legitimacy' is addressed and respected. Our analysis of complaints handlers (CH) focuses on how the right to complain and a 'patients' rights discourse' more generally is oriented to (or not) by handlers. We focus on patterns of affiliation (Stivers 2008)[1] and the role of 'formulations'. We note how orientations to institutionality (or deliberate avoidance of this) are deployed in interaction, and at strategic moments. Identity 'struggles' arguably occur for the CH in the delicate position they occupy as a 'mediator' between complainer and department that is the object of complaint, and when

[1] see also Tranekjaer, this volume.

the ideal forms of rapport involved in complaining sequences sometimes come into conflict with the institutional constraints of the event[2].

Conversation Analysis is an ideal means by which to explore the orientations of participants to complaints as they arise in interaction. The fine-grained discursive exploration of complaints calls offered in this chapter enable us to comment more empirically on the variety of communicative strategies for addressing complaints and may lead to a better understanding of the roles of complainer and complaints handler in the delicate business of complaining.

Complaints, consumers and the UK National Health Service (NHS)

A complaint is commonly considered to be an expression of dissatisfaction where a response or resolution is explicitly or implicitly expected. It is a problem, or at the very least, a gap between customer expectation and the receipt of a product or service (Barlow and Mellor 1996). Seminal customer research by Hirschman (1970) suggested dissatisfaction was expressed by two mechanisms; exit and voice. In short, customers simply leave or alternatively explicitly express their disapproval to amend, improve or seek remedy.

Consumer industries claim to view complaints as an opportunity to remain competitive: to improve service and increase customer loyalty (Davey 2011). Conversely, the NHS is a public service providing 83% of all health care in the UK (Klein 2005). Customer loyalty is therefore, a pre-requisite with 'exit' as an unlikely option (Hirschman 1970). Nevertheless,

[2] see also Ojwang, this volume, for a related discussion of the conflicts that sometimes arise between institutional and patient expectations.

assertive, well-educated and internet-informed citizens are increasingly giving 'voice' to their complaints with more than 50% of people now prepared to complain (Institute of Customer Service 2012). Accordingly, the significant and increasing number of public service complaints is perhaps to be expected. Nonetheless, there are patent differences between private 'consumers' and the patients of a publicly funded NHS.

Mulgan et al (2007) highlight the emotional value placed upon public services with compassion and care being an intrinsic expectation. The NHS is a revered public service developed partly to address the needs of post-World War II recovery and something that many – including the founder of the NHS, Anuerin Bevan – consider to be sacrosanct (Klein 1989). However, the NHS in the UK is not just a public service, free and available at the point of need - but is also viewed as a citizen's 'right'.

The public's sense of attachment to the NHS arguably co-exists with the implicit expectation that the service should be delivered to a high standard (Martin 2012, Simmons et al 2012) and complainants state that the main motivation for complaining is to prevent the problem or distressing event happening to others (Simmons and Brennan 2013). There is therefore, a 'mutuality of caring' between service and consumer: patients expect care and compassion, but also care about the NHS (Benner and Wrubel 1982). Death, dying, terminal diagnosis, disfigurement, distress and intimacy take place on a daily basis in the NHS and this inevitably creates a milieu of emotions and challenges for vulnerable patients and their relatives. It follows therefore, that any adverse event is likely to be magnified ten-fold, with attendant emotions ensuring the acuity of the incident persists well after the event. Thus, small acts of kindness or care are deified while poor care is seen as an abomination and for this reason, a huge amount of emotional investment accompanies the act of complaining. We believe the face-threatening area of NHS complaints is the perfect setting in which to explore identity

struggles in a unique service. Prior to outlining the complaints data, we provide a brief overview of the complaints process.

The NHS complaints process

The NHS Complaints procedure was first introduced in April 1996 and further revised in 2005 and 2012. The purpose of the NHS complaints procedure is 'to provide a simple, flexible, impartial and easily accessible system for the public as well as being fair to NHS practitioners and staff' (ISD 2013, 2). Nevertheless, the Francis Report (2013) highlighted several key failings with regard to complaints and complaint management. The reluctance of patients and their relatives to complain because they are fearful of the consequences was highlighted. The extensive 'legitimising' work that tends to accompany complaints in our data set partly supports this observation.

Telephone complaints or concerns to the Patient Relations and Complaints Department (PR&CD) are initially fielded by a Complaints Handler (CH). The CH determines the nature of the complaint and whether the issue can be resolved informally without recourse to the formal process or to exclude issues that fall beyond the scope of investigation e.g possible legal proceedings. Formal complaints can be made up to 12 months after the incident and are acknowledged within 3 days of receipt. Complainants are provided with information on the NHS complaints procedure, the Scottish Public Services Ombudsman (SPSO) and advocacy agencies. A Complaint Investigation (CI) officer – usually a member of clinical staff - is appointed to investigate the complaint with investigation and response to be completed within

20 days. If the complainant remains dissatisfied they can ask for further clarification, or refer the complaint to the Scottish Public Services Ombudsman for further review. Whilst this study does not cover complaint outcomes, it sheds light on the initial reception of a complaint when it is first raised.

Methods and Data

Our approach to analysing the telephone complaints data involves a conversation-analytical examination of the transcripts of audio-recorded calls to and from the Patient Relations and Complaints department at an NHS authority in Scotland. The data for this study comprises a set of 19 telephone calls made either by patients or their relatives wishing to make a complaint about their healthcare experiences, or by complaints handlers/investigators in the Patient Relations and Complaints department to callers who had already made a written complaint.

The calls were collected over a two week period and transcribed. Informed consent was secured from both handlers and callers, and anonymity for all participants (including individuals discussed within the calls) assured by the alteration of key, potentially identifying details of names and locations.

The use of ethnomethodology (EM), conversation analysis (CA) and Membership Categorisation Analysis (MCA) as analytical approaches or programmes of research is motivated by a concern with members' own formulations of the organisation of social life as it is revealed through talk and social interaction (see also contributions to the collection by

Burrow, De Stefani and Mondada, Tranekjaer). The 'accountable' nature of complaining means that our patients' complaints are particularly rich sources of 'accounting practices' and descriptions of 'normative' behaviours and actions.

CA involves the study of technical transcripts of recordings of everyday and institutional talk of various kinds, focusing on the turn-by-turn organization of interaction and concerned with explicating the 'technology of conversation' (Sacks 1984: 413). Some of the sequential concerns of CA (such as preference organisation, the uptake of turns, formulations and patterns of (dis)affiliation) are particularly relevant to our data. Membership Categorisation Analysis (MCA)[3] pays attention to the situated and reflexive use of categories (usually identity categories, such as teacher, mother, teenager) and how speakers locally manage categorizations of both themselves and others in their talk. In our data we notice a repeated pattern of appeals to membership of the category 'reasonable patient' and 'legitimate complainer', details of which we consider below. These approaches which we draw upon in our analysis enable a microscopic and reflexive focus on the way in which complaints and complaint responses are formulated.

Complaints and complaining have been well documented by CA/EM studies, many of which identify complaints as a response to some kind of deviation from 'normative' or expected social practice. Whilst many studies have examined informal complaints in conversational settings (e.g. Drew 1998; Dersley and Wootton 2000; Drew and Walker 2009; Edwards 2005; Holt 2012; Pomerantz 1986; Schegloff 2005; Selting 2010), a number have examined more formal complaints in institutional settings (e.g; Monzoni 2009; Orthaber and Márquez-Reiter 2011; Ruusuvuori and Lindfors 2009; Stokoe and Edwards 2007; Stokoe and Hepburn 2005; Whalen and Zimmerman 1990). There are key differences in the way that formal and

[3] See also Tranekjaer, this volume, for an analysis that uses MCA to explicate the local negotiation of membership and identity.

informal complaints are framed: complaining is arguably more accountable and stigmatised in informal settings; in contrast, complaining may be the legitimate and singular goal of some institutional encounters, such as the Patients Relations phone complaint data of our own study.

Data Analysis

In the analysis that follows we explore identity struggles and the management of expectations relating to complaints handling from two perspectives. It has been noted by many complaints researchers that moral and accounting work frequently accompanies the activity of complaining (e.g. Drew and Holt 1988; Edwards 2005; Stokoe 2009) and we begin by focusing on the kinds of identity 'work' that accompanies the formulation of complaints by patients and their relatives and discuss how these patterns suggest that complaining is a delicate and sometimes fraught activity for patients.

Within these sequences we can also observe that complaint *recipients* often reveal an awareness of the struggles around complaining and will frequently attempt to affiliate with the caller's complaint. The CA literature on complaints has identified that complaining embodies an interactional expectation of agreement or affiliation by the complaint recipient. Stivers (2008) describes 'affiliation' as the positive and agreeing stance taken to the proposition contained in the previous turn. A lesser degree of affiliation seems to correspond to the perceived 'institutionality' of complaints encounters and has the potential to come into

conflict with patients' expectations.[4] The second part of the analysis thus focuses on the work done by complaints handlers. Here we explore particularly the tension that sometimes arises between the expectation of affiliation and the institutional constraints of the encounter that means this affiliation is sometimes withheld.

The moral work required to complain

What is striking about our data is that regardless of 'complaining' being an inherently legitimate and purposeful activity of the institutional setting, callers still work hard to mitigate the negative associations accompanying the activity of complaining and identity of 'complainer'. This observation may be related in this specific context to Francis's conclusions that some patients and their relatives are fearful of the consequences of complaining (2013), but equally that patients do not want to be seen as 'ungrateful' for a service they care about.

In our own healthcare data, a complainer will sometimes emphasise their entitlement and epistemic authority through mentions of their own professional experience or that of relatives or friends with medical expertise ('I was very surprised and so was my retired doctor friend'). A caller may also mitigate a complaint by lavishing praise on another aspect of their healthcare experience: 'I'm not getting at staff at all... because staff are excellent'; 'the receptionists were fantastic they (weren't) to be blamed at all'. In this way, callers regularly appeal to membership of the implicit category 'reasonable patient', which often involves distancing from the activity of complaining (e.g. 'we're not really complaining people') or through the announcement of explicit membership of particular kinds of 'reasonable' identity

[4] See for instance Ruusuvuori and Lindfors on the differing responses between homeopathic (affiliative) and mainstream (non-affiliative or neutral) doctors; Stokoe and Edwards (2007) on mediators (affiliative) and police (non-affiliative or neutral) in the context of neighbour disputes.

categories (e.g. ‘Ah’m not an ignorant man’; ‘I'm the kind of person I say I'll nae bother naebody’); or through attributes or activities tied to the category ‘reasonable person’ (e.g. ‘don’t want anybody getting into trouble’)[5]. Through these self-constructions of normative, ‘reasonable’ identity and behaviour, patients’ narratives are able ‘to express or confirm the continuing integrity and moral virtue of the individual’ (Pollock 2005: 23). We see examples of these self-constructions in the following set of extracts. In each extract, CH refers to ‘complaints handler’ and C to ‘caller’. In this first sequence, the male caller is a patient who suffered a heart attack and is complaining about delays that occurred in being treated.

Extract 1

1	CH:	hh.where >wuz that you were taken back to<= ↑↑were you taken back to
2		[the ↑Royal]
3	C:	[Royal]
4	CH:	back to the ↓Royal=
5	C:	=aye
6		(0.3)
7	CH:	right
8	C:	an then I was up there gettin ma °operation° (1.0) a week ago or >summat like
9		tha> (0.9) I:: (0.2) an ee- (.) anyway (xxx) (1.2) ↑it’s= not healin= brilliant
10	CH:	ahuh (.) [you’re getting there (.) you’re ↓getting there]
11	C:	[but it’s comin along=]
12		=↓aye I’ve absolutely no complaints aboot that
13	CH:	ah↑↑uh
14		(1.0)
15	C:	what’s happening to me noo is (.) is ah ahm startin to greet (.) and break doon
16	CH:	right
17	C:	it’s all just startin’ ta hit me ↑noo
18	CH:	aye (.) [y=
19	C:	[but ah- ah- (.) ah want=to know why it’s taken so long (1.0) for
20		somebody to=come and see me (.) when ah was in hospital that night (.)
21		which was- ah thought was >an ↑absolute< ↓disgrace
22		(0.2)
23	CH:	right so this is when we’[re
24	C:	[ah’ve never complained or nothing in ma life

In this extract, the caller has been describing what happened to him on the night he had a heart attack. After long delays in being seen and diagnosed, during which time he suffered

[5] See also Stokoe and Hepburn 2005

considerable pain, he was finally transferred to the department where he had a bypass operation. On line 8, C reports that 'it's not healing brilliant', a negative assessment to which CH initially aligns with her preferred 'ah↑↑uh' but from which she subtly disaffiliates by offering an alternative, more positive assessment 'you're getting there'. This tendency for positive sequences/assessments to entail from negative sequences/complaints has been commented upon by a number of studies (e.g. Beach 2003 on 'managing optimism'; Holt 1993 on 'bright side sequences'; Maynard 2003 on 'good news exits').This more positive assessment of C's situation coaxes agreement from C ('aye') and suggests that CH and caller collaboratively orient to a more mitigated and 'reasonable' form of complaining, culminating in the assertion 'I've absolutely no complaints aboot that' which contains an extreme case formulation designed to enhance the moral and categorical force of the utterance (Pomerantz 1986), to which the Complaints Handler affiliates ('aye'). Crucially 'I've no complaints aboot that' signals that C is not a habitual complainer, but rather a judicious one and thus 'work[s] against the indexical category of dispositional moaner' (Edwards 2005, 24). On lines 17-19, C contrasts his satisfaction with the ward where he received his care, to his assessment of his care leading up to his admission, and the significant delay in being seen ('but ah- ah- (.) ah want=to know why […]). His indignant assertion that this was an'↑absolute< ↓disgrace' is mitigated by the acknowledgement that this was his opinion 'ah thought', which in turn conveys subjectivity without bias (Edwards 2005), and avoids the impression that this display of 'affectivity' (Selting 2010) is unreasonably asserted as fact- rather than opinion-based. The worked up identity of 'rational' and 'judicious' complainer is further emphasised with the support of more extreme case formulations in line 21: 'ah've never complained or nothing in ma life'.

In the next sequence, taken from the same call as extract 1, the CH attempts to clarify a detail mentioned earlier by the caller about having had a vodka to drink that night.

Extract 2[6]

1	CH:	so you had one vodka that [night]
2	C:	[so I felt (.) er-] ↑oh I'd only (.) one- had
3		↑one vodka=I mean that's (0.)2 but I'd have ta say (0.1) I think my daughter
4		had said on the phone he had had a drink >or summat like that<=
5	CH:	=right=
6	C:	=th- there <wuzane drink involved>
7		(0.2)
8	CH:	m↑huh
9	C:	if there was I wouldn't even be phoning yer
10	CH:	mhuh

The CH's first turn in extract 2 clarifies a point of information discussed earlier in the patient's narrative – that in her call to the NHS 24 phone line, the caller's daughter has mentioned that he had an alcoholic drink prior to his heart attack. The caller's point in topicalising this issue is to stress its irrelevance to his condition, but the complaints handler's turn reveals an ambiguity, whereby her request for confirmation of the drinking of 'one vodka' topicalises it and enhances its relevance to the narrative. The interactional 'trouble' that this question provokes is revealed in the 'defensive detailing' (Drew 1998: 297) provided by the caller in his next turn, where 'one vodka' is repaired to 'only one vodka'. In line 6, this assertion of the drink's irrelevance is upgraded 'there <wuznae drink involved>', and in line 9 further moral work is achieved in the claim that if the caller's drinking had been relevant he 'wouldn't even be phoning yer'. This exchange reveals normative understandings about how certain lifestyle choices (e.g. drinking alcohol, smoking, bad diet) might be thought to contribute to heart disease. In his repudiation of the identity of 'excessive' or 'habitual' drinker, the caller makes claims to a different kind of identity, that of 'responsible' patient, who therefore has the entitlement to complain about his treatment. The implication here is that if a patient were responsible for his own ill-health he would not be able to make a legitimate complaint about the way he was treated. Again, the appeal to a 'reasonable' and 'responsible' identity, in implicit contrast to other kinds of patient identity,

[6] This extract and extract 3 are also analysed in Benwell and Stokoe (2016)

is what underpins and legitimises the grievance.

In the following sequence, the caller in this sequence is the sister of a female patient taken into the Accident and Emergency department suffering from acute mental health issues.

Extract 3

1	C:	we waited over an hour to be assessed by a triage nurse which is ↑fine (.) cos
2		(.)↑you don't mind waiting your ↑turn (.) and (.) and there was just- full of
3		drunk people= and (.) injured people= and (.) we were kept waiting a further
4		two ↑hours
5	CH:	right
6	C:	for her to spend almost five minutes with a doctor

In this final extract we see another example of the self-construction of a 'reasonable' patient identity which is established prior to the expression of the grievance. The caller states that 'we waited over an hour to be assessed by a triage nurse', an utterance which might be thought initially to represent a complaint; however, this is confounded by her concession that this was '↑fine (.) cos (.)↑you don't mind waiting your ↑turn'. By uttering this statement, the caller reveals herself to be a 'reasonable' person, one who recognises that hospitals are busy, understaffed and full of equally entitled patients all awaiting treatment. However, the turn develops to flag up the presence of other kinds of patients, whose identities are marked, possibly in contrast to the caller's relative, as 'drunk' and 'injured' (and thus potentially responsible for their own condition). This detail contributes to the impression that the accident and emergency ward was a stressful and unpleasant environment in which to have been kept waiting (particularly for a patient suffering mental health problems), and the 'reasonable' hour-long wait is implicitly contrasted with a less reasonable 'further two hours' followed by the very minimal time actually spent with the doctor 'almost five minutes'. The category attributes of 'reasonable person' ('↑you don't mind waiting your ↑turn') are

strategically established in this account in order to manage the impression of the actual complaint as reasoned and fair.

In these extracts, we have seen how membership category work operates in the establishment and avoidance of certain kinds of identity. Notably, callers often work to construct themselves as 'good' NHS patients deserving of the service in contrast with other implied identities. Complaining is a fraught, evaluated and thus accountable activity, and callers to the complaints line must work hard to have their grievances heard as legitimate. A recognition of this delicacy is sometimes indexed in the interactional behaviour of the complaint recipients, and it is upon their turns that we now focus.

Conflicting agendas for complaint recipients

In the section above we explored how identity work by callers is prompted by the interactional constraints surrounding the act of complaining, even where the setting is institutional and functions formally to receive complaints. We now turn to the complaints handler in this interactional dyad in order to explore how this institutional identity role of complaint recipient is fraught with conflict between addressing the concerns of patients in an affiliative and sympathetic fashion[7], and meeting a set of institutional needs including the gathering of factual data, and suspending judgement about the actions of certain departments.

Complaints literature has made a distinction between 'indirect' and 'direct' complaints, arguing that complaints to third parties are likely to differ in character and form to those directed at the object of complaint (e.g. Monzoni 2009). Our own data occupies an

[7] Scottish Government guidance on handling complaints to the NHS state that 'Staff should always respond positively and appropriately to anyone who provides feedback, comments or concerns and acknowledge the feedback, comment or concern in an open and honest way demonstrating sensitivity and understanding'. (Scottish Government 2012: 17)

ambiguous space between direct and indirect, which is further complicated by its institutional status (see Ruusuvuori and Lindfors 2009). On the one hand, the complaints handlers are neutral recipients, not directly implicated in the blameworthy action(s)[8], on the other hand, they are employed by and representative of a public service[9]. The interactional behaviour of the complaints handlers in our study reflects this ambiguity, with a combination of indirect, third-party type responses more typical of informal conversations (explicit affiliation, empathy, assessments, even outrage) and direct-type responses associated with institutional settings (studiedly neutral, fact-securing responses, responses that are protective of the institution)[10]. We can gloss this distinction as 'patient vs institutional affiliation'.

The extent of orientation to the client/patient's needs tends to vary between complaint handlers, who manage conflicting affiliations in a range of ways. In complaint sequences there is usually some negotiation between institutional objectives and procedures, and complainant expectation, what Dewar (2011) describes as 'squaring the institutional and the caller view of the complaint'[11]. Whilst some examples show a clear orientation to either the institution's or the caller's agenda, sometimes these dual agendas come into explicit conflict for the complaints handler. The following example demonstrates a locus of tension for the complaints handler's professional identity between institutional and patient-centred alignment.

In a sequence from a complaint call made by a caller on behalf of her husband, a patient with

[8] This becomes clear in occasional comments by callers who explicitly praise the complaints line and its handlers in contrast to the treatment they have experienced.
[9] Other researchers characterise this relationship as direct, e.g. Orthaber and Marquez-Reiter (2011) in their study of complaints to a public transport department in Slovakia.
[10] Ruusuvuori and Lindfors (2009) note that private healthcare providers are usually more willing to affiliate to the patient's complaint than public healthcare providers.
[11] see also Orthaber and Marquez-Reiter (2011)) account of public transport service where these goals are in direct conflict

motor neurone disease who was admitted to hospital suffering from pneumonia, the complaints handler offers a possible identification of the nurse that the caller is complaining about[12].

Extract 4

1	CH:	is this Carol Purdie you're talking about
2	(0.4)	
3	C:	Sorry
4	CH:	is it Carol Purdie?
5	(0.3)	
6	C:	well that- if that's her name it's ward sixty-two that's it
7	CH:	I don't know not sure .h (1.0) ummm so-=
8	C:	=sorry what did you say her second name was
9	CH:	Purdie
10	C:	how d'ya spell that?
11	CH:	Pee Ewe Ar Dee Eye Ee
12	C:	sorry.
13	(1.0)	
14	C:	P
15	(1.0)	
16	C:	sorry P-
17	CH:	>I don't know if it is her or not it might not be her that's what I'm
18		sayin (.) I may be givin ya the wrong name here I don't know .h
19	C:	yeah well it probably will be-=
20	CH:	=Oh I don't know I don't know which ward she works in

The complaints handler's initial orientation to the needs and agenda of the complainant in providing a possible name for the object of complaint is received positively by the caller, who whilst unsure herself about this identification, accepts the authority of the CH and notes down the name in writing. At lines 7 and then later at line 17, however, the CH retreats from the categorical modality of his initial suggestion and introduces a significant amount of hedging and low modality in his reassessment of certainty of this positive identification of the nurse in question. Again we can see how the CH's initial impulse to support the patient's complaint evolves in response to his realisation of the possible professional consequences of naming (and even misidentifying) a colleague within the NHS in the context of a complaint. The

[12] All names have been changed to protect anonymity.

tension between the CH's alignment to the needs of the caller and his alignment to the institution for which he works is palpable in this sequence and offers an example of a professional identity in conflict.

Conversational Affiliation

Affiliation (and disaffiliation) as discussed earlier may also play a key role in conveying the position of the complaints recipient as aligned either to the patient or the institutional agenda. Strong conversational affiliation to the caller's complaint signals affiliation to the patient agenda:

Extract 5

1	C:	it's not very business-like °I'll give you that°=
2	CH:	=er well ↑no (.) it's not I totally agree with ya=

In this exchange the caller offers a negative assessment of the delays to his appointment which is strongly supported through the affiliative move of the officer, even at the risk of agreeing that the institution for which she works is not 'business-like'. Some CHs go to great lengths to empathise with a complaint, including completing or glossing the complaint on behalf of a caller:

Extract 6

1	C:	but I don't like [(1.0)]
2	CH:	[you don't like to bother people]

Extract 7

1	C:	and he had it up er er the xray was on the computer *cough* (.) and ah
2		said no that's for the crumbling spine and he said well that's there and
3		he pointed it oot the same but ya know you also have a hairline fracture

4 in ya ↑femur >femur<
5 CH: back then
6 C: yea[h
7 CH: [and nobody told ya=
8 C: =nobody told me

This kind of 'glossing' or 'formulation' (Heritage and Watson 1979) activity is common by CHs and plays a key role in establishing degrees of affiliation towards the complaint. Types of glossing which seem more explicitly to affiliate to the patient's interests include reformulations which enhance and extend the grievance:

Extract 8
1 C: I wuznae want to believe it
2 CH: you were trying ta ignore it

Extract 9
1 C: just dinnae want to go back at all
2 CH: you'd lost your confidence a wee bit.

In these examples the CH's glosses give support to the callers' complaint arguably at the expense of the professional reputation of the NHS departments under discussion and thus might be thought to challenge the institutional alignment of the CH.

However, complaints recipients do not always affiliate with a complaint and a range of more neutral, or less patient-affiliated responses can be seen across our data. These include simple repetition of the complaint in clarificatory responses (e.g. 'it's kitchen staff and nursing staff is it?'); neutral reformulation ('so outside ward two they go and smoke') and distancing from the complaint by attributing it to the opinion of the caller ('I'll bring it to people's attention that you believe there was a lack of wheelchairs'). The motivation for employing neutral forms in these contexts is likely to involve an avoidance of on-record admission of institutional culpability, but may come into tension with patients' implicit expectations of affiliative responses to their complaints. Indeed, where affiliation is perceived to be not

forthcoming, the complaint sometimes becomes more aggrieved. Orthaber and Marquez-Reiter's research (2011) reveals that interactional trouble is often generated by passive responses and neutral response tokens by the complaint recipient. In our own data we observe this pattern within the same complaint examined earlier (in extract 4), made by a caller on behalf of her husband, a patient with motor neurone disease who was admitted to hospital suffering from pneumonia[13]. The CH has been ascertaining the context of the complaint:

Extract 10

1	C:	ehm when ma daughter went in for the visiting at two am err two pm
2		[sorry] ehm (0.2) a-
3	CH:	[mhmm mhmm]
4	(0.4)	
5	C:	dad was in room sixty two (0.4) and suffering from pneumonia:
6	CH:	mhmm
7	(0.8)	
8	C:	(and) he had <u>just</u> a tee shirt ↑on .h the window was wide open (.) the
9		room was ↑frozen .h and there were no heatin and no buzzer (.) the
10		buzzer was still up in the wall
11	CH:	mmm=
12	C:	=err for ta contact the nurse .h ta >let ya understand< my husband has
13		got motor neurone disease and cannot <u>speak</u>
14	(0.4)	
15	CH:	o↓kay
16	C:	o↑kay
17	CH:	a↓ha
18	C:	ehm (0.2) when, (0.2) ma daughter spoke ta the ↑nurse (.) her name
19		was <u>Ca</u>rol don't ask me what ah think she is a ↑Sister .h she was told
20		ehm '↑I have <u>sixteen</u> <u>other</u> patients to look after and don't have time
21		for 'im'=
21	CH:	=this was in ↑Ward
22	(0.2)	
23	C:	B sixty two
24	CH:	B sixty two

The caller is at this point hearably aggrieved, furnishing her complaint with details of her husband's condition juxtaposed with the treatment he received. Through the work that typically accompanies complaints: defensive detailing, an escalating series of extreme case formulations ('wide open', 'just a tee-shirt', 'frozen'), 'incriminating' reported speech of

[13] This extract precedes the sequence examined earlier in Extract 7

the complainee (lines 19-20) (see Stokoe and Edwards 2007)), the caller actively pursues affiliation. The CH's responses however are neutral mimimal response tokens or requests for further factual information, neither of which provide any kind of assessment of the complainable actions.

Our first sense that this breaches the expectation of the caller comes in the pauses which follow the CH's minimal responses (lines 4 and 7), and then more clearly in line 16, where the caller prompts further assessment and checks understanding with her repetition of 'o↑kay' with a rising intonation. The CH responds neutrally to this possible pursuit of response with a downward tone 'aha' which indexes his role as recipient of information rather than assessor of a complaint.

The caller then goes on to detail further neglect, including her husband being left 'sittin in his own faeces .h for a couple of hours', to which the CH continues to respond with minimal response tokens. The caller then explains that the object of the complaint 'Carol' is now refusing to put her husband on an intravenous feed and not organising his prescription. At this point the CH responds:

25	CH:	.h well <u>ah</u>'ve no authority t- t- tae err change (.) Carol's mind I
26		think you should put this in the letter as well .h (.) >okay< I
27		think if f that's the way you feel about Carol you should put all
28		this in the letter ta me=we can >investigate that when it comes
29		in< .h let's just hope he gets out ↑tonight ↑ahm .pt .h (1.2)
30		↑↓hmmm (1.0) what time is ya hus- ya h- >ya husband just
31		waitin for transport to come home is ↑he .h
32	(0.7)	
33	C:	well ma daughter's away back up to the ward th' noo to see if
34		she's <u>ordered</u> transport .h if not she's goin down ta the- the (.)
35		.h (.) discharge lounge >fer to do it her↑<u>self</u>< (0.2) it's a
36		dis<u>grace</u> the way ma husband has been ↑<u>trea</u>ted (1.0) an' I am
37		<u>not</u> (0.2) leaving it this time because this is the second time
38		he's been in that ward .h and the second time he's been treated

39 like a (.) lump of ↑sh:it

The CH's turn beginning at line 25 could be described as distancing from and disaffiliative to the caller's complaint, citing his own lack of authority and institutional procedure ('you should put all this in the letter' (l.26)), and emphasising the contingent and subjective quality of the caller's complaint ('if f that's the way you feel about Carol'(l.27)) for which explicit agreement might imply a judgement on a colleague[14]. He then offers a neutral 'hope' that the caller's husband is discharged which avoids attributing any agency to such a decision. A pause follows the CH's turn (l.32) and after clarifying the arrangements for hospital transport for her husband, the caller resumes her complaint which is now amplified: her tone is hearably 'affective', there is an explicit assessment of the situation as being 'a disgrace' (l.35) and she puts on record her commitment to pursuing her complaint until it is resolved: 'I am not leaving it this time' (ll.36-37). This formulation further suggests that there have been previous incidences of poor care that she has not yet complained about demonstrating that it is the series of events that has prompted the complaint. Finally her turn culminates in a taboo expression which combines idiomatic qualities and extreme case formulation to describe her husband's care: 'treated like a (.) lump of ↑sh:it' (ll.38-39). This face-threatening and emotive assessment is the end point of the replaying of a difficult and upsetting series of experiences and is arguably prompted by the caller's failure to secure affiliation to preceding elements of the complaint which has thus provided no 'legitimate' outlet for her emotions. One reading of the dynamics of this sequence is that the CH's possible reluctance to put on record a negative assessment of the hospital's professional practices comes into conflict with the caller's expectation that he will acknowledge the legitimacy of her complaint and in a

[14] This reading is also supported by the analysis of Extract 4, whereby the CH retreats from identifying the nurse in question.

sufficiently supportive and sympathetic way.

Conclusion

In this discussion we have highlighted how the act of complaining in an institutional setting may prompt identity dilemmas for both caller and complaints handler. For the caller, complaining is an accountable activity which necessitates a degree of defensive moral work in justifying the grounds and legitimacy of the complaint. For the complaints handler, responding to complaints in ways that attend to the caller's sense of legitimate grievance may sometimes come into conflict with aspects of institutional procedure or alignment (such as breaching impartiality).

Arguably this rhetorical work by callers is largely moral rather than argumentative. The purpose of the complaint in this setting is not simply to persuade the recipient of its justness or accuracy, thus gaining reparation (since this occurs at a later stage of the process[15]), but to solicit agreement that the complainer has the right to complain. By providing affiliative responses within the necessary constraints of the institutional process (a delicate and sometimes fraught balancing act), the complaints handlers perform the important function of attending to the rights and dignity of the patient, their desire to be respected and listened to, and in this way provide an important gauge of the attention paid to a patient-centred 'culture of caring' in the NHS (Francis report 2013: 72).

[15] Similarly complaints are 'worked up' in institutional complaining contexts, even where the function of complaining should be a given.

The concept of Patient Centred Care (PCC) is a well-meaning policy initiative seeking patients to be partners in healthcare, but its principles may, as Ojwang and Sowinska highlight elsewhere in this volume, find themselves compromised by competing contextual demands such as – in examples in our own data - an institutional orientation to 'being neutral'. Our small study suggests that local complaint handling might benefit from drawing upon discursive approaches by using authentic interactions in training interventions for both new and established complaints handlers not dissimilar to that advocated by Stokoe (2014). The use of authentic data, such as that examined in this paper, is likely to highlight the key role of conversational affiliation by complaints handlers in their receipt of complaints, the importance, from the outset, of affirming the legitimacy and moral rights of the complainer, and the emotions that attend their complaint.

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