NHS Complaints Managers:
A Study of the Conflicts and Tensions in their Role

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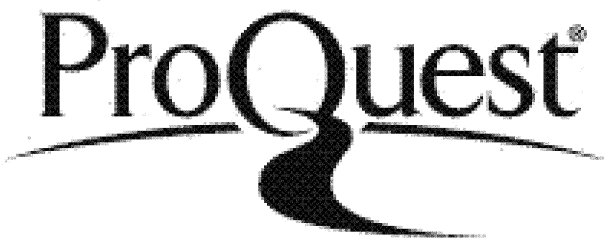

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Clare Xanthos
1st October 2003

Abstract

This thesis is an interdisciplinary study of the conflicts and tensions in the role of NHS complaints managers. The thesis sets out to explore the contradictions inherent in the role of complaints managers and the ways complaints managers deal with these contradictions.

The interdisciplinary theoretical underpinning of the research is informed by conceptualizations of the complaints manager in the specific socio-legal sense of 'complaints handler'/ third-party dispute handler;' a broader public administration framework, of 'administrator'/ bureaucrat, and finally a wide-ranging sociological/ social psychological framework, as 'social actor'. Thus the thesis draws on an eclectic range of literature from socio-legal studies, public administration, sociology, and social psychology. It also draws on non-theoretical social policy literature in relation to the policy context of the thesis.

In relation to methodology, the research uses a qualitative approach. It is based on in depth telephone interviews recorded with thirty NHS complaints managers, which were transcribed verbatim and are the focus of systematic analysis. The complaints managers' interviews are supplemented with documentary analysis of job descriptions and person specifications of NHS complaints managers and email interviews with 'NHS complaints experts' (who are not complaint managers) who have a specialist knowledge of the complaints manager role.

Three key areas emerged as the principal findings of the research:

- The complaints manager's role encompasses inherent contradictions, regardless of the personal style or individual approach of the complaints manager;

- Complaints managers exhibited opposing stances (that is very different responses/ reactions) to the inherent contradictions in their role in relation to 'organization orientation' versus 'complainant orientation';

- There were different types of complaints managers. Accordingly, a typology of complaints managers was generated with specific reference to their responses and reactions to the inherent contradictions in their role, in terms of complainant orientation versus organization orientation.

In conclusion, the thesis argues that there are without doubt fundamental contradictions in the role of NHS complaints managers in terms of reconciling complainants' rights with organizational requirements. However, ultimately, *individual* complaints managers respond and react very differently to the inherent contradictions in their role.

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My greatest thanks are reserved for my mother, Frances, for her continuous emotional support, her belief in me, and the financial sacrifices she has made to enable me to complete this thesis, which is dedicated to her.

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Introduction

This thesis is a study of the conflicts and tensions in the role of NHS Complaints Managers. Complaints managers are faced with a fundamental contradiction: as employees of the complained about organization, how do complaints managers impartially oversee a complaint about it? How do they balance their duty to complainants against organizational loyalty/ organizational constraints? (See Simons 1995; Mulcahy and Lloyd-Bostock 1994). It could be argued that balancing these conflicting obligations entails encountering an inherent contradiction or inbuilt conflict in the role of the NHS complaints manager.[1] These inbuilt contradictions or conflicts may or may not result in the complaints manager experiencing *tensions* as shown in the course of this thesis.[2] However, it could be argued that *working through these contradictions* is an essential part of the complaints manager's experience. In short, this thesis is about the inherent contradictions in the post of the NHS complaints manager and how the complaints manager responds and reacts to these contradictions.

The importance of the role of the NHS complaints manager in a policy context

Complaints about health care are a fundamental aspect of medical accountability; in any democratic society, there needs to be a system where the public can seek redress for their grievances (See Longley 1993: 67). Also complaints procedures are used by the majority of aggrieved citizens as opposed to legal and quasi-judicial systems used by relatively few (Leabeater and Mulcahy 1996: 1). Additionally the effectiveness of the NHS complaints procedures is particularly important because as a public service

[1] This contradiction or conflict primarily manifests itself in NHS Trusts in terms of a conflict between organizational loyalty and duty to complainants and in NHS health authorities as a conflict between organizational constraints and duty to complainants although there is some overlap between the two sources of conflict.

[2] For the purpose of this thesis, *conflict* or *contradictions* will considered as a distinct construct from from *tensions*. Thus, while conflict or contradictions refers to the *situation confronting complaints managers*, tensions, refers to a possible *response/ reaction to the conflict/ contradictions*.

the NHS is in a monopoly position and health care consumers rarely have the opportunity of exiting the service (Allsop and Mulcahy 1998a: 170).

The role of the complaints manager is especially important; the complaints manager is a key player in the NHS complaints procedure as complaints managers are the staff group with the most comprehensive overview of the operation of the complaints procedure (Department of Health 2001a: 39). NHS complaints managers are of particular significance because they oversee the administrative decision-making process at the initial stage of the complaints procedure in which the vast majority of complaints are dealt with; the second stage of complaint handling involves very few numbers of complaints and unlike the complaints handlers in the second stage,[3] complaints managers are the only official complaints handling staff that are employed by the complained about organization. Administrative law scholar, Martin Partington (1999: 541-542) argues that the focus of good administrative justice should be on this initial stage of complaints management. He reasons that if complaint handling at this point is satisfactory, the need for further appeal and review might be diminished. In a similar vein, the Department of Health (2001a) observes that a complaint can be escalated and positions entrenched by poor initial handling by frontline staff or managers (2001a: 23). According to the Department of Health (2001a), one of the most common characteristics of long-drawn-out cases is the failure to deal satisfactorily with the complaint at the outset. The Department of Health states that poor initial handling of a complaint often makes the situation significantly worse, adding to the distress of complainants and to the costs of the procedure (2001a: 25). This appears to be a problem particularly where a complaint involves bereavement or other serious incident (2001a: 30). The Department of Health suggests that poor handling of complaints in the critical first few days might increase claims for medical negligence (2001a: 26).

Accordingly it has been argued that a complaint handled well can prevent complaints escalating into legal claims (Nicol 1999: 243). A speedy and sensitive response to a complaint can frequently settle a problem so that issues are not pursued through the

[3] 'Complaints handlers' at the second stage of the complaints procedure would include a convener, a lay chair, and an additional nominated person. In addition clinical assessors may be appointed depending on the case. See Chapter Two of the thesis.

more formal mechanisms generating rising costs and adding dissatisfaction *with the complaints process* to the original cause of the complaint (See Allsop and Mulcahy 1999: 124; Lloyd-Bostock 1999: 109); satisfactory management of complaints can avoid significant expense and distress on all sides (Lloyd-Bostock 1999: 122). In short, NHS Complaints managers have an important role to play; indeed, the way complaints are handled could well have a major impact on the public image of the NHS.

In the remainder of this Introduction I will explore the aim of thesis, the scope of the thesis, the contribution of the thesis and the structure of the thesis.

The Aim of the Thesis

The aim of the thesis was to explore three propositions which (in combination) consider the 'conflicts and tensions in the NHS complaints managers role'. The first proposition is that *there is an inherent contradiction in the role of the NHS complaints manager* due to the likelihood that complaints managers are caught between their duty to complainants and their loyalty to the organization/ organizational constraints. In terms of pressure coming from the organization, it is well documented that medical staff and health service managers tend to respond defensively to complaints (For example, see Lloyd-Bostock 1992: 219; Bristol Royal Infirmary Inquiry 2001: 272). Lloyd-Bostock's (1992: 213) study of hospital complaints procedures found that the defensive way in which complaints were responded to by the hospital indicated that hospital administrators[4] tended to think of complaints as: 'some kind of mini claim', which had a detrimental effect on their relationship with the complainant. Lloyd-Bostock and Mulcahy (1994) suggest:

> Responding to hospital complaints is felt to be a difficult and often unwelcome task ... even in those cases where the hospital feels that a complaint is totally unjustified, understanding of the complainant's perspective and wishes may nonetheless help the organization to respond to

[4] Comparable to complaints managers.

> complaints in ways that will maximize the complainant's satisfaction and avoid aggravating his or her sense of grievance (1994: 142).

In short, complaints managers operate in an environment which is often defensive towards complainants at the same time as having a duty to complainants to handle complaints impartially. It could be argued that these inconsistencies lead to an inherent contradiction in the role.

The second proposition is that complaints managers will *exhibit different or opposing responses/ reactions to the contradictions experienced in their role,* which may be indicative of tensions for the complaints managers concerned. Thus, it was important to understand complaints managers' responses or reactions to the inherent contradictions in their role. It was decided to explore this idea by analyzing complaints managers' behaviour, attitudes and emotions with reference to organizational loyalty/ adhering to organizational constraints (instances where complaints managers showed organizational orientation) and with reference to duty to complainants (occasions where complaints managers showed complainant orientation). It is possible to speculate that an orientation towards impartial complaints handling with a regard for complainants' interests is likely to cause tension for the in-house complaints manager in an organization, which may be biased against complainants, as this stance would conflict with organizational norms.

Finally, the third proposition was that there would be *different types of complaints managers* in terms of their responses and reactions to the inherent contradictions in their role.

These propositions are supported by theoretical and empirical literature on complaints handlers, administrators and social actors drawn from a number of social science disciplines including socio-legal studies, public administration and sociology.[5]

[5] Public administration literature included a significant amount of 'administrative ethics' literature which is a branch of the broader public administration literature. See Chapter One of the thesis.

The methodological approach adopted for the research

This is a study about *social actors* as opposed to a *system*; while complaints managers are actors, complaints procedures represents a system. In relation to the first proposition outlined above (that there were inherent contradictions in the role of the complaints manager), I wanted to provide an account, which demonstrated the inherent contradictions in the complaints managers' role in intricate detail, which highlighted the complex position of the complaints manager. In relation to the second proposition (complaints managers' responses or reactions to the inherent contradictions in their role), I wanted to explore the complexity of complaints managers' behaviour, attitudes and emotions in relation to complainants and the organization complained about. Essentially, how do complaints managers cope with the conflict between organizational loyalty and duty to complainants; how do they handle the conflict between organizational constraints and duty to complainants? Responses and reactions to their role illustrated by complaints managers' behaviour, attitudes and emotions were a key aspect of the thesis. The third proposition (types of complaints manager) also involved exploring behaviour, attitudes and emotions. Because of the focus on behaviour, attitudes and emotions, it could be argued that qualitative interviews would be especially suited to exploring these propositions. As Rubin and Rubin (1995:1) point out:

> Qualitative interviewing is a way of finding out what others feel and think about their worlds. Through qualitative interviews you can understand experiences and reconstruct events in which you did not participate.

In-depth telephone interviews were carried out over a two-month period (July and August 1999) with thirty NHS complaints managers. In addition, email interviews were carried out with 'complaints experts' as a means of further validating the complaints managers' interviews. Finally, it was necessary to assess the structural/objective constraints placed on managers and to relate those to the discourses of managers produced through interviews. This was achieved through the

documentary analysis of complaint managers' job descriptions and person specifications.[6]

The Scope of the Thesis

As indicated above, the literature used in this thesis is eclectic. Because this is an interdisciplinary thesis based on the work on a number of disciplines, it is particularly important to make clear the boundaries of the subject areas of the thesis. Due to the wide scope of subjects covered in some of the disciplines reviewed, it was necessary to be selective in my review of the concepts, models and theories used in this study. I have deliberately chosen to confine the literature to that which is manageable, useful and had the greatest opportunity of producing original insights into the conflicts and tensions experienced by the NHS complaints manager. This selective review of the literature does not invalidate other conceptual frameworks, which can be investigated by other researchers.[7]

Additionally, it is necessary to appreciate that the thesis touches on certain issues which are not the focus of the thesis. For example, in relation to the issue of discretion, findings have indicated that the status of the complaints manager has a bearing on what a complaint manager can do, and thus their level of discretion in terms of their duty to complainants. However, the focus of the thesis is on *conflicts and tensions* in the complaints manager role rather than the amount of discretion in the role. Accordingly, I do not attempt to use the literature on discretion as a framework for analyzing conflicts and tensions in the complaints manager's role as this would be beyond the scope of the thesis; although the issue of discretion is alluded to, the thesis is not about discretion or decision-making. Neither is the focus

[6] See Chapter Three of the thesis for a full account of the methods used in this study.

[7] Indeed, it could be argued that the situation of the individual caught in the middle of two competing demands (in this case the complaints manager caught between the organization and the complainant) is a universal phenomenon in social life. Thus a number of conceptual frameworks drawn from the social sciences could arguably be used to make sense of this phenomenon in a whole range of disciplines, for example, social work, nursing research, management literature, organizational psychology, occupational sociology, human relations literature.

of the thesis on the job stress experienced by complaints managers although, this too, is alluded to in the findings.

Finally, it is necessary to distinguish between research on *complaints/ complaints systems* for which there is little in-depth theoretical or empirical work (see Mulcahy 1996 *et al*: ix) and *complaints handlers* where existing literature is even more limited. Thus there was the necessity to find a suitable conceptual framework (s) for the *complaints handler* as opposed to *complaints/ complaints system*. Because there were not any adequate frameworks in complaints literature for understanding the conflicts and tensions of *complaints handlers* (the subject of the thesis), it was necessary to explore frameworks *outside 'complaints' literature*; indeed outside of socio-legal studies (the traditional discipline relating to much of complaints literature). Hence, although this thesis is an obvious contribution to the literature on the NHS complaints procedures and the wider complaints literature, the conceptual framework draws from outside this area to a significant extent.

The Contribution of the Thesis[8]

Contribution to the literature on the NHS complaints procedures and the broader complaints literature

As referred to above, in their bibliography of the literature on public sector complaints, Mulcahy *et al* argue (1996: ix) that there is little in-depth theoretical or empirical work, which specifically focuses on complaints as a matter of academic interest (1996: ix). Thus specific references to complaints handling in the NHS are restricted to mainly professional literature in practitioner journals and policy documents; academic theoretical literature and/ or academic empirical literature on complaints in the NHS is limited. In particular a key shortcoming of the academic literature has been the scarcity of both theoretical and empirical work on the role of *complaints handlers* in relation to health service complaints, especially on the

[8] This section explores the contribution of the study in general terms and differs from the section on the research contribution in the Conclusion (Chapter Seven of the thesis), which considers specific aspects of the findings in terms of their contribution for researchers and policy makers.

conflicts in the role played by organization complaint handlers (See Mulcahy *et al* 1996: xi); we do not yet have a satisfactory explanation of health service complaints handlers, or indeed complaint handlers in general which specifically explores the conflicts and tensions in their role. Indeed, this has been identified as an area, which needs in-depth exploration (Mulcahy *et al* 1996: xi). Mulcahy *et al* (1996: xi) observe that across all disciplines there is a lack of detailed analysis of the roles played by low-level dispute-handlers in public sector organizations, in particular, the conflicts and tensions in the role of complaint handlers:

> ... little account has been taken of the tensions experienced by complaint-handlers created by factors such as prevailing ideologies, socio-political context, public relations needs, budgetary constraints, requirement of efficiency, professional and managerial culture, promotion prospects, preferences of colleagues and workplace politics. The extent to which these concerns marry or conflict with individual characteristics of actors and their personal morality also needs exploring.

Table 1.1 Comparable studies relating to complaints handlers and third-party dispute handlers

Author		Title
Mulcahy and Lloyd-Bostock	1994	Managers as Third-Party Dispute Handlers in Complaints about Hospitals in *Law and Policy* (journal)
Kolb	1987	Corporate ombudsmen and organizational conflict resolution in *Journal of Conflict Resolution* (journal)
Klein	1973	*Complaints Against Doctors. A Study in Professional Accountability* (Book)
Simons	1995	*'I'm not Complaining But ...' Complaints Procedures in Social Services Departments* (Book)

This study differs crucially from the most comparable study on hospital managers as third-party dispute handlers (Mulcahy and Lloyd-Bostock 1994) in that this thesis provides a detailed, analytical account of the *conflicts and tensions* in the complaints handlers' role, which is not the focus of Mulcahy and Lloyd Bostock's study.[9] In terms of other relevant studies, neither Rudolf Klein's (1973) nor Ken Simons' study (1995) make complaint handlers the central focus of their research. Deborah Kolb's

[9] See Chapter One of the thesis for a review of these studies. See also the Conclusion (Chapter Seven of the thesis).

(1987) study focuses on ombudsmen, which while comparable to complaints handlers were not complaint handlers in terms of complaints made by the public. While these comparable studies *touch* on some of the themes of the thesis, they lack the systematic in-depth analysis provided by this thesis. Where there are parallel ideas from previous work, this study develops, adapts and refines these ideas. For example, in the aforementioned study on managers as third-party dispute handlers, Mulcahy and Lloyd-Bostock (1994: 190) draw attention to the notion that third-party roles within the organization being complained about are characterized by 'inherent tensions' in trying to promote the interests of the organization whilst dealing impartially with a dispute about it. In a similar vein Klein (1973: 136-137) found that to a certain extent Clerks and their staffs (complaint handlers) had conflicting roles. This thesis has substantially built on this theme of inherent tensions and conflicting roles.

Accordingly, there is a gap in the literature which it is the intention of this study to fill, by exploring the conflicts and tensions in the role of the NHS complaints manager. Thus the thesis is a contribution to the academic theoretically informed empirical literature on the NHS complaints procedure in particular and also on the complaints literature in general.

Contribution to sociological literature

A case could be made that the theme of conflicts and tensions of in-house complaints handlers is an important *sociological* concept that has been hitherto ignored in sociological literature. It could be argued that the theme of role conflict in terms of inherent contradictions in a role and responses/ reactions to contradictions in roles is prevalent in social science literature although the terminology used may differ in different disciplines. As suggested by Berger and Luckmann (1967: 91) roles 'are an essential ingredient of the objectively available world of any society.' Kahn *et al* (1964: 3) state that conflict and ambiguity are among the major characteristics of our society. Accordingly it could be argued that the conflicts and tensions of the NHS complaints managers in this study are a microcosm of the conflicts and tensions

experienced by social actors in society and as such this analysis is a contribution to the existing sociological literature on role conflict and roles in society.

Innovation in research methodology

This study shows innovation in research methodology compared with previous practice in the field. First, this is one of the very few academic studies relating to the NHS complaints procedures in which qualitative interviews are the primary source of data. Previous studies have relied heavily on complaints correspondence and complaints files (Lloyd-Bostock 1992; Lloyd-Bostock and Mulcahy 1994; Mulcahy and Lloyd-Bostock 1994; Allsop 1994; Nettleton and Harding 1992). Where qualitative interviews have been used, they have typically been combined with large-scale surveys (See Mulcahy 1996). The only other British study that makes use of qualitative interviews as a primary source of data is Jain and Ogden's (1999) study of GPs' responses to complaints.

Thus, it could be argued that more 'pure' qualitative research is needed on the NHS complaints procedure, i.e. studies where qualitative research is the primary source of data. In a sense, the need for more qualitative research is two fold. With reference to the NHS, health care deals with people and there is a whole set of questions about human interaction which points to a qualitative rather than a quantitative approach (See Pope and Mays 2000: 4). With reference to complaints literature, the study of complaints is a complex and sensitive topic, which also indicates the need for a qualitative approach. Ken Simons (1995: 15) has made the point that complaints research is almost certainly going to be a sensitive issue for the authorities concerned. For example, Simons notes:

> The research has a built-in bias. It deals only with situations where something, at some stage, has gone wrong; it does not even begin to look at the things the Department got right.

Thus the *combination* of health care and complaints is likely to relate to highly emotive subjects. As one respondent remarked:

> In the NHS, health is such a very personal matter ... and so people do get extremely agitated really quickly.

Given that health care complaints is such a sensitive topic, it could be argued that it should be explored in studies that probe more profoundly into the experiences of the various actors in the complaints process, namely qualitative research. Indeed, Klein (1973: 130) acknowledges that some statistics obtained relating to (complaints clerks) views in his Clerks survey did not:

> ... Reveal either the subtlety of the situation or the finer shades of meaning conveyed in the comments of the Clerks. Some of these made it clear that they thought they were being asked to give simple answers to what were complex questions.

In short, 'pure' qualitative research on the British health service complaints system is especially limited. Accordingly, this study endeavours to contribute to the literature in terms of filling this 'methodological gap.' A strong point of this study is the richness of data collected from the interviews.

Second, the main source of data collection utilizes an innovative method of social research: qualitative telephone interviews. I consider that the use of telephone interviews was a strength, in terms of the sensitive nature of complaints research. Telephone interviews have been noted for the evidence of smaller interviewer effects on responses (See Frey 1983: 47 and Chapter Three of the thesis). As indicated above, complaints research is particularly sensitive. The interviews explored in-depth issues (previously uncovered) on NHS complaints handlers' behaviour, attitudes and emotions. The sensitivity issues described above are particularly pertinent with regard to the organization's complaint handlers, as it could be argued that the complaint handler would be expected to show loyalty to the organization complained about. In this study, some questions were particularly sensitive in that they required complaints managers to discuss conflicts, which may have occurred with members of their organizations. In short, the challenging nature of this research provided an opportunity to employ qualitative telephone interviews as the primary source of data, showing innovation in research methodology.

Contribution to the policy context

As far as the writer is aware, this is the first study of NHS complaints handlers in the post 1996 complaints system.[10] In addition, the designated post of complaints manager became a standard role in the post 1996 complaints procedures. The NHS Executive (1996:10-11) stated that each Trust/ Health Authority must have a designated complaints manager, readily accessible to the public. Complaints managers were established to fulfill the role of 'complaints officer' detailed by the Wilson Committee (Department of Health 1994: 52; Department of Health 2001a: 47); the prime role of the complaints manager was to oversee the complaints procedure.[11] Thus, from a policy perspective, the research is particularly important as it looks at the functioning of a relatively new post. Additionally, in focusing on complaints handlers, the research throws light on an area which has been given little consideration by practitioners or policy makers;[12] policy literature relating to NHS complaints tends to focus on complaints systems rather than complaints handlers. Moreover, the research raises important policy issues relating to the impartiality and neutrality of a paid official when attempting to resolve a complaint against the employing institution.

An innovative conceptual framework

This study differs conceptually from previous comparable work in so far as this is very likely to be the first study on NHS complaints handlers to draw from *three* social science disciplines, and as far as the author is aware, the first study on complaints handlers per se to draw from three social science disciplines. This study

[10] The NHS complaints system was reformed in 1996 (and later in 2003).

[11] Prior to 1996, hospital complaints were supposed to be handled by a designated officer but in practice, were often handled by a number of different staff other than the designated officer (Longley 1992: 22; Nettleton and Harding 1994: 43).

[12] Also see the earlier section in this chapter on the importance of the role of the NHS complaints manager in a policy context.

conceptualizes complaints managers using socio-legal, public administration[13] and sociological perspectives;[14] former studies are much narrower in their focus. For example, although the managers handling complaints are important legal actors as argued by Mulcahy and Lloyd-Bostock (1994: 185), it could be argued that the confinement of this analysis to a 'legal' perspective is restrictive. Managers handling complaints are also important *administrative actors* and important *social actors*. Thus, it follows that a purely socio-legal approach would not adequately explain the range of behaviour, attitudes and emotions expressed by complaints managers in responding to the contradictions in their role; it does not adequately conceptualize the *tensions* (strain, pressure) possibly caused by the conflict or contradictions in the role. Neither would it explain the contradiction inherent in the role adequately (administrative ethics literature in particular is a useful additional framework for exploring the inherent contradiction in the NHS complaint manager's role). Thus in my view the existing 'socio-legal' literature on complaint handlers and third-party dispute handlers does not provide an adequate framework for exploring the conflicts and tensions in the role of complaints handlers.[15]

Drawing from public administration and administrative ethics concepts such as 'organizational loyalty' and from sociology, theories of 'responses/reactions to role conflict,' it was possible to generate an in-depth, all-encompassing account of the conflicts and tensions in the complaints manager's role. In this way it was possible to 'deconstruct' the role of the complaints manager in order to fully understand the role played by these actors in the complaints system. This approach is in keeping with Mashaw's proposition in *Bureaucratic Justice: Managing Social Security Disability Claims* (1983: ix) of integrating administrative law and organizational theory. Kagan describes this proposition as the need to merge administrative law with the disciplines of administrative science and organizational behaviour in order to develop appropriate principles to govern the behaviour of lower-level administrators (Kagan 1984: 828). According to Kagan, administrative law needs to develop a framework, which

[13] Including administrative ethics (a branch of public administration).

[14] Including social psychology.

[15] On the other hand, the socio-legal framework was useful for explaining the *contradictions (conflicts/ inconsistencies)* in the complaints managers' role.

incorporates bureaucratic principles and the realities of organizational life (Kagan 1984: 816). In a similar way, this study's synchronization of disciplines (broadly socio-legal studies, public administration and sociology) is an attempt to capture the complexity of the complaint handler's role.

Additionally, I have made use of a typology to further interpret the findings of the empirical research. The typology of complaints managers generated in this study differs substantially from the typologies in previous relevant studies in that the typology draws from public administration literature. The existing comparable studies focus largely on 'legal' typologies, which while appropriate for the studies in question were not adequate for this study in terms of the conflicts and tensions of the complaints handler. As argued earlier, a purely legal framework does not provide an adequate account of the conflicts and tensions in the NHS complaints manager's role.

In short, in searching for an all-encompassing conceptualization of the conflicts and tensions in the role of in-house complaints handlers, I have employed applicable concepts, models and theories from a number of disciplines. Accordingly, a contribution of this study is that it draws on a wide range of social science disciplines to provide a multifaceted analysis of the role of the complaint handler in the NHS as well as in-house public sector complaints handlers in general.

The Structure of the Thesis

Chapter One sets out an interdisciplinary conceptual framework for the thesis, which comprises three core themes, consistent with the three propositions outlined earlier:

- The inherent contradictions in the role of complaint handlers;[16]
- complaint handlers' possible responses/ reactions to the inherent contradictions in their role;

[16] The term *complaint handler* as opposed to *complaints manager* is used in Chapter One of the thesis to reflect the conceptual nature of the chapter.

- applicable typologies for understanding complaints handlers' responses/ reactions to the inherent contradictions in their role.

This chapter also draws on relevant empirical studies, exploring four comparable studies in depth. NHS complaints managers are referred to as 'complaints managers' as opposed to 'complaints handlers' from Chapter Two onwards.

Chapter Two places the study in its policy context. It looks at the impact of medical self-regulation on the complaints system, sets out the NHS complaints procedure at the time of the study;[17] and provides an analysis of the key problems of the current complaints system.

Chapter Three describes the methods adopted for this study. The chapter begins with a reiteration of the conceptual framework and states the research questions. The qualitative approach adopted is then discussed. This is followed by an account of the research process relating to the complaints manager interviews (sampling, data collection and data analysis). The other methods of data collection are described next (the content analysis of complaints managers' job descriptions and person specifications and the 'complaints experts' interviews). The chapter ends with a consideration of the methods used.

Chapters Four to Six present the findings of the study. Chapter Four demonstrates that there are inherent contradictions in the NHS complaints manager's role. It begins with an account of the complaints manager's role drawing from job descriptions and person specifications. It then systematically explores the inherent contradictions in the complaints manager's role with reference in broad terms to the limits of the complaints managers impartiality; and specifically relating to negotiating with staff in relation to complaints investigations in trusts; the complexity of mental health cases in trusts; constraints to investigating practice (primary care) complaints; constraints to being proactive in using complaints to improve service quality; and withholding information from complainants.

[17] Changes were taking place in national policy even as this research was being completed.

Chapter Five considers NHS complaints managers' *responses/ reactions* to the inherent contradictions in their role with reference to key conflict variables in terms of organizational versus complainant orientation. It was shown that complaints managers exhibited opposing stances on all the 'conflict variables,' that is, issues, explored. Essentially, on all issues, complaints managers demonstrated opposing standpoints in terms of organizational orientation and complainant orientation. The following issues were considered: advising/ supporting complainants; investigating complaints in trusts; 'unjustified' complaints; being proactive in using complaints to improve quality of services; fairness and justice in the complaints system; mental health cases; withholding information from complainants; and emotional reactions to complainants and complained against staff.

By exploring the interrelations between organization oriented stances and complainant oriented stances, combining different standpoints, and drawing from the public administration typologies described in Chapter One, a typology of complaints managers' responses and reactions to the inherent contradictions in their role was generated. Chapter Six presents this typology of five types of complaints managers. These were the 'institutionalized person', accommodators (complainant oriented accommodator and indifferent accommodator), the 'split personality,' and the reformer'.

Chapter Seven, the Conclusion to the thesis, provides an overview of the research. It then considers the limitations of the study and makes suggestions for further research. This is followed by setting out the research contribution in terms of the implications of the research for researchers and finally the research contribution in terms of the implications of the research for policy makers.

Chapter One: An Interdisciplinary Framework for Studying the Role of the NHS Complaints Manager

Introduction

This chapter sets out an interdisciplinary conceptual framework for the thesis, which comprises three core themes, drawing from a number of social science disciplines. These are:

- Theme One: the exploration of the inherent contradictions/conflicts in the role of complaint handlers, which draws from (a) socio-legal studies and administrative law; (b) public administration, administrative ethics, and sociology relating to the study of bureaucracy; and (c) sociology.
- Theme Two: complaints handlers' possible *responses and reactions* to these inherent contradictions/conflicts in their role, which draws from (a) socio-legal studies; (b) public administration, administrative ethics, and sociology relating to the study of bureaucracy; and (c) sociology relating to role conflict, and social psychology.
- Theme Three: *typologies* of organizational actors *responses and reactions* to the contradictions or conflicts inherent in the organizational situation, which draws from public administration typologies.

In addition, I draw on a number of relevant empirical studies, exploring in depth, four key empirical studies.

With reference to the interdisciplinary framework, it could be argued that the socio-legal analysis provides a framework for understanding the role of the NHS complaints manager in terms of *complaints handler* or *third-party dispute handler*. The limited literature relating to complaints handlers (Klein, 1973; Kolb, 1987; Mulcahy and Lloyd-Bostock, 1994; and Simons 1995) has required that I also utilize the relevant work on third-party dispute handlers, and a broader area of work discussing the impartiality and independence of complaints systems. Secondly, it could be argued that the public administration literature provides a framework for examining the NHS complaints manager's role in the broader sense of an *administrator* employed in a

public service. Thirdly, by drawing from role theory, the concept of sociological ambivalence, and just world theory (social psychology), the complaints manager can also be considered in the all-encompassing conception as *social actor*.

Theme One: A Socio-Legal Framework for Understanding the Inherent Contradictions in the Role of In-House Complaints Handlers

A socio-legal framework for understanding the inherent contradictions in the role of complaint handlers needs to pay particular attention to the issues of impartiality and independence, since these issues are at the heart of the contradictions in the complaint handler's role. On the one hand, these goals are considered to be important objectives in any complaints system; in theory, complaints handlers and third-party dispute handlers are expected to deal impartially with a dispute, and they are expected to be independent. Mulcahy and Lloyd-Bostock (1994: 198) point out that an essential characteristic of both arbitration and adjudication is that an independent third party whose interests are not related to either of the parties hears the dispute. They state:

> A much-quoted principle concerning the application of administrative justice is that those processing complaints should be independent and impartial and that independence must be manifest and undoubted rather than purely formal. This can be seen as a refinement of the rule of natural justice against bias. Part of the rationale behind this requirement is that it is only by demonstrating independence that providers will be able to engender public confidence (Mulcahy and Lloyd –Bostock 1994: 190).

On the other hand, the arguments presented in this section suggest that impartiality and independence are not manifest. A number of commentators have questioned the impartiality of third-party dispute handlers. Laura Nader in particular (1980:30) holds a sceptical view of the impartiality of the third-party complaint handler. She argues that without the law as a back up, third-party complaint handlers are of limited use; she makes the case that *if the party resolving the case is also the party being complained against*, the odds of the complainant achieving success are small (Nader 1980: 30). Also, in their paper, 'Towards a Theory of the Third Party', Donald Black and Mary Baumgartner (1983: 85) state that many third parties who claim to be neutral in a conflict are actually biased in favour of one side or the other. More

recently, Linda Mulcahy (2001) discusses the question of whether the neutrality of mediators[1] is possible. Mulcahy contends that the concept of neutrality as illustrated in adjudication and mediation literature is not an empirical possibility (2001: 506), and that inequality is pervasive, existing in all disputes and interactions to some degree (2001: 523). She notes that mediators frequently revealed their bias to particular disputants, outcomes, or normative frameworks (2001: 514).

In particular, employees of a complained about organization may have little chance of being unbiased due to the limits of their impartiality in in-house complaints systems. In other words, the position of the complaints handler is made particularly difficult if the complaints system lacks independence, as invariably there could be doubts that working in the complained about organization might cause professional loyalties to override fair play (See DoH 1994: 49). It could thus be argued that while in-house complaints systems may pay lip service to the language of impartiality and independence, in practice impartiality and independence may be highly unlikely. In turn, it could be argued that *paying lip service to the rhetoric of impartiality in a system that lacks impartiality produces inherent contradictions or conflicts for the complaint handlers operating the system.*

The limits of impartiality of in-house complaints systems

This section focuses on the particular issues of impartiality and independence relating to in-house complaints systems, where the complaint handler is a member of the organization being complained about. It is argued that there are fundamental problems concerning the impartiality and independence of in-house complaints systems; a number of authors indicate that the situation whereby *complaint handlers are employed in the complained about organization* may result in complaints handlers placing the organizational agenda before fairness and justice to the complainant.

In broad terms, Nader and Shugart (1980) emphasize the importance of complaints handlers being independent from 'sellers', that is, the organization being complained about. They argue that without independence from sellers, third-party handlers are in

[1] A mediator is a type of third party dispute handler.

effect 'crippled' (1980: 75). In a similar vein, Black (1989:16) notes that 'intimacy' to one party causes partisanship as either side of the case typically benefited from having a close associate as the third party. This could be argued to be the case with NHS complaints managers; as employees of the complained about organization, they, as third party, are closer to one side, i.e. the organization. Black points out that judges and jurors normally disqualified themselves if they were a close associate of one of the disputing parties (1989: 16). He uses the example of police officers to illustrate what may transpire when a third party is a close associate of one of the disputing parties:

> ... a citizen bringing a criminal complaint against a police officer typically finds that the officer's colleagues side with their colleague from the beginning and rarely even pretend to be impartial (Black 1989: 17).

In the context of the United States, administrative law scholar, Walter Gelhorn (1966) was concerned about the impartiality and independence of those employed by the 'complained about' organization, stating:

> Only when an impartial mind examines the matter complained about can the complainant's doubtings be dispelled (1966: 140-1).

> ... nobody outside the administration is likely to see the file materials and thus be able to judge for himself whether the story has been fully and fairly told (1966: 140).

Consequently, for Gelhorn (1966: 218), self-policing was ill advised:

> Self-policing, highly valuable though it be for managerial purposes, will never be a wholly accepted means of redressing errors so long as administrative heads may veil their own or their subordinates' discovered blunders in order to avoid possible embarrassment.

With particular reference to public sector complaints systems, A UK legal scholar Lawrence Lustgarten (1986: 146-7) argues that there is no successful model of complaints procedures at any level of British Government. This is particularly true in the case of the police where he pointed out that complaints about police misconduct are not always investigated thoroughly and impartially. He commented:

> In 1984, 8 percent of all complaints actually investigated were held to be substantiated ... Either those who do bother to complain are all liars, or there is something wrong with the system (1986: 154).

Equally, in their review of complaints and redress procedures in public services, Leabeater and Mulcahy (1996: 38) contend that internal complaints procedures can never be fully independent or impartial. While an independent element might be present at a later stage, *the complaints handler in the **first stage** is always an employee of the complained about organization.*[2] They recommended introducing an independent element into the first stage.

In the specific context of the NHS, the Department of Health report *Being Heard* (1994: 49) has referred to the doubts about the impartiality of employees of the complained about organization. Indeed, policy and organizational development consultant, Fedelmer Winkler (1987: 6) suggests that most complaints systems are in reality, systems to protect the doctors and the institution. She argues that independent, outside members who are not colleagues of those under criticism are an essential component of any good complaints system. Correspondingly, in the book, *Who Cares About the Health Victim?* John Elder (1998: 162 - 165) considers that the key flaw of the post 1996 NHS complaints procedures[3] was the use of internal complaints investigations. He recommends a statutory, independent health complaints body. In his 1998 study, Elder (1998: 43) emphasizes that the most powerful message coming from patient support agencies and complainants (respondents in his study) was the question mark against the impartiality of the NHS complaints procedure as a whole.

In short, it could be argued that *engaging in the rhetoric of impartiality in a system that lacks impartiality produces contradictions for the complaint handlers operating*

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[2] This is the case with the NHS complaints manager in the first stage of the current NHS complaints procedure (*local resolution).* See Chapter Two and Chapter Four of the thesis.

[3] The post 1996 complaints procedures refers to the current system, i.e the system under which this study was conducted.

the system.[4] In-house complaint handlers are faced with a conflict of interest, namely, allegiances to the complained about organization, *and* a duty to the complainant.

Theme One: A Public Administration Framework for Understanding the Inherent Contradictions in the Role of In-House Complaints Handlers

As well as being *complaints handlers*, complaints managers are employees of bureaucracies. Thus, the complaints manager role can also be explored from a public administration perspective, in terms of an *administrator* or *street-level bureaucrat*[5] *working in a public sector organization.* Accordingly, the concept of *administrator* and/ or *street-level bureaucrat* provides another context for looking at how complaints managers might experience contradictions or conflicts in their role. In other words, the literature on bureaucrats/ administrators is equally applicable to complaint handlers and is of direct relevance to the conception of inherent contradictions in the complaints handler's role. From this standpoint, the *organizational agenda (in terms of organizational loyalty and organizational constraints) versus duty to the public* could be argued to be a key facet of the contradictions or conflicts faced by the NHS complaints manager.

In the following subsection on the organizational agenda versus duty to the public, I draw from the work of authors, which point to the inherent contradictions in the role of public administrators. In the two subsequent subsections, I consider in greater depth first, the predominance of the organizational agenda, and second, the notion of duty to the public/ taking a moral stance.

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[4] See Chapter Two of the thesis for an analysis of the limits of impartiality in the NHS complaints procedures.

[5] 'Street-level bureaucracy' relates to the position of the individual in public services such as schools, police, welfare departments, and other agencies whose workers interact with and have wide discretion over the dispensation of benefits or the allocation of public sanctions (Lipsky 1980: xi). Lipsky's study, *Street-Level Bureaucracy - Dilemmas of the Individual in Public Services*, seeks to understand how and why public organizations often perform contrary to their own rules and goals, by exploring how the rules are experienced by workers in the organization, and what other pressures they are subject to (1980: xi).

The organizational agenda versus duty to the public

This section demonstrates how the organizational agenda versus duty to the public cause contradictions or conflicts in the role of public administrators. In the book, *The Responsible Administrator,* administrative ethics specialist, Terry Cooper uses the concept of 'conflicts of authority' to explain conflicts between two or more objective responsibilities imposed upon us by two or more sources of authority, such as organizational supervisors and the public (1990: 85). Cooper (1990: 85) reasons that the imposition of dual responsibilities, which demand incompatible actions, can lead to the individual feeling torn between the two sources of authority (1990: 85). He explains:

> 'Damned if you do, damned if you don't' is a common way of expressing this feeling of being caught between incompatible alternatives (1990: 83).

Another way of looking at the organizational agenda versus duty to the public is to see it as 'democracy versus bureaucracy'. In the article, 'The management of ideals: a political perspective on ethics', administrative ethics scholar, Kathryn Denhardt (1989: 188) argues that the public administrator '... must strike an effective and justifiable balance ...' between bureaucratic and democratic ideals. Bureaucratic ideals (e.g. efficiency, economy, standardization) may conflict with democratic ideals (e.g. individual rights, liberty, justice, and equality) (See p 188). She (1989: 188) makes a case that institutional structures and procedures designed in accordance with bureaucratic ideals can impede democratic ideals. In the same way, it could be argued that the NHS complaints manager is expected to reconcile the values of maintaining efficiency while being fair to citizens (complainants). Jacobsen (1996: 45) describes the clash between the values of bureaucracy and democracy as the possible conflict between bureaucratic 'closedness' and openness towards citizens.

In a similar, vein, Lipsky (1980: 71) observes that to deliver street-level policy through bureaucracy is to embrace a contradiction; on the one hand, service delivery invokes a model of caring and responsibility; on the other hand, service is delivered through a bureaucracy invoking a model of detachment under conditions of resource

limitations and constraints, making care and responsibility conditional. Thus, the helping orientation of street-level bureaucrats is incompatible with the requirement to judge and control clients for bureaucratic purposes (1980: 73).

In the article, 'Democracy, bureaucracy and hypocrisy redux: a search for sympathy and compassion', Louis Gawthrop (1997) states that to try and combine the values of bureaucracy with democracy is hypocritical (1997: 206), and that the notion of 'administrative neutrality' is a misconception:

> In attempting to maintain the artificial appearance of duty, many public administrators have sought to link their commitment of service to the amoral pretense of detached objectivity, neutral competence, and dispassionate rationality. Admittedly, the rationale that undergirds this perspective has a long and impressive legacy in the history of administration. In theory, this concept also appears unassailable, especially when related to a system of democratic governance (1997: 208).

Gawthrop's proposition is consistent with the argument in the previous section that the impartiality and independence of in-house public sector complaints systems is questionable, and would thus promote moral dilemmas for complaints handlers overseeing the system.

Yet another way of articulating this conflict between the organizational agenda and duty to the public is to see it as a conflict between 'personal' and 'corporate' agendas. In the book *Conflicting Agendas – Personal Morality in Institutional Settings*, Don Welch (1994: 49) notes that conflict between personal and corporate agendas is unavoidable. Welch reasons that one is hardly ever completely socialized into a particular group's morality, and no single institutional arrangement will conform to all the various components that make up an individual's agenda. In other words, organizational actors are not completely socialized into the organizational agenda. There is a potential for a conflict between the individual agenda of an organizational actor (for example, their personal morality) and the organizational agenda.

In a variety of ways, then, these public administration/ administrative ethics scholars indicate that there is a *conflict between the organizational agenda and duty to the*

public in the role of public administrators. This in turn produces, inherent contradictions or conflicts in the role of public administrators.

The predominance of the organizational agenda

The predominance of the organizational agenda has been indicated by a number of academics in the area of public administration, administrative ethics, and sociology relating to bureaucracy. Two particular subjects are highlighted: the issue of *bureaucracy*, and the issue of *conformity*.

With reference to the question of bureaucracy, Sjoberg *et al* (1966: 64) suggest that bureaucratic structures socialize organizational actors in such a manner that they are frequently incapable of understanding the world-view of the 'lower class' client. Similarly, in the book, *The Ethics of Public Service – Resolving Moral Dilemmas in Public Organizations'*, Kathryn Denhardt (1988) makes a number of observations relating to how *bureaucratic organizations by their very nature hinder moral practice in organizations*; the responsibility of the individual/ moral duty is undermined in a number of ways. First, ethical behaviour is undermined by hierarchical authority structures (Denhardt 1988: 85-88). Denhardt (1988: 88) asserts that hierarchy encourages organizational members not to take on responsibility at the lower ends of the hierarchy. Furthermore, she argues that those who reach the top levels of the hierarchy might have lost the necessary neutrality to make independent moral judgments in the organization. Support for this view is provided by William Scott and David Hart (1979: 86) who note in their book *Organizational America* that the higher an employee rises organizationally, the more the employee is dominated by the demands of managerial roles. They contend that rising up the organizational hierarchy necessitates greater individual obligation to the values of the organization:

> Most top managers have so internalized their organizational roles that they find it difficult to separate the values that are derived from them and the values they hold as individuals (Scott and Hart 1979: 86).

Second, Denhardt demonstrates how the division of labour in bureaucracies weakens individual responsibility and moral duty. Denhardt argues that while a task can be

divided into parts, it is much more difficult to divide ethical judgements into parts (1988: 85). She contends that when one is working on only part of a task, it effectively deflects from responsibility for the task as a whole (1988: 85). Third, Denhardt also shows how complex procedures and rules are an aspect of bureaucracies, which impede ethical behaviour. This complicated system of rules and procedures allows members of the organization to act without stopping to reflect over what should be done in each situation. Because no deliberation is called for, there is little opportunity or reason for anyone to question the rules or think about the morality of their actions (1988: 88). Fourth, Denhardt observes that the organizational norms and values of efficiency, effectiveness and rationality discourage ethical behaviour (1988: 92-6). These norms and values dictate that a decision, or act can only be considered as worthy if it is efficient, effective, and was arrived at using the appropriate logical method. Thus, no consideration of the morality of the objective is articulated (1988: 93-4).

With reference to the issue of conformity, Cooper (1990: 192) shows that the pressure to conform in organizations inevitably results in organizational goals being placed before ethical behaviour; there is a need for total loyalty to the organization. Linked to this argument is Denhardt's (1988: 96) contention that organizational reward systems strongly encourage loyalty to the organization, obedience to organizational authority and rules, and strongly encourage identification with the organization. She states that the organizational member is likely to suppress personal and social values when this conflicts with the norms encouraged in the organization (1988: 97). Scott and Hart (1979: 62) also note that obedience is an important aspect of the organization. They draw attention to the notion of 'organizational amorality', namely, the willingness to substitute organizational values for personal values (1979: 63). They (1979: 64) contend that individuals must be 'personally amoral' and 'organizationally moral', that is, they must internalize the goals of the organization as their own goals. Thus, Scott and Hart reason that it takes a formidable personality to be disobedient to the demands of managers responsible for the interests of their organization. When confronted with organizational obligations, conflicting individual values are easily relinquished or transformed into organizationally useful values.

Duty to the public: taking a moral stance

In light of the above observations, employees who attempt to place duty to the public above the orderly operation of his/her organization are invariably viewed as a serious threat (Cooper 1990: 192); those public administrators who ultimately choose personal morality over the organizational agenda (organizational loyalty and organizational constraints) may seriously put at risk their livelihood (Cooper 1990: 190-191). 'Whistle blowing,' of course, is the ultimate expression of personal morality over the organizational agenda (Cooper 1990: 188); in this scenario, the conflict between individuals and the organizations in which they are employed is particularly pertinent. Sjoberg *et al* (1966: 65) argue that bureaucratic organizations tend to penalize those of their members who 'over identify' with clients. For example, social workers who over identify with their clients, or teachers who over identify with their students, are considered to be indulging in non-professional action (1966: 65). Although it is possible for administrators to choose not to be blindly loyal to the organization, and to instead choose to follow the values of society and the moral order, this often means considerable sacrifice, such as the loss of job, wages, and status associations (Denhardt 1988: 79). For these reasons, it is clear that adherence to the values of duty to the public can be a highly problematical stance for the individual involved.

In short, the ideas of 'duty to the public' and 'personal morality' are useful constructs for exploring the behaviour, attitudes and emotions of complaints managers', who may perhaps take this duty seriously, and also provides some explanation as to why many managers may be reluctant to identify with complainants.[6]

[6] See Chapters Five and Six of the thesis.

Theme One: A Sociological Framework for Understanding the Inherent Contradictions in the Role of In-House Complaints Handlers[7]

As well as being complaints handlers and administrators, NHS complaints managers can be conceptualized as *actors* in the social system. Accordingly, sociological literature on role conflict and sociological ambivalence was another framework, which was useful for understanding the inherent contradictions in the role of in-house complaints handlers.

Role theory and role conflict[8]

Role theory provides another useful framework for understanding the contradictions or conflict inherent in the role of the complaints handler. This conceptualization of the complaints handler's role is much broader than the two previous frameworks. Indeed, the concept of role is one of the most popular ideas in the social sciences, and provides a framework for discussing or studying many social issues (Biddle 1986: 67-8). *Role conflict* (1986: 69-70) is a concept derived from role theory, which has been the subject of much of role research and is of particular interest with regards to this study. First, role conflict can be explained in terms of *incompatible roles* (See Argyle 1983: 178); an individual might have two roles, which are not compatible with each other. Robert Merton (1957: 110) states that each social status (position) involves not a single role, but an assortment of roles. He labelled this basic feature of social structure, the 'role-set'. Second, role conflict might consist of *conflicting expectations* from different groups of people (See Argyle 1983: 178). In his theory of role strain (a comparable concept to role conflict), William Goode (1960: 485) states

[7] Although I refer to this perspective as sociological, this should be seen as a broad definition as it also draws from some psychological literature, ie Argyle, M. (1983) *The Psychology of Interpersonal Behaviour,* Harmondsworth: Penguin Books.

[8] There are two key sociological approaches to role theory: the *structural functionalist* and *interactionist* approaches. Both these approaches are useful for explaining the responses of social actors to conflicting expectations, although functionalists and structuralists prefer focusing attention on the person in terms of their social position, while the interactionists prefer focusing attention on the person as an individual (See Biddle 1986: 86). Biddle has argued for a role theory, which integrates the different approaches (1986: 87). For the purpose of this thesis, role theory and role conflict will be examined in broad terms without highlighting the different perspectives within role theory.

that each role relationship typically demands *several* activities or responses. Essentially the individual cannot meet all the demands of his/ her role to the satisfaction of all persons who are part of his/ her total 'role network'(Goode 1960: 485). Third, there could be a *conflict between a designated role and personality*, that is, when the behaviours called for by others do not fit the self-concept of the role enactor (See Argyle 1983: 178). Social Psychologist Michael Argyle (1983: 178) provides the example of an authoritarian personality working for a democratic organization. In the context of the NHS complaints manager, it could be argued that this example is actually more likely to be reversed. In the light of earlier discussions on the limits of impartiality of in-house complaints handlers, and the predominance of the organizational agenda at the expense of duty to the public, a case could be made that there are more likely to be conflicts of personality with complaints managers who try to be complainant oriented rather than the other way round.[9]

Role conflict has particular relevance to the study of organizations (See Salaman 1980: 133) in that organizations frequently employ numerous staff; all these people are likely to be involved in an occupational role, which may be at odds with their organizational expectations and demands. According to this proposition, workers will routinely experience conflict and frustration within their employing organization. (Salaman 1980: 133). In this vein, Goode speculates that with most occupations, the various demands create some strain, for example, the conflict between norms of quantity and quality; and the conflict between technical excellence and human relations skills (Goode 1960: 485).

Sociological ambivalence

In 1976, Robert Merton and Elinor Barber developed the concept of 'sociological ambivalence'. Using the example of the physician, Merton and Barber argue that although the physician's role requires both detachment from the patient *and*

[9] It is important to note that *complainant orientation* in this thesis refers to a stance whereby the complaints handler takes seriously their duty to complainants (rather than an excessive bias toward complainants). At the same time *organization orientation* refers to a stance whereby the complaints handler puts the organizational agenda before the complainant.

compassion simultaneously, in practice these norms cannot be expressed simultaneously in behaviour. They argue that these norms are instead expressed in:

> an oscillation of behaviors: of detachment and compassion ... (1976: 8).

Behaviour oriented *wholly* to dominant norms (detachment) would defeat the functional objectives of the role, so role behaviour manifests itself in an *alternation* of dominant norms and subsidiary counter-norms as a coping mechanism for people facing predicaments in fulfilling their different roles (1976: 18). Thus, the medical student is taught to be oriented toward *both* the dominant norm of detachment and the subsidiary norm of the expression of compassion and concern for the patient (1976: 18). Accordingly, sociological ambivalence manifests itself in terms of individuals exhibiting contradictory emotions, attitudes and behaviour.

Theme One: Key Empirical Studies Relating to the Inherent Contradictions in the Role of In-House Complaints Handlers/ Third-Party Dispute Handlers

As indicated in the Introduction to the thesis, in their review of the literature on public sector complaints, Mulcahy *et al* (1996: ix) found that the largest body of work specifically relating to complaints was principally directed towards practitioners. As a consequence, little in-depth theoretical and/ or empirical work was discovered which specifically focused on complaints as a matter of academic interest (See Mulcahy *et al* 1996: ix). This argument is even more pertinent in the case of academic literature on *complaint handlers* as opposed to complaints in general. Nevertheless, I have identified four studies (Kolb 1987; Mulcahy and Lloyd-Bostock 1994; Klein 1973 and Simons 1995), which have particular relevance for this thesis. These four studies are drawn from socio-legal studies literature (Kolb 1987; Mulcahy and Lloyd-Bostock 1994) and social policy literature (Klein 1973 and Simons 1995). Because of the limited number of studies, I have reviewed these four studies in depth, with different aspects of the studies discussed in relevant sections of this chapter.

With regard to the focus of the studies, only two studies are directed *solely on complaint handling/ third-party dispute handling* (respectively Mulcahy and Lloyd-Bostock 1994 and Kolb 1987). Klein's and Simons' studies both explore complaints handlers' roles *amongst a number of other issues*. The emphasis of Klein's study is on the professional accountability of doctors, while the emphasis of Simons' study is on the social services complaints system. In relation to the 'NHS' studies, Klein's study (1973), and Mulcahy and Lloyd-Bostock's study (1994) both explore the role of complaints handlers in the NHS. Both studies deal with the 'old' complaints system as opposed to the 'post-1996' complaints system, which is the subject of this thesis. While Klein deals with primary care, Mulcahy and Lloyd-Bostock deal with secondary care.

In this section, all four studies, in varying degrees of sophistication, indicate *contradictions in the role of in-house complaint handlers/ third-party dispute handlers.*[10] In terms of the specific issue of *inherent contradictions in the complaint handler's role*, Mulcahy and Lloyd-Bostock consider the conflicts or contradictions inherent in the complaints handler's role by way of conjecture rather than explicit empirical findings. Thus, they focus on the multifaceted legal roles complaints handlers adopted rather than providing substantive evidence for the inherent contradictions in the complaints handler's role. Simons' study lacks conceptual underpinnings, and is consequently not pursued in the second theme (later in this chapter). Whilst Simons draws attention to the lack of independence in the complaints system, and some dilemmas confronting complaints officers, he does not conceptualize these dilemmas in terms of inherent contradictions in the complaints officer role. While Klein does provide evidence for inherent contradictions in the role of complaint handlers, the only study where the contradictions or conflicts inherent in the role of the complaint handler/ third-party dispute handler are the principal focus of the study, is that of Kolb.

[10] Although the studies do not necessarily refer explicitly to 'inherent contradictions' in the role of complaint handlers/ third party dispute handlers, all the studies make implicit reference to this contradiction.

Klein 1973

In his book, *Complaints Against Doctors*,[11] Rudolf Klein incorporates a survey of the administrative mechanics of the complaints system relating to GPs in England and Wales (See Klein 1973: 105). One of the aims of this survey was to explore the way in which Executive Councils[12] operated, and how their Clerks (complaints handlers) viewed their role as gatekeepers to the complaints system (1973: 121). In terms of the methodology used, all the Executive Councils in England and Wales were asked to supply information about their activities relevant to the operations of the disciplinary machinery (1973: 104). A questionnaire was sent to the Clerks of all the one hundred and seventeen Executive Councils in England and Wales in March 1972 (1973: 179). Klein (1973: 130) points out a limitation of his Clerk survey, hinting that some of the questions were too complex to be answered adequately in a survey.

With reference to the inherent contradictions in the role of the in-house complaints handler, Klein's study lends support to the idea of complaints handlers (in this case called Clerks) facing conflicting roles due to the contradictory demands placed upon them by doctors and patients (1973: 136). A key finding was that of considerable ambiguity as to how active Clerks could be in trying to resolve disagreements between complainants and doctors (1973: 137). Although Clerks were servants of a judicial tribunal and were expected to avoid bias to either party (1973: 136), what was supposed to be a form of neutral conciliation had the potential to turn into bias on behalf of either party (1973: 137). Thus, while there appeared to be general support for a conciliatory approach, Clerks were aware that conciliation could be interpreted as an attempt to put an end to the dispute in favour of the doctor, that is, an attempt to 'hush things up' (1973: 131). At the same time, there was considerable uncertainty as

[11] Rudolf Klein's book was the first major academic analysis of complaints handling in the NHS. Generally the study looks at the complaints system in relation to general practitioners, and considers what conclusions can be drawn from the operation of the system (Klein 1973: 1). An underlying theme of the study is the question of professional accountability (1973:12); Klein considers whether any checks on professional power can or should be introduced (1973: 1).

[12] Executive Councils administered primary health care in England and Wales at the time of Klein's study.

to how far Clerks could go in helping the complainant to prepare their case, without appearing to take sides (1973: 137).

Kolb 1987

Deborah Kolb's study (1987) (conducted in the United States), explores the role of the corporate ombudsman (who dealt with disputes relating to employees in organizations) and indicates inherent contradictions in the role of these third-party dispute handlers (ombudsmen). With reference to the methodology used, Kolb's study (reported in the article 'Corporate Ombudsmen and Organization Conflict Resolution') is based on ethnographic interviews with seven ombudsmen in six organizations. The interviews related to a series of fifty-six ongoing cases that these ombudsmen were involved with at the time (1987: 676), which were followed on an ongoing basis by repeat interviews (1987: 677). The cases covered a range of employee problems, such as relationships between managers and subordinates (1987: 677).

In relation to the issue of inherent contradictions in the role of complaint handlers/ third-party dispute handlers, on the basis of her findings, Kolb's proposition is that in responding to clients, ombudsmen appeared to face an 'inherent tension' in their position between the desire to assist a complainant, and a need to represent the organization's best interests (1987: 675). Kolb argues that this tension is structured into the job, and 'pulls ombudsmen in opposing directions'. Thus, Kolb states that most ombudsmen empathize with employees, and want to help them to represent their interests; at the same time, the ombudsmen in the study were all managers, and identified with the corporate aims of efficiency and lack of disruption; they realized that protecting the company and its interests from civil suits and other problems was part of their function. Accordingly, the ombudsmen in the study alluded to the tension they felt in the role, in the context of how they handled cases (1987: 681).

Mulcahy and Lloyd-Bostock 1994

A UK study conducted by Mulcahy and Lloyd-Bostock (1994) and reported in the paper, 'Managers as third-party dispute handlers in complaints about hospitals' explores the role of senior managers in the handling of hospital complaints. Data for the study drew on three hundred and ninety nine hospital complaints files entering the National Health Service's formal complaints procedure, and twenty-five interviews with managers who dealt with complaints (1994: 185; See also p 193).[13] A weakness of Mulcahy and Lloyd-Bostock's study is that they provide limited information relating to their methodological approach. For example, they do not say whether their interviews were audio taped or how long they lasted.

Although the key focus of the article was the multifaceted roles managers took on in relation to complaint handling, the authors make some insightful observations pertinent to the contradictions inherent in the role of complaints handlers. For example, Mulcahy and Lloyd-Bostock drew attention to the fact that the actors being examined had an allegiance to the organization being complained about and at the same time, as public servants also had a duty of care towards the complainants to consider their best interests (1994: 205). Accordingly, Mulcahy and Lloyd-Bostock (1994: 190) state that third-party roles within the organization being complained about are characterized by the inherent tensions in trying to promote the interests of the organization while dealing fairly with a dispute about it (1994: 190). The authors speculate that these tensions could be greater in the public sector where managers are placed in a difficult situation as they are expected to take into account the interests of service users as well as the organization. The authors' state:

> ... there are inevitably tensions in the operation of any internal complaints procedure in the public sector, as it is a service provider which is evaluating whether the service has failed (1994: 190).

The authors also drew attention to specific difficulties faced by complaints handlers.

[13] The article draws on data collected from two related studies of hospital complaints (Mulcahy and Lloyd-Bostock 1994: 193).

For example, what action was taken when the dispute involved one person's word against the other? Did complaints handlers identify with the interests of the complainant or the member of staff being complained about? Mulcahy and Lloyd-Bostock speculate that impartiality and independence would be affected by the extent to which actors identified with the complainant or the member of staff being complained about and suggest that managers identifying equally with both parties might achieve fairness (1994: 198). At the same time, they indicate that fairness will not necessarily be a key factor in the role of the manager as dispute handler. Other factors will be significant such as culture, ideology, public relation needs, budgetary constraints, and preferences of colleagues. Indeed, Mulcahy and Lloyd-Bostock (1994: 189) question whether complaint handlers can ever perform anything other than an 'opposition role' to complainants, that is, a role that is essentially biased against complainants.

Simons 1995

In a UK study on complaints procedures in social services, Ken Simons (1995: 91-92) drew attention to the lack of independence in the complaint system and highlighted some of the dilemmas complaints posed for complaints staff. With reference to the issue of independence, Simons (1995: 91- 92) found that many complainants believed that it would be preferable for complaints to be investigated by an independent body. First, there was cynicism about the capacity of the social services department to regulate itself. Second, there was a widespread belief that self-regulation simply was not fair practice. However, he points out that the question of an independent complaints system posed problems, as there were no obvious models of independent complaints procedures to draw upon. Nevertheless, he identifies possibilities for increasing the independence of internal procedures. For example, he considers the use of independent investigators. In addition, he recommends that at the very least, operational managers should not undertake investigations.[14] He also suggests that dedicated complaints officers ought to undertake investigations.

[14] Operational managers are managers involved in the line management of the provision/ service concerned. In relation to the findings of this thesis, these managers were generally referred to as *service managers* or *business managers*.

With reference to the dilemmas that complaints posed for complaints staff, concerning the conflict caused by competing expectations from the organization and complainant, Simons' study included interviews with four complaints officers (1995: 82).[15] In relation to these interviews, Simons draws attention to the notion of having to 'balance' the wishes of the complainant and the views of the department (1995: 84). Complaints officers also found complaints involving personalized conflict between a member of staff and a user very difficult to deal with.

In terms of specific conflicts emanating from the organizational agenda pertaining to their complaint-handling role, Simons found that some complaints officers considered that they were inevitably associated by their colleagues with problems (1995: 85). With regards to complainant interests, some complaints officers were critical of the quality of investigations conducted by operational managers (1995: 83); some complaints officers felt that their colleagues did not always attach the same priority to dealing with complaints as fully and as fairly as they did (1995: 86). Additionally some complaints managers were concerned that opportunities to learn some of the wider lessons from complaints had been missed (1995: 84); some felt the department had failed to invest sufficient resources in effective complaints handling (1995:86). In addition, some complaints officers recognized that their own conclusions had not always been accepted by others within the complained about department (1995: 83). At the same time, there was reluctance on the part of complaints officers to be critical of staff (1995: 85).

Thus this study illustrates the lack of independence in the complaints system, and the conflict between the organizational agenda and duty to complainants.

These studies will be explored again in this chapter in relation to theme two, that is, complaints handlers' responses and reactions to the inherent contradictions in their role.

[15] This part of the study related to interviews with a total of twenty-three professionals in an attempt to explore the attitudes of staff to complaints. The twenty-three professionals included front-line staff, managers and four complaints officers (1995: 87).

Theme Two: A Socio-Legal Framework for Understanding Complaints Handlers' Responses/ Reactions to the Inherent Contradictions in their Role

The work of a number of socio-legal scholars points to possible responses and reactions of complaints handlers to the contradictions in their role. For example, Nader (1980: 38) proposes that organization complaint handlers play a role which benefits the organization; that there is a strong 'anti complainant ethic' amongst complaint handlers; and that complainants are immediately labelled as deviants[16](1980: 44). According to Nader, only the most conspicuous cases of unfair treatment are ever resolved, and only the most persistent complainants (the potential troublemakers) are satisfied (1980: 38). Nader argues that an important part of the complaints handler's role is to diffuse complaints; and to stop them harming the organization by a variety of techniques. Thus, complaint handlers might pacify the complainant, or discourage the complainant from pursuing the complaint. As a result of this kind of approach, Nader argues that the complainant withdraws his/her complaint while feeling it was their decision, consequently masking their essential powerlessness. In other words the complaint handler gives the complainant the opportunity to rationalize away his/her powerlessness by letting him/her view his/her dropping out as a calculated decision of his/her own (1980: 40):

> First, the consumer is placated by being shown that help indeed exists. He is not alone in his struggle against the organization. The next strategy is delay - one of the most important methods of cooling out. The anger from frustrated expectations diminishes with time (1980: 39).
>
> The consumer is made to believe that his problem does not result from personal or corporate inadequacy. Possible solutions retreat from view, and he comes to accept the difficulty as a fixed aspect of the world to which he must resign himself. In short, he learns not to care (1980: 40).

David Serber's (1980) study of complaint handling in the Policy Services Bureau (PSB) (a unit in the California Department of Insurance) (1980: 317) supports Nader's

[16] However, Nader believes that complaints handlers are probably not conscious of this aspect of their role.

propositions.[17] Formal processes were only the rhetoric of complaints management. In practice, informal procedures and polices were far more common and differed noticeably from the official line (1980: 339). Serber found that the complaints handlers were biased in favour of the organization being complained about. He explains that a severe lack of resources compelled the Policy Services Bureau to limit the number of complaint cases it could consider. Thus staff restricted the public's awareness of the bureau, and discouraged, avoided and 'deselected' complaints (1980: 339). Indeed Serber's findings showed that the complaint handlers systematically deselected the complaints of the less powerful members of society. Likelihood of the complaint being processed depended more on the social characteristics of the complainant (e.g. race, gender, class) than on the technical merits of the case (1980: 339).[18] According to Serber, this deselection helped to eliminate what was potentially a vast backlog of work, and permitted a smoother running bureaucracy, at the cost of a large section of the population that was degraded and frustrated (1980: 339).

Moreover, even when the complainants fell into the social categories acceptable to the staff, and even if detailed investigations supported the complaint, staff did not wholeheartedly pursue the disputes (1980: 340).

Nader and Serber, then, put forward an interpretation of the complaint handler, as being overwhelmingly biased against the complainant; essentially the complaint handler is compelled to adhere to the organizational agenda. Thus, Nader and Serber appear to ignore the potential for tensions in the role, as their arguments seem to be based on the assumption that the complaint handler is inevitably organizationally oriented; there seems to be no room for an individualized response/ reaction to the complaint-handling role.[19]

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[17] This study investigates consumer complaints about insurance companies. The procedure could be argued to be in-house in the sense that the Policy Services Bureau (PSB) was not an autonomous entity in the department of insurance. It was totally under the supervision of the insurance commissioner (Serber 1980: 321).

[18] Race, gender and class determined who was likely to obtain satisfactory redress. Serber observed that complainants who were white males, who appeared to be middle to upper-middle class and were articulate and persistent, were more likely to be successful in having their complaint resolved to their satisfaction than individuals outside this group (1980: 339).

[19] However, see the section on empirical studies relating to complaints handlers'/third party dispute handler's responses/ reactions to the inherent contradictions in their role for Kolb (1987) and Klein

What are the implications of these propositions for NHS complaints managers? Would they be consistently organizationally oriented as suggested by Nader (1980) and Serber (1980), or would they take on individualized approaches as suggested by Kolb (1987) and Klein (1973)?[20] For example, would there be one particular approach to advising/ supporting complainants or would there be different, individualized approaches?[21]

Theme Two: A Public Administration Framework for Understanding Complaints Handlers' Responses/ Reactions to the Inherent Contradictions in their Role

Public administration literature points on the one hand to an organization oriented response/ reaction to the situation of an employee working in an organization, and on the other hand, to a variety of responses and reactions to the organizational situation. The literature reviewed here, on the administrator's responses/ reactions to the competing goals of duty to the public and the organizational agenda is indicative of two ideas:

- Administrators respond/ react to conflicting goals in terms of organization orientation.
- Administrators respond/react to conflicting goals in a number of different ways; they might respond/react with organization orientation/ primary identification with the organization; they may perhaps respond/ react in terms of values concerning duty to the public.

(1973) who in contrast to the above authors both identified *individualized* responses to the complaint-handling role.

[20] See later section in this chapter with regards to key empirical studies relating to complaints handlers'/ third party dispute handlers' responses/ reactions to the inherent contradictions in their role.

[21] See Chapter Five of the thesis.

Responses to organizational dilemmas consistent with organization orientation

A number of authors discuss responses and reactions to the organizational situation in terms of organizational orientation, that is, primary identification with the organization.

Sjoberg *et al* (1966: 65) argue that the bureaucrat finds it difficult to step outside his/her formalized role. In addition, Sjoberg *et al* (1966: 64-65) suggest that, as a result of his/her role commitment, the bureaucrat tends to impose his/her own expectations and interpretations of reality upon the client. They believe that if the bureaucrat seeks to take on the role of the client, in the sense of understanding the client's belief and value system, he/she will ultimately have to challenge, or at least question some of the rules that govern the operation of the system:

> For if he understands why clients act the way they do, he is likely to recognize that they have valid reasons for objecting to his conception of reality or, more specifically, to some of the bureaucratic regulations (1966: 65).

According to Sjoberg *et al*, faced with noncompliant clients, the typical office holders will say effectively:

> 'if only clients would act properly, everything would be all right, and we could get on with our work'[22] (1966:65).

Lipsky (1980: 149) has observed that street-level bureaucrats sometimes cope with their jobs by privately modifying the scope of their authority, since limiting the scope of their authority frees workers from perceived responsibility for outcomes. Thus denying the ability to use discretion is a common way to limit responsibility. Strict adherence to rules and refusals to make exceptions, where exceptions might be made,

[22] Although this study reported by Sjoberg *et al* is incorporated into the public administration framework for this thesis, the work of Sjoberg *et al* is strictly speaking, sociological literature. However, this study has been placed in the public administration framework because it relates to the study of bureaucracy. This should not be confused with the *sociological framework for this thesis,* which deals with role theory and sociological ambivalence. This point is also relevant to Blau's two studies considered later.

provide street-level bureaucrats with defences against the possibility that they might be able to act more, as clients would wish. In a similar vein, Denhardt (1988: 81-2) draws attention to the idea that strong organizational control mechanisms serve individual needs as well as organizational ones. Many individuals find the responsibility of making judgments too overwhelming; organizations are designed in such a way to avoid that responsibility. In addition, the individual might find it easier to accept the organizational perspective simply because it is perhaps more clearly defined than the consideration of moral values (1988: 79).

Opposing responses and reactions to organizational dilemmas

The literature considered in this section suggests that organization orientation is not the only response to the organizational situation. There are a *variety* of possible responses and reactions to organizational dilemmas. For example, in a study concerning the orientation of caseworkers toward clients in a public welfare agency in a large American city, Blau (1960: 242) identifies a number of reactions to the organizational dilemma *in addition* to organizational orientation or primary identification with the organization. In relation to the study, he suggests that professional training in social work has an important socializing function in inculcating an orientation toward clients that *combines impersonal detachment with serious concern for their welfare.*[23] In Blau's study, beginners (unsocialized) were typically very concerned with helping clients, but were unprepared to cope with their own reactions to either the 'sympathy-evoking plight' or 'the threatening aggression of recipients'. The workers' response to the tensions produced by these experiences was to either become emotionally involved, or to escape by leaving the agency, or, perhaps (most often) to lose concern with the welfare of recipients as a means of avoiding these tensions (Blau 1960: 242). Blau concludes:

> To produce a detached service approach - the peculiar combination of a strong interest in furthering the welfare of clients and a detached attitude toward them - is an important function of professional training in social work (Blau 1960: 242).

[23] This is reminiscent of the concept of sociological ambivalence covered previously in this chapter.

In an earlier study (*The Dynamics of Bureaucracy)* Blau (1955) reports on how workers in a public employment agency responded to conflict with clients (1955: 82-96).[24] Essentially conflicts with applicants produced a need for coping with the tensions they generated. As a result, social mechanisms emerged which enabled respondents to adapt to strained relations with clients (1955: 87). It could be argued that Blau found responses that were indicative of both organization orientation and client orientation. In terms of organization oriented responses, Blau (1955: 88) reports that officials' conflicts with clients were irritating and led to antagonism against them, which in turn gave rise to feelings of guilt and tensions because officials *at the same time* identified with public service ideals (1955: 88). Blau found that workers discovered ways of offloading such tensions, that is, complaining and joking about clients, whose actions had irritated workers (1955: 88-95). Blau argues that joking was based on a common 'disidentification' with difficult clients, producing a stereotype with which workers could hardly sympathize (1955: 93). Essentially, jokes dissolved uncertainty and self-reproach, and transformed inconsiderate treatment of clients into a socially approved practice, to the detriment of the agency's clientele. In other words, they took an organization oriented approach to their work, by detaching themselves from the clients. Conversely, some workers who were strongly oriented toward serving clients objected to these anticlient norms (1955: 93). Blau observed that respondents, who were strongly oriented toward serving clients, had few conflicts with clients. Consequently they had little need for releasing antagonism against applicants, and for assuaging guilt feelings by complaining or ridiculing clients (1955: 93).

Theme Two: Sociological and Social Psychological Frameworks for Understanding Complaints Handlers' Responses/Reactions to the Inherent Contradictions in their Role

As referred to in relation to theme one, NHS complaints managers can be conceptualized as *actors* in the social system (as well as being complaints handlers

[24] These findings are drawn from the book *The Dynamics of Bureaucracy: A Study of Interpersonal Relations in two Government Agencies* (Blau 1955). The goal of the study was to contribute to the understanding of bureaucracies by exploring the patterns of social interaction within them.

and administrators). Accordingly, sociological and social psychological literature on responses/reactions to role conflict was useful for understanding complaints managers' responses and reactions to the inherent contradictions in their role.

Negotiating roles and role conflict resolution

When people experience role conflict, they will be subjected to conflicting demands, will suffer stress, and will have to 'resolve' the problem by adopting some form of coping behaviour (See Biddle 1986: 82). Indeed, social actors employ all sorts of strategies to resolve any role conflict they are experiencing. As explained by Zurcher, they might conform to roles; modify established roles; create new roles; or negotiate workable compromises between the behavioural expectations they have for themselves, and the behavioural expectations they perceive others have for them (Zurcher 1983: 9). Zurcher's (1983: 9) research demonstrated:

> Even when a role was rigidly embedded in a highly structured setting, they [actors] found some way ... to put their 'mark' on it.

Certainly, much role theory literature suggests that NHS complaints managers would adapt to their role with *a variety of* behavioural, attitudinal and emotional responses. In other words, they would not necessarily adhere rigidly to a stipulated role.

A number of authors have offered models for the individualized resolution of role conflict, which provide possible frameworks for understanding complaints managers' responses/ reactions to conflicting expectations from complainants and the organization.[25]

Kahn *et al* (1964) identified a number of coping responses to role conflict. First, direct attempts at solving the objective problem by compliance and conformity; second, persuading relevant individuals to modify incompatible demands; third, attempts to avoid the sources of stress; and fourth, the use of defence mechanisms to

[25] Two examples of studies concerning role conflict resolution are given here. However, it should be noted that a number of other studies have been conducted in relation to this subject.

distort the reality of a conflictual situation in order to relieve anxiety. These defences could be taken individually, or in combination (1964: 28-9).

In the article, 'A model of coping with role conflict: the role behavior of college educated women' (1972), Douglas Hall presents a model of role conflict coping behaviour. Through a survey of college-educated women, sixteen specific behaviour strategies were identified and classified under three general types (1972: 471). First, *structural role redefinition* involves redefining the expectations held by other people so that fewer conflicting demands are placed upon the person, and a new set of behaviours is expected from that person by other members of the role-set (1972: 476). This has obvious similarities with the notion described by Kahn *et al* (above) regarding persuading other people to modify incompatible demands. Second, *personal role redefinition* involves *changing one's perceptions of his/ her role demands* rather than attempting to change the environment. By choosing to view one's own behaviour or external expectations in a different light, one attempts to reduce the amount of conflict experienced (1972: 477). This could be linked to the notion of Kahn *et al* regarding the use of defence mechanisms to distort the reality of a conflictual situation in order to reduce anxiety (see above). Third, coping through *reactive role behaviour* involves aiming to meet all of the role demands experienced. This is reminiscent of the conception of Kahn *et al* relating to direct attempts at solving the objective problem by compliance and conformity described above. Hall argues that this strategy would probably be indicative of considerable strain on a person's energies as it involves attempting to do everything demanded rather than trying to reduce conflicts and demands (1972: 480).

A social psychological perspective - Just world theory

Social psychologist, Melvin Lerner (1980) devised a model to explain the way people respond to injustice and unfairness, that is, a model of the social psychological processes that may be involved in people's continuation of the belief that the world is just. This could be argued to be of relevance to NHS complaints managers, in that they may perhaps encounter frequent injustices in their complaint-handling role.

Lerner (1980: 19) identifies a number of coping strategies[26] employed by individuals to eliminate threats to their belief in a just world. For example, people might accept the 'reality of injustice', namely, the acceptance of one's limitations. This stance is exemplified by the attitude that there is only so much that can be accomplished with finite resources. Also, there is the psychological defence of 'denial' and 'withdrawal' (1980: 20). Essentially this involves selecting the information to which one is exposed, that is, psychologically editing out unwelcome information or evidence. Additionally, there is the psychological defence of 'reinterpretation of the event'(1980: 20-21). This could be achieved by reinterpreting the cause of an injustice. Lerner points out that one could attribute the victim's fate to something he/ she did, or failed to do, and then our sense of justice is often fulfilled (1980: 21). Alternatively, one can reinterpret the personality of the victim, that is, judge an injured party as being of dubious character in order to reduce guilt about any unfairness or bias (1980: 21).[27] Thus, Lerner (1980: 105) considered that the device of finding or inventing reasons why 'everyone got what he or she deserved' could be a way of avoiding tension. According to this line of thought, the observer who sees a victim's fate as entirely deserved, need not feel frustrated, or experience any tensions concerning their integrity as a decent citizen for failure to get involved; there is no loss of self-image for being unable to compensate the injured party and/ or punish the inflictor of the injustice.

Theme Two: Key Empirical Studies Relating to Complaints Handlers'/ Third-Party Dispute Handlers' Responses/ Reactions to the Inherent Contradictions in their Role

The studies explored in a previous section (key empirical studies relating to the inherent contradictions in the role of in-house complaints handlers/third-party dispute handlers) are revisited in this section in relation to theme two (i.e. complaints handlers' responses/ reactions to the inherent contradictions in their role) with the

[26] I have been selective in the strategies drawn from Lerner's book due to some strategies being beyond the scope of the thesis.

[27] This has obvious similarities with Nader's notion of an anti complainant ethic (1980), and the idea of labeling complainants as deviants (previously referred to in this chapter).

exception of Simons' study (1995), which did not explore this theme. The studies reviewed in this section, then, all in varying degrees, consider the responses and reactions of complaints handlers/ third-party dispute handlers to the inherent contradictions or conflicts in their role. While the studies covered in this section do not conceptualize the findings in *specific terms of responses and reactions to inherent contradictions in the role*, the findings of the studies, all, in effect, suggest responses or reactions to the inherent contradictions in the role of complaint handlers/ third-party dispute handlers; all three studies point to *approaches to complaint handling* through their identification of complaint handling roles. For example, in Klein's study (1973) complaint handler types of *legalist* and *conciliator* were identified. With Kolb's study (1987), ombudsmen were classified as *fact-finders* and *helpers*. Additionally, Mulcahy and Lloyd-Bostock (1994) conceptualize complaints handlers as *gatekeepers* and *clinicians' agents*.

How were these complaint-handling roles/ approaches to complaint handling determined? In what terms were these roles/ approaches conceptualized?
In terms of organization orientation versus client orientation/ complainant orientation, both Kolb and Klein hint at the idea of client-oriented approaches to complaint handling, as well as organization oriented approaches.

With reference to the notion of individualized approaches to complainant handling, in Klein's study, complaints handlers' responses and reactions to the contradictions in their role seemed to depend on *personal style*. While, Kolb's study touches on the idea of personal style in her conception of fact finding and helping ombudsmen, she suggests that these individual approaches of ombudsmen may actually be determined by the *situation* the ombudsman faces, rather than personal style. While Mulcahy and Lloyd-Bostock *allude* to the issue of personal style, they do not explore this topic in any depth. [28]

[28] The authors acknowledge that in emphasizing the importance of managers being seen as having multifaceted roles, there is a danger that this concept is overstated, and that the impact of *individual approaches* of managers is ignored (1994: 205).

Klein 1973

In relation to Klein's study, (which incorporated a survey of the administrative mechanics of the complaints system [1973: 105]), Klein found that with Clerks (complaints handlers), on almost every issue, it was possible to find an opposing point of view or interpretation of their role (Klein 1973: 131). In other words, the interpretation of their role seemed to depend on the *individual approach* of the Clerk. For example, Klein describes one Clerk as seeing himself as a 'paternalistic conciliator'. He describes another as seeing himself as being in a managerial role, carrying out his legal obligations (1973: 132). Klein identifies two main themes that emerged from the replies of Clerks. First, dealing with complaints is seen as *an exercise of conciliation* where there is a need for sympathy, tact and understanding. Second, dealing with complaints is seen as *an exercise in applying a set of rules*, where the need is primarily for a thorough knowledge of the regulations (1973: 126). For example, on the question of whether there should be hearings in cases of emotional distress, (particularly those involving deaths of patients), Clerks who took the view that there should be such hearings were classified as *conciliators*. Those who rejected it were described as *legalists*[29] (1973: 132).

Another of the questions put to Clerks in Klein's survey was, whether aside from advice about regulations, procedure and sources of information, they helped complainants to prepare their case (1973: 126). The comments of the Clerks clearly outlined two very different views about their relationship with complainants. At one extreme, there were those who strictly limited their role to explaining the regulations. At the other end of the spectrum, some Clerks were prepared to give assistance, though making it very clear that this stopped short of advocacy (1973: 126). Mostly the emphasis was on strict impartiality, and in particular on only giving advice and help to both sides, that is, complainant and doctor (1973: 127).

[29] Klein formulated a typology of complaints Clerks in terms of their personal approach to complaints handling, classifying Clerks into five groups ranging from the *pure legalist* at one end to the *pure conciliator* at the other. No Clerk appeared to be a *pure legalist*; five were classified as *modified legalists*; twenty-two as *middle-of-the-roaders*; thirty-five as *modified conciliators*; and twenty-one as *pure conciliators* (1973: 133). I have not drawn on this typology in relation to the typology of NHS complaints managers in Chapter Six of the thesis.

In short, Klein found that significantly, Clerks' responses depended more on the *personal style of the Clerk* than the constraints of the system, and that Clerks had very different attitudes to complaints handling (See p 131).

Kolb 1987

Kolb's study (1987: 673) on the role of the corporate ombudsman shows how ombudsmen resolve the conflict in their role by emphasizing one facet of the role. Kolb suggests that 'helping' ombudsmen invented individualized solutions to the problems people presented, whereas 'fact-finding' ombudsmen investigated whether proper organizational procedures were followed, and if there existed plausible explanations for a complaint. Also, fact-finding ombudsmen were less likely to go out of their way for the complainant than helping ombudsmen (Kolb 1987: 681). Kolb speculates that the phenomenon of ombudsmen as 'helpers' or 'fact-finders' was related to the extent to which they were 'embedded' in the organization (1987: 673). The fact finders were, with one exception, the ombudsmen who had minimal authority or connectedness within the organization. They therefore tended to confine their activities to formal channels and have few resources to offer the complainant (1987: 686). In contrast to the fact finders, helping ombudsmen had access to certain informal resources that they could mobilize to assist clients out of a problematic situation (1987: 686).

A weakness of the study was that the sample was small (seven ombudsmen). Kolb acknowledges that a much larger sample of ombudsmen, firms, and cases would be required to test how consistently ombudsmen favoured one approach or the other. She suggests that perhaps with a larger sample, helping and fact-finding may be identified as two different styles that are used more or less by all ombudsmen depending on the circumstances (1987: 686-687). In this sense, Kolb is shifting the explanation of ombudsmen behaviour, to being influenced by *the situation* rather than the *personal style* of the ombudsman. Had a larger sample been used, perhaps findings may have indicated conversely that 'helpers' and 'fact-finders' were influenced significantly by the personal style of the ombudsman. In other words, the fact that certain ombudsmen were fact finders or helpers may relate more to the fact

of their personal approach rather than their contacts in the organization. In addition, with a larger sample, other personal styles may have emerged in addition to fact finders and helpers.

Mulcahy and Lloyd-Bostock 1994

In their study exploring the role of senior managers in the handling of hospital complaints, Mulcahy and Lloyd-Bostock (1994: 191) identified the 'gate-keeping role,' and the role of 'clinician's agent.'[30]

With regard to the gate-keeping role, this could be argued to be an organization oriented complaint-handling role in that the gate-keeping role allows a significant facility to discourage complaints at the source and as they progress through various stages (1994: 191). The authors theorize that the gate-keeping role may be required by an organization or imposed by organizational constraints or culture, and may be in conflict with what is formally required of the actor. The gatekeeper's motivation is to essentially minimize conflict regardless of the legitimacy of the complaint because conflict has the potential to damage the organization being complained about, or is likely to increase the gatekeeper's workload (Mulcahy and Lloyd-Bostock 1994: 191).

In relation to the role of clinician's agent, Mulcahy and Lloyd-Bostock suggest, that whilst making use of the rhetoric of third-party dispute resolution, in practice, managers tended to act on the behalf of the clinician in cases relating to clinical care (1994: 206). These roles identified by Mulcahy and Lloyd-Bostock, suggest approaches to complaint handling, which are characterized by bias against complainants. Although the authors hint that there were divergences of practice by

[30] In addition, Mulcahy and Lloyd-Bostock generated a typology of the multifaceted roles hospital managers took on. The managers interviewed identified at least four clusters of roles, which had to be played in the handling of complaints, for example, *facilitator/ mediator, peacemaker/ conciliator.* None of the managers felt restricted to just one role and all mentioned performance of at least three. This typology emphasizes the complaints handler's approach in terms of being *tailored to the situation* rather than the individual disposition of the complaints handler (the approach taken in Chapter Six of this thesis).

individual complaints handlers, they do not pursue this theme to any significant extent (1994: 205).

Theme Three: Typologies of Organizational Actors Responses and Reactions to the Inherent Contradictions in their Role

In order to build on the previous theme of responses and reactions to inherent contradictions in the role of complaints handlers, it is useful to explore *typologies* of coping with the inherent contradictions or dilemmas posed by organizations. This focus is particularly valuable in exploring the concept of different types of complaints handlers, as the typologies all demonstrate the theme of resolving conflict. Indeed it could be argued that all the typologies represented in this section exhibit responses and reactions to conflict and contradictions in the role. The typologies of three authors are explored which were particularly useful in interpreting the study findings.[31]

First, in the book, *The Organizational Society*, political scientist, Robert Presthus (1979: v) developed a theory of organizational behaviour that hypothesized three ideal types of accommodation to big organizations. He suggested that individuals in organizations fitted into three main types:

- Upward-Mobiles
- Indifferents
- Ambivalents

Second, in 1994, Don Welch developed a typology in the book *Conflicting Agendas*, based on the contradictions between individual norms and institutional norms (Welch 1994: 172). Welch's typology[32] consisted of:

- The Institutionalized Person
- The Accommodator
- The Reformer

[31] See Chapter Six of the thesis.

[32] The 'hermit' and the 'convert' are not included in this review.

- The Split Personality
- The Convert
- The Hermit

Third, in 1983, Wendy Sherman and Stanley Wenocur modified Marlene Kramer's typology (concerning nurses' methods of resolving role conflict) (1974) to relate it to the public welfare organization,[33] and formulated a typology[34] with the following types:

- Capitulation
- Noncapitulation
- Niche finding
- Withdrawal
- Self-victimization
- Functional noncapitulation

Drawing from these typologies, it was possible to discern four main types of organizational actor, which could be applied to this study:

- First there was a type that showed 'extreme organizational orientation', consistent with Presthus' 'Upward Mobile', Welch's 'Institutionalized Person', and Sherman and Wenocur's stance of Capitulation'.

- Second there was a type that displayed 'extreme client orientation', consistent with Presthus 'Ambivalent', Welch's 'Reformer', and Sherman and Wenocur's response of 'Non Capitulation.'

- Third, there seemed to be a 'middle-of-the-road' approach to organizational life consistent with Presthus' 'Indifferent,' Welch's 'Accommodator' and Sherman and Wenocur's response of 'Functional Non Capitulation.' In other words actors in organizations were neither particularly organization oriented nor solely client oriented. On a continuum of extreme organization orientation to extreme client orientation, they fitted somewhere in the middle.

- A fourth notable type of organizational actor appeared exclusively in Welch's work, namely, the 'Split Personality.' This is an organizational type that finds value in both organizational values and their own moral values, but fails to reconcile the two value systems harmoniously.

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[33] See Kramer, M. (1974) *Reality Shock - Why Nurses Leave Nursing.* Saint Louis Mosby Co. Although both Kramer and Sherman and Wenocur's typology are relevant to the study, I have primarily drawn from Sherman and Wenocur's version because it related to this study more readily than Kramer's typology. However, I have made occasional reference to Kramer's work in this section.

[34] Niche finding, withdrawal and self-victimization are not included in the main review.

Extreme organization orientation

Drawing from the typologies of Presthus, Welch, and Sherman and Wenocur, it was possible to locate a distinct type of organizational actor, exhibiting 'extreme organization orientation' namely, Presthus' 'Upward Mobile', Welch's 'Institutionalized Person' and Sherman and Wenocur's stance of 'Capitulation.'

A key characteristic of 'extreme organization orientation' was *identification with the organization.* Presthus argues that acceptance of the organization's goals predisposes these individuals (upward-mobiles) to conformity, and intolerance towards any opposition to organizational goals (See Presthus 1979: 161). Indeed, Welch's comparable institutionalized person submerges his/her values into the groups, automatically taking on the institutional agenda as his/her own (1994: 13). Similarly Sherman and Wenocur propose in their related notion of capitulation that these types of workers identify with the values of the organization (1983: 376).

In terms of resolving role conflict, this group of individuals have resolved or avoided the problem of conflicting agendas by simply accepting the institutional agenda; no problem exists because their personal agenda is identical to or subsumed under the agenda of the institution (Welch 1994: 75). In addition, Sherman and Wenocur (1983: 376) indicate that such workers took on little overt accountability for what they were not able to do in terms of their duty to clients:

> They screen out the double-bind messages of the agency and of the client transactions, thus diminishing their conflicts.

Further, Presthus suggests that these individuals (upward mobiles) avoid reality by deluding themselves that the actions of the organization bring about perfect justice (Presthus 1979: 152). At the same time, they take the stance that if the organization's actions occasionally result in injustice, this is inevitable in an imperfect world (1979: 160). Presthus states that their deference to authority may help them reconcile any ethical conflict arising from everyday injustices; if the good of the organization is assigned the highest value, individual values must be subordinate to this goal (1979:

175-6). Accordingly, they have a particular propensity to accept the inequities that organizational power brings (1979: 176).[35]

On one hand, Sherman and Wenocur argue that a drawback of such an adaptation to the organizational situation is that workers switch off their empathic responses and are unable to be effective advocates for clients (1983: 376). On the other hand, it is perhaps not surprising that these types find the bureaucratic situation agreeable, and often adapt to it with relatively little strain (Presthus 1979: 183).

Extreme client orientation

Organizational actors exhibiting 'extreme client orientation' were also found in the typologies of Presthus, Welch and Sherman and Wenocur, namely, Presthus' 'Ambivalent', Welch's 'Reformer' and Sherman and Wenocur's stance of 'Non Capitulation.'

A significant attribute of this group was the conflict of their personal values with the values of the organization. In relation to Presthus' construct, the ambivalent, Presthus considered that the values of the ambivalent conflict with the bureaucratic requirements for organizational loyalty (1979: 228). Thus, the ambivalent is essentially unable to meet the demands of a bureaucracy (See Presthus 1979: 228); they are unable to accept the traditional bases of authority (1979: 229). Similarly, Sherman and Wenocur propose in their comparable response of non-capitulation that workers reject the values and behaviour of the organization, and retain their own values (Sherman and Wenocur 1983: 376). Workers adopting this stance, identify with clients beliefs that the organization creates barriers to meeting clients needs (1983: 376). Presthus (1979:230) states that there is always a gap between the ambivalent's perception of himself/ herself as an independent professional and the realization that he/she is really an employee. He (1979: 230) describes the ambivalent as 'sensitive' and 'emotionally undisciplined'. In addition, he states:

[35] Much of this argument is reminiscent of Lerner's just world theory explored earlier.

...the ambivalents' tragedy is that they care too much, but can do too little (1979: 251).

In terms of resolving conflict, this group seeks to cope with organizational conflict by reforming the institutional agenda into one that is more compatible with his/her own (Welch 1994: 13). Dissatisfied with the institutional agenda that contradicts the personal agenda, (reformers) attempt to *change* the institutional agenda (1994: 97). This organizational type, then, seeks to resolve the conflict by bringing the groups expectations in line with his/ her personal values (1994: 97).

It has been pointed out that this group has a potential to impart an innovating influence on the organization. Presthus observed that ambivalents could provide insight and inspiration for organizational change and thus could provide an innovating role (1979: 228). However, Presthus (1979: 228) notes that this tendency is often suppressed because the authority and money needed to institutionalize change remains in the hands of organizational elites (1979: 228). Sherman and Wenocur speculate that sooner or later the organization would put a stop to this kind of response of extreme client orientation (non capitulation). They suggest that workers quickly become isolated and identified as rebels; at best they are dismissed as idealistic and naive; more often they will be harassed out of the job if they do not first resign (1983: 376). Presthus (1979: 228) believes that ambivalents constitute a small residual category of individuals in organizations. In other words, organizational actors exhibiting extreme client orientation are rare.

Middle-of-the-road orientation

Organizational actors exhibiting 'middle-of-the-road orientation' were also represented in the typologies of Presthus, Welch and Sherman and Wenocur. These were Presthus' 'Indifferent', Welch's 'Accommodator' and Sherman and Wenocur's stance of 'Functional Non Capitulation'.

The quintessential attribute of this type of organizational actor seems to be one of compromise. According to Presthus, indifferents have the ability to be responsive to organizational values, but do not necessarily identify with them (1979: 205). Similarly

Welch's accommodator searches for compromise, attempting to follow an approach that is amenable to both the organizational agenda and their individual agenda without removing the tensions between them (1994: 13). Sherman and Wenocur state that the related response/ reaction of functional non capitulation (1983: 377) is one in which workers neither abdicate their values in favour of the organization's values nor reject the organization's values, i.e. take the stance of 'non-capitulation' (covered in the section above). With regards to conflicting value systems, workers learn to cope with two value systems; workers compromise between their own ideological positions, and that of the organization with respect to client demands (Sherman and Wenocur 1983: 377; Kramer 1974: 162).

On the one hand, this type of actor takes their duty to clients/ the public seriously. Welch states that personal morality *does* have a part to play in the role of accommodators (1994: 117). Unlike organizational actors showing extreme organizational orientation, this group maintains some independence with regard to values, personal control and choice (See Welch 1994: 116). At the same time, this group put a firm limit to their responsibilities to the public. Because the workers have limits to their jobs, say Sherman and Wenocur, this group acknowledges to their clients that their anger may be justified, and direct clients to other avenues to pursue their interests (1983: 377). Along these lines, workers establish realistic expectations with their clients about the limits of their responsibility and influence (1983: 377).

In short, this type of organizational actor *tolerates* the situation whereby institutional expectations cannot be changed to correspond with his/her personal agenda (Welch 1994: 17); he/she chooses to balance various personal norms, needs and interests against the costs of continued membership of the organization (Welch 1994: 117).

It is important to note that this group still has unresolved tensions. While this middle-of-the-road response/ reaction to organizational conflict can be viewed as a flexible response, it also has the potential to be intolerable through lack of certainty (See Welch 1994: 133); this pattern of accommodation does not eliminate tensions

between different agendas (Welch 1994: 13).[36] In a similar vein, Sherman and Wenocur state that this stance is about *managing conflict* rather than resolving it (1983: 377).

Presthus believes that 'indifference' or 'withdrawal' is the typical pattern of accommodation for the majority of organization people (1979: 184). In other words, this middle-of-the-road orientation is the most common type of accommodation or adjustment to the organizational situation.

The split personality

A fourth category only identified by Welch, was the Split Personality, who finds importance in both the organizational agenda, and the personal agenda, and divides his/her life into personal and institutional settings (1994: 13). Split personalities follow organizational agendas, while acknowledging the weaknesses and even immorality of the organizational agenda (1994: 94). Ultimately the split personality adheres to an institutional agenda despite moral principles to the contrary (1994: 94). At the same time, this response can be seen as providing too little support for the organization, because the split personality does not grant to the institution *absolute moral authority* (1994: 95). The difference between Welch's conception of the split personality and the institutionalized person, is that the split personality does not relinquish moral authority to the institution (1994: 92). Welch (1994: 92) theorizes that the split personality may acquiesce with the organization's orders in certain circumstances, but does not necessarily like it. At first glance, the split personality may not seem to differ markedly from the middle-of-the-road orientation outlined earlier. However, an important difference is the implication that this type of organizational actor adjusts poorly to the organizational situation, namely, Welch's statement that the conflict of agendas results in split personalities that are often *'unstable personalities'* (Welch 1994: 95).

[36] This strategy may possibly be linked to Merton and Barber's concept of sociological ambivalence referred to earlier in this chapter.

Conclusion

In this chapter I have explored the inherent contradiction in the role of in-house complaint handlers; I have considered complaints handlers' possible responses and reactions to these contradictions; and I have drawn from three public administration typologies, which could be used to conceptualize different types of complaints handlers. In addition I have analyzed four empirical studies, in depth, in relation to the first two themes, as well as drawing less intensively from other empirical studies.

With reference to *the inherent contradictions in the role of in-house complaints handlers* (theme one), first, exploring the complaints handler from a socio-legal standpoint, I have argued that the lack of impartiality and independence in an in-house complaints system will invariably produce conflicts of interest for complaint handlers. Second, from a public administration perspective, I have argued that there are conflicts between the organizational agenda and duty to the public for administrators in public services. Third, from a sociological perspective, using role concepts, I have argued that role conflict and sociological ambivalence is inherent in any social position.

I have also drawn on the previously described perspectives as a framework for understanding the *complaints handlers' responses/reactions to the inherent contradictions in their role* (theme two). In addition to the above-mentioned disciplines, I have drawn on Lerner's just world theory (social psychology) to illustrate individual actors' responses to injustice.

In addition, I make particular use of public administration literature to explore *typologies of organizational actors' responses and reactions to the inherent contradictions in their role* (theme three). It was considered that these typologies from the broad area of public administration were the most useful typologies in terms of interpreting the findings of this study. Overall these typologies suggest a continuum of extreme organization orientation to extreme client orientation. What are the implications of these typologies for NHS complaints managers? If there are different 'types' of complaints manager, this may suggest that some complaints

managers could experience tensions in their role, while others would not. These questions are explored in Chapter Six of the thesis.

With reference to the analysis of key empirical studies, a general conclusion that can be drawn from all the studies was that complaints handlers/ third-party dispute handlers can find themselves in a difficult position in terms of needing to balance duties to the complainant against the agenda of the complained about organization. In addition, complaint handlers may respond or react to their role in different ways, according to their own personal style.

In summary, it could be argued that this review of the theoretical literature supports the following propositions:

- In-house complaints handlers occupy a role which encompasses inherent contradictions;
- Complaints handlers will exhibit a variety of responses and reactions to the contradictions experienced in their role in terms of organization orientation versus complainant orientation, which may result in tensions for the complaints handlers concerned.
- It would be possible to generate a typology of complaints handlers' adjustment to the contradictions in their role.

Chapter Two: The Study in its Policy Context

Introduction

The aim of this chapter is to place the study in its policy context at the time of data collection (1999). With regard to the NHS complaints policy, this study began three years after the complaints procedure had been reformed (1996). In terms of the wider health policy, the study was conducted at a time when there was an increasing concern about accountability and quality in the NHS. In recent years, a number of medical blunders and scandals in the NHS have helped to put quality and accountability to the forefront of government policy. The government refers to:

> ...a series of well-publicised lapses in quality that have prompted doubts in the minds of patients about the overall standards of care they may receive.
> (NHS Executive 1998: 5)

An inquiry into children's services at Bristol Royal Infirmary[1], which reported in July 2001 suggested that in the future patients' safety must be the focal point of quality; learning from mistakes rather than seeking someone to blame must be a main concern to facilitate improvements in safety and quality; openness and transparency should be fundamental to the development of trust between healthcare professional and patient and ultimately the trust between the NHS and the public (Bristol Royal Infirmary Report 2001: 11). Health policy scholar, Brian Salter (2001: 872) argues that the Bristol Inquiry in particular has converted

> ... a general scepticism about medical authority into a high-profile, media-sensitive political issue of public trust ...

Consistent with this speculation is the fact that complaints about NHS services are rising; the total number of written complaints received about Hospital and

1 Bristol Royal Infirmary Inquiry (2001) *Learning from Bristol: The Report of the Public Inquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984- 1995*. London: The Stationery Office. (This inquiry reported on a scandal at Bristol Royal Infirmary relating to children's heart surgery which received wide media coverage in 1998).

Community Health Services increased sharply between 1999-00 and 2000-01 by 10.9% (See Department of Health 2001b); the number of written complaints received about Family Health Services increased between 1999-00 and 2000-01 by just under 12% (See Department of Health 2001c).

The remainder of the chapter is as follows. First, it looks at how medical self-regulation has impacted on the NHS complaints system in terms of it being an in-house complaints procedure. Second, it sets out the operation of the complaints system at the time of the study. Third, it identifies key problems of the system.

The Impact of Self-Regulation on the Complaints System

Medical practice, as an occupation, which is regarded as professional, has a state-mandated licence to 'self-regulate' (See Allsop and Mulcahy 1998a: 180); on this basis the medical profession has asserted its right to exercise clinical autonomy and personal judgement in their practice. This has posed particular problems for the regulation of medical work in general and the operation of complaints systems in particular (See Allsop and Mulcahy 1998a: 181). Essentially, medical professionals assertively defend the guiding principle that their actions should only be judged by fellow professionals who have the necessary expertise to judge a fellow professionals work. On this basis many complaints systems are either run by professionals themselves or complaints systems draw on professional expertise to make decisions (Allsop and Mulcahy 1998a: 181). This in turn limits lay involvement in the assessment of complaints (See Nettleton and Harding 1994: 38). Sociologist, Margaret Stacey (1974: 433) argues that the insistence of doctors upon clinical autonomy was a major impediment to an effective complaints system. In a similar vein, Nettleton and Harding (1994: 56) argue that self-regulation of the medical profession was one of the primary factors holding back progress with the complaints procedures; and that there needed to be a shift in the balance of power between the providers and the consumers.

In view of the above, the NHS complaints system is an internally based system in the sense that the procedure is an in-house complaints procedure. A key theme running through criticisms of the complaints procedures since its inception has been that it is weighted in favour of the medical profession. Indeed, I argue that weaknesses in the current complaints system stem from the fact that the system is internally based and thus continues to be weighted against the complainant. In this context the position of the NHS complaints manager is fraught with difficulties as there is a question mark as to whether working for the complained about organization might cause professional loyalties to override fair play.[2] The Association of Community Health Councils for England and Wales (ACHCEW) (1990: 3) comment that since the introduction of the NHS in 1948, it has often appeared to be organized for the convenience of the providers with a paternalistic 'professional-knows-best' attitude to patients. They point out that many complainants considered the procedure was beholden to the medical profession. For example, serious allegations were investigated and handled by medical professionals themselves, with many medical staff viewing complaints with hostility (1990: 6).

Since its inception, there have been a number of calls to make the complaints procedure more impartial. In 1973, the Davies Committee (1973: 33), appointed to review the NHS (hospital) complaints procedure suggested that the complaints system could not work properly unless there were much stronger external checks and safe guards. In 1992, The Association of Community Health Councils for England and Wales (ACHCEW) and Action for Victims of Medical Accidents (AVMA) argued that many complainants felt that the current system was not independent and consequently medical negligence claims were increasing:

> Despite the cost, difficulties and delays involved in court actions, an increasing number of complainants have in recent years sought redress in the courts. The reason: the impartiality of the courts – an impartiality which many victims feel they do not get within the self-regulatory system which operates in the Health Service ... (ACHCEW and AVMA (1992: 2-3).

[2] See Department of Health (1994) *Being Heard The Report of a Review Committee on NHS Complaints Procedures*, chaired by Professor A. Wilson. London: Department of Health. Also see Chapter One of the thesis.

In 1992, ACHCEW and AVMA drew up proposals for an independent health standards inspectorate and proposed that the inspectorate should be comprised of a substantial lay membership along with representatives of health professionals, patient groups, health services managers and unions (1992: 6). In 1996, the complaints system was reformed but to date has remained very much an internally run complaints procedure.[3]

In terms of progress made relating to wider health policy, Brian Salter suggests that recent government measures relating to accountability and quality represent a challenge to professional self-regulation of the medical profession in that the state now has established its own 'bureaucratic vehicles' of regulation; that a number of recent quality and accountability oriented initiatives have placed self-regulation within a '... state-administered apparatus of accountability...' This has the purpose of modernizing self-regulation so that it is more transparent, responsive in terms of change, and accountable for professional standards (Salter 2001: 874). Many of these initiatives introduced in the Government document, *A First Class Service* (1998) included 'clinical governance', a 'Commission for Health Improvement,'[4] 'A National Framework for Assessing Performance' and an 'Annual National Survey of Patient and User Experience of the NHS' (NHS Executive 1998: 9). Taking the example of the clinical governance initiative, the Department of Health describes 'clinical governance' as a framework for making NHS organizations accountable for service quality by '...creating an environment in which excellence in clinical care will flourish' (NHS Executive 1998: 33); the document states that clinical governance has an important role to play in restoring public confidence in the NHS; for the first time the NHS will be required to implement a '... structured and coherent approach to clinical quality' (NHS Executive 1998: 34). Salter argues that clinical governance has had the effect of reducing the influence of medical self-regulation in that self-regulation is no longer regarded as a sufficient guarantee of high-quality health-care provision (Salter 2001: 873). Nonetheless, it is important to note that these initiatives

[3] See later section in this chapter: an analysis of the key problems of the current complaints system. Also see the Government document: *NHS Complaints - Making Things Right* (DOH 2003) regarding reforms, which are planned to make the system more impartial.

[4] To be replaced in 2004 by the Commission For Healthcare Inspection and Audit (CHAI).

were not designed to bring professional self-regulation to an end (See NHS Executive 1998: 46-47) and the NHS complaints procedure continues to be internally run.[5]

[5] The Government document, *NHS Complaints – Making Things Right* proposes radical reform to the independent review stage (second stage of the complaints procedure) by placing responsibility for it with the new Commission for Healthcare Audit and Inspection (CHAI) (Department of Health 2003: 3).

The NHS Complaints Procedure in 1999[6]

The complaints system is divided into two stages, *local resolution* (stage one) and the *independent review* (stage two).

Box 2.1 Local resolution – stage one

The NHS Executive (1996) states that the primary objective of local resolution is to provide the fullest possible opportunity for investigation and resolution of the complaint as quickly as possible 'aiming to satisfy the complainant while being scrupulously fair to staff.' Many complaints should be able to be resolved early on, where possible by those on the spot (NHS Executive 1996: 17). In Trusts, complaints can be initiated with frontline staff in the wards, in clinics, at reception desks or with departmental managers. However, if the recipient of the complaint is unable to investigate the complaint adequately, then it should be referred to the complaints manager either for advice or handling (1996: 17). In reality, complainants may prefer to make their initial complaint directly to the complaints manager or Chief Executive (See NHS Executive 1996: 18). The complainant should receive a written reply from the relevant trust/ health authority[7] in response to a written complaint (1996: 19); this letter should aim to satisfy the complainant that the complaint has been fully and fairly investigated, with an appropriate apology where things have gone wrong, and detailing what is to be done to prevent a recurrence (1996: 21).

With regards to Family Health Services Practitioners, complaints procedures are 'practice-owned' and thus complaints are managed exclusively by the practice. One person is designated by the practice to be responsible for overseeing the administration of the procedure. Thus the health authority will only become involved if the practice procedure does not appear to meet the national criteria; or if asked to do so by the complainant and/ or the practitioner (1996: 19). All the above-mentioned aims of local resolution are applicable to practices but are carried out by a *practice complaints manager*. In spite of the significant control of the local resolution process by the practice, health authorities are allowed a limited role in the family health services local resolution process; if a complainant does not wish for some reason to have a complaint handled by the practitioner, health authorities can if both parties agree act as 'honest broker' between the complainant and the practitioner to settle the complaint at practice level. Health authorities can also provide lay conciliators as a service to complainants and practices. Indeed conciliation may prove crucial if complaints are to be resolved satisfactorily at practice level.[8]

Source: NHS Executive 1996

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[6] At present, the complaints procedure is operating under the same regulations as in 1999. However, the Government document, *NHS Complaints – Making Things Right* published in February 2003 sets out the Governments plans to improve the NHS Complaints procedure.

[7] Health authorities were abolished from 1 October 2002 and responsibility for handling the independent review stage for complaints about Family Health Services practitioners passed from Health Authorities to Primary Care Trusts (See Department of Health 2003b).

[8] Conciliation is a process of facilitating agreement between the practitioner and complainant (1996: 20).

Box 2.2 Independent review – stage two

Complainants who are dissatisfied with the trust/health authorities response or family health services response as a result of the local resolution (stage one) process can submit a request for an independent review panel (IRP) to the convener either orally or in writing. This request should be made within a period of twenty-eight calendar days from the completion of the local resolution process (NHS Executive 1996: 23). It is important to note that the right of the complainant to request the convener to set up an independent review panel is not a right to proceed automatically to the Independent Review stage (1996: 21); there may be occasions when the convener considers that local resolution has been satisfactorily carried out, in that the complaint has been properly investigated and an appropriate explanation given, and that nothing further can be done, although the complainant remains dissatisfied. However, if an independent review request is refused, the complainant has the right to put their case direct to the Ombudsman (1996: 24).

The role of the non-executive convener is fundamental to activating procedures under the independent review.[9] The convener's role is to ensure that the complaint is dealt with impartially at the convening stage, that is, to determine whether all avenues for satisfying the complainant during local resolution have been considered and fully exhausted and what issues if any could be referred to an independent review panel. Before making the decision on whether to convene a panel, the convener will contact a nominated independent lay panel chairman from the regional list (1996: 24). Where a complaint appears to relate in whole or in part to action taken in consequence of the exercise of clinical judgement, the convener is obliged to take appropriate clinical advice in deciding whether to convene an independent review panel (1996: 25). It is, however, ultimately the convener's decision whether or not to recommend proceeding with the establishment of a panel and to explain why he/she has made this decision (1996: 24).

If the convener agrees to an independent review, an independent review panel is set up. The panel consists of three members: an independent lay chairman, the convener and a third person.[10] Where the convener decides that the complaint is a clinical complaint, the panel will be advised by at least two independent clinical assessors nominated by the regional office, following advice from the relevant professional bodies (1996: 29). The purpose of the panel is to consider the complaint according to the terms of reference decided by the convener and in the light of a written statement provided to the convener by the complainant. The panel will investigate the facts of the case, taking into account the views of both sides. It will set out its conclusions, with appropriate comments and suggestions in a written report (1996: 29).

Completion of the complaints procedure for trusts and health authorities is when the Chief Executive writes to notify the complainant of both the result of the independent review by the trust/health authority board of the independent review panels report and the complainant's right to complain to the ombudsman if still dissatisfied (1996: 37). In cases of complaints involving family health services practitioners, completion of the complaints procedure is when

[9] The convener is the non-executive director of the trust/ health authority, or a person specifically selected by the board of the trust/ health authority to act in this role (NHS Executive 1996: 55).

[10] According to official guidance provided by the NHS Executive in 1996, in the case of Trust independent review panels, the third person is either a Health Authority non-executive or a GP fund-holder nominated by the fund-holding practice, which purchased the service concerned. In the case of Health Authority panels, the third member of the panel will be another independent person nominated by the Secretary Of State for Health (NHS Executive 1996: 29). Since the guidance was issued in 1996, a change has taken place whereby *Primary Care Trusts* will now be expected to provide the third independent review panel member in relation to complaints about Trusts (See Department of Health 2003c).

the panel's report is sent to the complainant by the Chief Executive of the health authority. The Chief Executive must send the independent review panels report to the complainant and the practitioner together with appropriate covering letters as soon as possible after receiving it. The covering letter must inform the complainant of their right to refer their complaint to the Health Service Ombudsman if still dissatisfied (1996: 38).[11]

Source: NHS Executive 1996

An Analysis of the Key Problems of the Current Complaints System

I argue that there are four key problems in the current complaints system (the complaints system at the time of the study).[12] First, local resolution (particularly in primary care) lacks impartiality (Public Law Project[13] 1999: vii) Second, access to the independent review stage is unlikely to be impartial and the independent review stage itself lacks impartiality (in both primary and secondary care) (Public Law Project 1999: ix). Third, in general, complaints are not being used to improve services; lessons are not being learned from complaints. The Public Law Project's research demonstrated that the NHS only had weak mechanisms in place for improving services and performance in the NHS (Public Law Project 1999: x). This can be linked with the lack of external monitoring and overseeing of the implementation of independent review panel recommendations for improvements to the service (See Public Law Project 1999: x). Fourth, there are restrictions on the information given to complainants regarding disciplinary action taken against staff, which is a problem in terms of the accountability of health professionals (Public Law Project 1999: xi).

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[11] The main stages at which complaints may be made to the Ombudsman are where: the responsible NHS body has refused to investigate a complaint because it fell outside the NHS time limits; or where a complainant is dissatisfied following local resolution and the convener has refused his/ her request for an Independent Review; or the complainant is dissatisfied with the process or the outcome of the Independent Review (NHS Executive 1996: 44).

[12] These problems have been identified by the author as being of special significance, particularly with reference to the role of the complaints manager as demonstrated in Chapter Four and Five of the thesis. Others may highlight additional/ different problems.

[13] In July 1997, the Public Law Project (PLP) (A national legal charity which aims to improve access to public law remedies for those whose access to justice is restricted by poverty or some other form of disadvantage) received funding from the National Lottery Charities Board to carry out the first, independent national evaluation of the operation and effectiveness of the NHS complaints procedure introduced in April 1996. The Public Law Project's aim was to explore issues of fairness and independence, and the complainants' satisfaction with both the handling and outcome of their complaint, thus evaluating the procedure from the perspective of health service users (Public Law Project 1999: vii).

The lack of impartiality at local resolution stage (stage one of the complaints procedure)

The local resolution stage essentially lacks impartiality as at this stage the organization is investigating its own complaints, which gives rise to a potential conflict of interest (Public Law Project 1999: vii). Because the process of local resolution is internal to the organization, how well it works varies between organizations depending on the training and attitude of individual members of staff and on the culture of the organization itself. There is no mechanism to ensure that complaints are adequately addressed or that necessary action follows from a complaint (DOH 2001a: 49). Elder (1998: 45) drew attention to the views of some complainants that investigating officers nearly always accepted the versions of the hospital personnel involved in a case.[14]

In particular, in primary care, there have been concerns about staff investigating complaints made against themselves in practices. Three key concerns arise from this issue. First, the complaints handling process itself is unlikely to be impartial. In terms of complaint handling, the practice complaints administrators (often practice managers) overseeing practice-based complaints brings about a clear conflict of interest. In other words, it is fair to suggest that practice managers undertaking this role are likely to find it difficult to be impartial about complaints about their colleagues. Even more worrying, some GPs may wish to take on the role of complaints administrators themselves which would mean in theory that complaints administrators could be investigating complaints against themselves. Second, local resolution might not be appropriate for many complaints. It could be argued that informal resolution would be unsuitable for serious complaints. Third, many complainants simply find it intimidating to complain directly to the practice they are complaining about. Recent research by the Public Law Project (1999) supports these concerns. The research by the Public Law Project (1999) demonstrates that complainants worry at the idea of having to confront the person concerned, particularly if they are feeling vulnerable. Some are doubtful about whether they will

[14] See Chapter Four of the thesis.

receive impartial explanations. They were also apprehensive about possible reprisals, such as being struck off the doctor's list, or being badly treated (1999: viii). The Public Law Project (1999) recommends that as a matter of priority, the Department of Health should reform local resolution in primary care to enable users to complain to an officer who is independent of the practice concerned and who has responsibility for investigation of the complaint (1999: 63). The Department of Health (2001a: 71) evaluation[15] too has advised that there is a need to offer complainants an opportunity to avoid the need to complain directly to the practice.[16]

Informalism and the lack of accountability in practice complaints procedures

Even before the current procedures were in introduced, Public law scholar, Diane Longley (1993: 74-75) hinted that informalism in complaint handling could lead to matters of public concern never coming to the fore. The National Consumer Council (1997: 19) also advised that local resolution was likely to bring about more oral than written complaints, which could lead to complaints not being recorded properly (1997: 19). With regard to primary care, because the emphasis is on practice-based resolution, and only limited data are formally collected about complaints in primary care, health authorities have no means of meaningfully monitoring trends in complaints. In other words there are insufficient external checks on primary care complaints (Public Law Project 1999: x). The Public Law Project research respondents questioned how continuing bad practice or poor performance would become evident and be adequately addressed, if no one was responsible for monitoring where failings in the service lay, or if complainants could not direct their complaints to a higher authority. It was widely believed that this had led to a loss of accountability of primary care practitioners (1999: x). In addition, research participants were worried that there were inadequate mechanisms in place to contend with complaints which raised serious questions about performance, conduct or competence that might put patients at risk (1999: viii). The Public Law Project (1999:

[15] In 1999 the Department of Health commissioned a two-year UK wide evaluation study of the NHS complaints procedure. The report was published in March 2001.

[16] The Government document, *NHS Complaints – Making Things Right,* proposes to enable patients to complain direct to their Primary Care Trust (PCT) – either informally through the Patient Advocate and Liaison Service (PALS) or formally to the complaints manager – where they have concerns about a practitioner but do not wish to raise these with the practice directly (Department of Health 2003: 11).

71) recommended that health authorities should be given authority to monitor complaints handled under practice-based complaints procedures. As part of this process, primary care practitioners should be required to submit more detailed information to health authorities about complaints including the nature of complaints they have received, how local resolution was approached and remedial action taken as a consequence. The Department of Health (2001a: 70) too asserted that current mechanisms for local resolution are inadequate to ensure that complaints are properly addressed or that necessary action follows from a complaint.

Mulcahy (1999a) suggests that the emphasis on informalism in local resolution, and in particular, primary care has given greater power to the complained about. In the paper 'Being Seen to Be Heard', Mulcahy (1999a: 81) points out that GPs now have the opportunity for early notification of dissatisfaction and time to resolve an issue before it escalates. Emphasis has been placed on the privacy of dispute resolution. Thus the reformed procedures (reformed in 1996) did little to enhance the power of the service user Mulcahy (1999a: 81). In a similar vein, Susan Kerrison and Allyson Pollack (2001) make the case that informal disputes procedures allow the state to decide which complaints get expressed, by whom, to whom, in what form and forum, how they are processed, and what remedy is determined. Thus Kerrison and Pollack argue that the reduction of procedural safeguards associated with formal adjudication typically operates in the interests of stronger institutional litigants rather than the disadvantaged, leaving the stronger litigant free to engage in coercive or manipulative actions (2001: 122).

The lack of impartiality at the independent review stage (stage two of the complaints procedure)

A second important criticism of the current complaints procedure is that access to the independent review stage is unlikely to be impartial and the independent review stage itself lacks impartiality (in both primary and secondary care) (Public Law Project 1999: ix). The Department of Health (2001a: 6) evaluation of the NHS complaints procedures concluded that the independent review stage of the complaints procedure

does not offer an *independent* review process and does not have the *authority* to ensure its recommendations are enforced.

First, the decision about whether or not an independent review panel should be established is the responsibility of conveners appointed by Trusts and Health Authorities. The National Consumer Council (1997: 24) has pointed out that because complainants do not have an automatic right to an Independent Review Panel, the independence of conveners is crucial in facilitating the second stage of the complaints procedures. However, there are significant doubts about the impartiality of conveners in that many conveners are non-executive directors and may feel defensive about criticisms of services (See National Consumer Council 1997: 23). In addition, conveners are required to set up an independent review panel where appropriate, regardless of the cost. However, as non-executive directors, they must also ensure that the trust or health authority keeps within its budget (National Consumer Council 1997: 23). The Public Law Project's study revealed serious doubts about the ability of conveners to be impartial (1999: ix). The most remarkable finding was that nearly one half (forty-six percent) of conveners in healthcare trusts *themselves* believed that it was difficult to be impartial; they felt that being involved in the trust as a non-executive director and knowing the staff, invariably introduced a bias in favour of the complained about. Conveners also acknowledged that complainants did not see them as independent. The obligation on a convener to consult a lay chair for an independent opinion on a complaint was not considered a sufficient safety measure against possible bias, because ultimately the judgment whether or not to hold a panel still rested with the convener (1999: ix). Thus it could be argued that the impartiality of the convener's 'gatekeeping function' whereby complaints are screened for consideration is unacceptable (Solomon 1994: 91).

Second, a concern is that the convener has a pivotal role in the independent review panel itself. Thus for the same reasons stated above, it could be argued that the independent review panel itself could be flawed in terms of impartiality. In addition, the Public Law Project study suggested that other independent review panel members and clinical assessors did not always behave in a way, which reassured complainants of their impartiality in the process (1999: ix). The Public Law Project recommended that the Department of Health should establish *independent regional complaints*

centres, which are responsible for handling complaints, which fail to be resolved at local resolution. Under this proposal, conveners would no longer be part of the organization complained about but an independent appointment (1999: xii).[17]

Failure to use complaints to improve the quality of the service

A third problem has been the general failure in NHS organizations to use complaints to improve the quality of the service.[18] In the paper 'Medical accidents in the UK: a wasted opportunity for improvement?', health services researcher, Kieron Walshe (1999: 68) points out that complaints remain a largely underused resource in quality improvement:

> There are still no formal mechanisms for trying to ensure that NHS healthcare providers use complaints to trigger wider reviews of services and processes, so that they learn from instances of poor-quality care and act to prevent future similar problems. In many NHS providers, the arrangements for dealing with patients' complaints, though they may now work much better than they used to, are still curiously disconnected from systems for clinical audit and quality improvement (Walshe 1999: 68).

Similarly, in the Government document, *An Organisation With a Memory*, the Chief Medical Officer for England and Wales, Liam Donaldson, (2000a: 73) reports that the NHS is failing to learn from the things that go wrong and has no system to put this right. He considers that the NHS has an out of date approach in this respect compared to some other sectors.

Furthermore, The Public Law Project's research (1999: x) demonstrated that the NHS has only weak mechanisms in place for using complaints to improve services and performance in the NHS. Many of the complainants interviewed for the Public Law Project study were sceptical about whether their complaint would have any impact on

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[17] As noted earlier, the document, *NHS Complaints – Making Things Right* sets out the Government's plans for radical reform to the independent review stage by placing responsibility for it with the new Commission for Healthcare Audit and Inspection (CHAI) (2003: 3).

[18] 'Quality enhancement' is considered an important goal of the complaints procedures. The Department of Health (1994) noted that complaints provide important management information about the quality of services from the perspective of service users; complaints could help identify problems and sometimes suggest solutions (Department of Health 1994: 37).

the quality of services. Indeed, the Public Law Project identified problems in acting on complaints at both local resolution and independent review stage (1999: x). At local resolution stage, a major concern of respondents in the Public Law Project's study was the lack of external monitoring of primary care complaints as explored previously. At independent review stage, there was a lack of confidence in the effectiveness of independent review panels' recommendations in achieving improvements in services. The key issues were: the lack of commitment on the part of some organizations to improving service delivery and the absence of an external body formally charged with monitoring and overseeing the implementation of panel recommendations (1999: x). The Public Law Project (1999: xii) recommended that the Department of Health should introduce procedures for monitoring the implementation of independent review panel recommendations by an external body, and for ensuring that quality issues identified by panels are disseminated for the benefit of the NHS as a whole.

Complaints and disciplinary action

A fourth problem of the current complaints procedure is the lack of transparency of the disciplinary process; in relation to those complaints that are referred for disciplinary action, this is an invisible process for complainants, as they have no right to know the outcome of such action except in general terms (Public Law Project 1999: xi). The Public Law Project argues that consequently, complainants may be denied information about one of the most important outcomes they seek in making a complaint - that remedial action has been taken to address failings in care for the benefit of future patients. Without such information a common feeling is that health professionals are not accountable for their actions (Public Law Project 1999: xi). Also in terms of actual disciplinary action taken, where failings in performance are identified, these are increasingly dealt with by *more informal processes of review* and thus lack the threat of penalties, which arguably could make health professionals more accountable (See Public Law Project 1999: xi). The Public Law Project recommended that the disciplinary process should be made more transparent and complainants should as a matter of course, be informed of the outcome of disciplinary action (1999: 73).

Conclusion

This chapter has placed the NHS complaints manager in a policy context by considering the impact of self-regulation on the complaints system; setting out the complaints procedure; and providing an analysis of the key problems in the current complaints system.

The NHS complaints system is *in theory* an impartial system; previously in this chapter it was stated that the aim of the local resolution stage of the complaints procedure (stage one) was to satisfy the complainant that the complaint has been fully and fairly investigated, with an appropriate apology where things have gone wrong (NHS Executive 1996: 21). In 1994, the Department of Health recommended that the NHS complaints system incorporated a number of key principles and listed impartiality as one of these fundamental principals (DoH 1994: 37).[19] In *practice*, however, this chapter has suggested that the complaints system is considerably weighted against the complainant and thus far from impartial. Indeed, it could be argued that the key problems in the complaints system contribute to the inherent contradictions in the complaints managers' role. All four identified problems in the current complaints system arguably cause contradictions in the complaints manager role either directly or indirectly in that they contribute to a system that is, in practice, weighted against the complainant, while the official line promotes impartiality.[20]

Furthermore it is worth noting that the key weaknesses of the system are also those areas, which are most important in securing the satisfaction of complainants, (with the complaints manager caught between the system and the complainant). ACHCEW and AVMA (1992:3) outline the key needs and wishes of complainants as being:

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[19] See *Being Heard: The Report of a Review Committee on NHS Complaints Procedures* (Department of Health 1994: 37). The nine principals recommended by the Review Committee were responsiveness, quality enhancement, cost effectiveness, accessibility, impartiality, simplicity, speed, confidentiality and accountability (Department of Health 1994: 37).

[20] See Chapter Four of the thesis regarding the inherent contradictions in the complaints manager's role and Chapter Five of the thesis regarding complaints managers' views on the impartiality of the independent review stage of the complaints procedure.

- What happened and why it happened (that is, impartial investigations).
- Whether anyone is to blame and if so what action will be taken against that person/ institutions (that is, accountability in terms of disciplining the person/ institutions).
- What action is going to be taken within the system to try and ensure that it does not happen again? (that is, quality enhancement/ quality assurance goal).

In short the NHS complaints system is beset with contradictions since the complaints system is in theory an impartial system while in practice the system appears to be biased against the complainant and thus lacks impartiality. In fact, the significant theme emerging from *both* the socio-legal literature on the inherent contradictions in the role of in-house complaint handlers [21] *and* the policy literature[22] is that the complaints system is weighted against complainants. Thus the complaints manager is effectively caught between two competing interests; the rhetoric of impartiality versus the reality of overseeing a system which is far from impartial; the rights of the complainant versus the requirements of the complained about organization. Hence, it could be argued that in-house NHS complaints managers, overseeing a system, which is weighted against the complainant, are likely to confront significant contradictions in their role.

[21] Reviewed in Chapter One of the thesis.

[22] Reviewed for this chapter.

Chapter Three: The Methods Adopted for this Study

Introduction

This chapter discusses the research methodology used in the study. It begins with a reiteration of the conceptual framework[1] used in the study, linking this with the key research questions. Next, there is a description of the methodological approach adopted. This is followed by a description of the complaints manager interviews (the principal method of data collection for the study) in terms of sampling, data collection and data analysis. After that, there is a description of the other methods of data collection: the documentary analysis of job descriptions and person specifications in terms of sampling, data collection, and data analysis, and the email interviews carried out with 'complaints experts', again with reference to sampling, data collection, and data analysis. Finally there is a consideration of the methods used in the study.

The Conceptual Framework and Research Questions

The conceptual framework (literature exploring concepts, models and theories relevant to the contradictions inherent in the complaints managers' role and responses to these contradictions) and research questions evolved over a period of time during data analysis. As shown later in this chapter, the initial coding system was not developed from the conceptual framework but generated inductively from the interview transcripts. However, the sub categories generated by the interview transcripts were subsequently placed into three key general categories generated by the *conceptual framework in conjunction with the sub categories/ interview transcripts* (in other words, the general categories were generated by the conceptual framework in conjunction with the empirical data). This process is in keeping with the interplay between deduction and induction (See Bulmer 1983: 248). Martin

[1] Described in Chapter One of the thesis.

Bulmer states that there is a constant interplay between research and theorizing (1983: 248).[2] Thus, the conceptual framework was fully developed *after* the initial data analysis had taken place. The research questions (matching the key propositions of the thesis), then, were generated through an analysis of *both* the empirical findings *and* the theoretical literature. As such, readers should be aware that while the research questions, because they correspond with the propositions outlined in Chapter One, may appear to have been generated through the literature alone, in fact, these propositions are equally informed by the empirical data. In other words, the propositions were not defined a priori. Thus, at the beginning of the study, a review of the literature led to the identification of the proposed project. In turn the findings and subsequent data analysis led to searching for additional literature which explained the data, and so on. Accordingly, the theoretical literature and the empirical data are closely intertwined. This is in keeping with Michael Patton's observations that qualitative inquiry designs cannot be completely specified in advance of fieldwork; a qualitative design unfolds as fieldwork unfolds (1990: 61). In a similar vein, Rubin and Rubin (1995: 41) suggest that the qualitative researcher needs to have a high tolerance for uncertainty, especially at the beginning of the project, because the design will continue to change as the researcher makes sense of the data.

Socio-legal studies, public administration, and sociology/ social psychology seemed to provide the best framework for exploring the key themes of the study. Ultimately, it was possible to fit the key general categories that emerged into to three themes, synonymous with the research questions:

- Is there an inherent contradiction and conflict in the NHS complaints manager's role?
- How did the complaints managers respond and react to the contradictions/ conflict in their role?
- Were there different types of complaints managers?[3]

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[2] For example, at the outset of this study, the conceptual framework proposed was role theory. However after initial data analysis, other important frameworks emerged such as public administration, and socio-legal studies. Also, while the themes relating to the first two research questions were incorporated into the research design at the outset, the third research question emerged after initial data analysis.

[3] This is an abridged version of the research questions. A full version is given later.

The first theme and research question explores the issue of *inherent contradictions in the complaints manager's role*. Drawing on concepts, models and theories from socio-legal studies, public administration, and sociology, it was possible to speculate that there would be inherent contradictions in the role of the NHS complaints manager due to the fact that complaints managers were caught between their duty to complainants and the organizational agenda (their loyalty to the organization/ organizational constraints).

The second theme and research question explores complaints managers' *responses or reactions to the inherent contradictions in their role*. I was particularly interested in exploring the extent to which complaints managers adapt to the inherent contradictions in their role in terms of *organizational orientation* versus *complainant orientation*. I explored these reactions or responses to the complaints managers' role in relation to key conflict variables.[4] This theme of complaints managers' responses to the inherent contradictions in their role was supported by literature from socio-legal studies, public administration, and sociology/ social psychology. In broad terms, this literature pointed to instances of both conformity with the dominant institution and non-conformity with the dominant institution, which could be argued to be indicative of organizational orientation and complainant orientation respectively.

The third theme and research question explored the issue of *different types of complaints managers* in terms of their responses to the inherent contradictions in their role. In formulating the typology of NHS complaints managers for this study, I have drawn primarily from public administration literature, that is, the work of Welch (1994), Presthus (1979), and Sherman and Wenocur (1983).[5] While a number of different types of organizational actor were identified in terms of their responses to the contradictions/ conflicts inherent in the organizational situation, it was possible to discern three broad types of actors that were dominant in the literature:[6] actors

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[4] See Chapter Five of the thesis.

[5] See Chapters One and Six of the thesis.

[6] See Chapter One of the thesis.

showing *extreme organizational orientation;* actors showing *extreme client orientation*; and actors showing '*middle-of-the-road' orientation.*

To finish, the study asked the following research questions:

- Is there an inherent contradiction and conflict in the complaints manager's role? How did this manifest itself?
- How did the complaints managers *respond and react to the contradictions in their role*? How did the complaints managers respond and react to their role in terms of *organization orientation versus complainant orientation*?
- Were there different *types of complaints manager*?

A Qualitative Approach

The specific focus of the thesis is on the *conflicts* and *tensions* in the complaints manager role, which can be related to more general concepts of behaviour, experiences, attitudes, perceptions and emotions. Thus the research is concerned with what complaints managers do, think, and feel; how complaints managers make sense of the world, and cope with problems presented to them, namely the types of issues that are best studied using qualitative methods.

With reference to the concept of *conflict* (the inherent contradictions in the complaint managers role), this issue is usefully explored by qualitative research because in exploring whether conflict/ contradictions exist, it is necessary to understand experiences and reconstruct events (Rubin and Rubin 1995: 1). For example, in terms of the speculation there is an inherent contradiction in role of the complaints manager (Research question one), I was concerned with complaints managers' behaviour and experiences in matters such as complaints investigations, negotiating with staff, and constraints to investigating practice complaints. It would be difficult to ascertain the complexity of the inherent contradictions and conflict in the complaints manager's role with a quantitative approach; respondents would not be able to explore their

replies in for instance, a structured questionnaire (a quantitative method). Additionally, all the issues explored in Chapter Four of the thesis which highlight the contradiction in the complaints mangers role, were illustrated by detailed quotations. This is clearly consistent with the qualitative interpretive approach of generating rich descriptions of respondents' worlds, work and experiences (See Rubin and Rubin 1995: 35).

In terms of the *tensions* aspect of the thesis, that is, the complaints manager's *responses to the contradictions/ conflicts in their role*, a qualitative approach is necessary because the subject matter being studied concerns behaviour, attitudes and emotions. This study particularly emphasizes the role of the *individual* responses to different issues and situations. A quantitative approach would not be appropriate for this aspect of the study in that quantitative research is about overall sums and averages, ignoring the detail and richness of individual behaviour (Rubin and Rubin 1995: 34). Rubin and Rubin consider that the 'counting aspects' of research, although useful, tell only a small part of the story and not always the most interesting or useful part (1995: 34). In addition, this study also explores how complaints mangers adapt/ adjust to their situations, which again lends itself to a qualitative approach, which enables us to ascertain this kind of information (See Rubin and Rubin 1995: 34).

In light of the above points, it is clear that this thesis is not primarily concerned with collecting facts on what complaints managers do per se (which is why the analysis of complaints managers' job descriptions was a supplementary research method). In other words the thesis is about the conflicts and tensions in relation to NHS complaints managers; it is not merely a study of 'the role of the NHS complaints manager;' neither is the thesis about establishing 'statistical regularities' (See Cotgrove 1968: 27). For example, complaints managers might be able to give a precise answer regarding their job title, status, or number of years spent in their post, but in terms of exploring ideas, which are not as easily defined, the positivist/ quantitative approach becomes problematic (Rubin and Rubin 1995: 33). Complaints managers may have *different* conceptions of fairness and justice; they may have *varied* ideas of what constitutes an 'unjustified complaint'. Hence, trying to impose one definition with a quantitative approach may be misleading or confusing (see Rubin and Rubin 1995: 33).

In short, qualitative methods are best suited to exploring individuals' experiences in depth; a quantitative approach, involving collecting statistics, would not bring an adequate understanding to these issues. Thus, it was considered that it would be logical to use a qualitative methodology.

Which qualitative paradigm?

One way of elucidating qualitative strategies is to consider how a qualitative inquiry constitutes a methodological paradigm (See Patton 1990: 37). In this sense, a methodological paradigm is a worldview or general perspective, which informs the study; a theoretical construct for clarifying basic assumptions about the nature of reality (See Patton 1990: 37-39). In terms of designing research studies, different methodological paradigms have influenced how qualitative studies are conducted (Patton 1990: 65). Indeed, there is a wide range of options within qualitative research in terms of different theoretical perspectives that are closely associated with qualitative methods (Patton 1990: 65), for example, ethnography, phenomenology, ethnomethodology, hermeneutics, heuristic inquiry, symbolic interactionism (1990: 67- 85). Yet, it could be argued that a study is not necessarily required to adhere rigidly with one paradigm or the other. As Pope and Mays (2000: 2) point out, the distinctions between methodological perspectives are not clear-cut; the link between the research and the framework may not be clear, i.e. sometimes the link is implicit. In Patton's view (1990: 38) focusing rigidly to one methodological paradigm constrains methodological flexibility and creativity. Bearing this in mind I am cautious about aligning this study with a specific qualitative paradigm. Be that as it may, it is worth pointing out that this study corresponded significantly with a number of the fundamentals of the symbolic interactionist paradigm.

The origins of the symbolic interactionist perspective lie in the individualistic focus of American social science as it developed at the turn of the twentieth century (Bilton 1987: 590). Symbolic Interactionism as a perspective forms a central position in the tradition of qualitative research into the ways actors negotiate situations and roles (1987: 590). The symbolic interactionist's epistemological position is that social

reality can only be known through understanding the viewpoint of social actors, their meanings and definitions of their situations (1987: 521).

The symbolic interactionists general conception of social organization (Worsley 1987: 483) is that while the structure within which social actors operate may establish the broad outlines of their role, this leaves plenty of room for social actors to *negotiate* (my emphasis) situations and roles (Worsley 1987: 484). In Zurcher's words,

> We not only conform to role expectations, we interpret, organize, modify, and create them. (Zurcher 1983: 13).

Zurcher (1983: 13) argues that even if some roles are embedded in social institutions and organizations and are not very flexible, individuals usually find ways to enact even the most structurally rigid roles with an *individualized* approach:

> ... we usually find a way, guided by our self-concepts and through interaction with others in the setting, to establish a workable role for ourselves.

Hence, this concept of an individualized approach corresponds strongly with the second and third themes of the thesis, that is:

- Complaints managers exhibit very different responses/ reactions) to the inherent contradictions in their role (theme two);
- There were different types of complaints managers (theme three).

Put another way, the symbolic interactionist perspective argues that the social actor attaches meanings to symbols, for example, an individual's status, dress, gestures in response to the behaviour and reactions of others (See Thompson 1982: 12-13). Indeed, the *meanings that people give to situations* and the *interpretations they make of actions and events* are a crucial feature of the symbolic interactionist approach. With reference to this particular study then, a complaint might be interpreted as 'unjustified' by one complaints manager and as a 'valid complaint' by another; the complaints system might be considered to be 'fair' by some complaints managers and 'unfair' by others; a complaint investigation might be viewed by one complaints manager as 'satisfactory' and as 'flawed' by another complaints manager. Equally

individuals attribute different meanings to what might seem to be the same experience (Thompson 1982: 13). For some complaints managers, empathizing intensely with complainants might seem a logical and normal way to react to an upsetting complaint. For others it might be an indication of weakness or lack of self-control. According to this perspective, then, there is no such thing as only one social reality (See Thompson 1982: 13).

While stressing the way individuals can negotiate their roles, it is important not to underestimate the impact of constraints on a social role. Indeed, theme one of the thesis relates to the notion that the complaints manager's role encompasses inherent contradictions, regardless of the personal style or individual approach of the complaints manager. In this sense, complaints managers may be constrained by their roles; the complaints manager does not have a free rein in his/ her post and is restricted by the limits of the job. Welch has noted (in the context of response to conflicting agendas) that the individual both constructs his/her social context and at the same time is constructed by it (Welch 1994: 145). Thus, *both* the institution and the person influence a person's response to the institutional agenda. Accordingly, it is necessary to explore the role of complaints managers with reference to *structure* and *action* (See Bilton 1987: 525); 'structure' takes into account the constraints of the job of the complaints managers, while 'action' depicts the complaints managers' personal input to his/ her role. Although symbolic interactionism does pay attention to both structure and action, by a consideration of individual responses to *constraints* from the social structure (relating to theme one of the thesis) (Bilton *et al* 1987: 599), in the view of Bilton *et al*, one weakness the symbolic interactionist approach is that social structures are somewhat neglected in symbolic interactionist analysis (Bilton 1987: 592). Nonetheless, overall, the symbolic interactionist approach corresponds to all three themes of the study, with particular emphasis on themes two and three of the study dealing with the personal input into the complaints managers role, that is, the fact that *individual* complaints managers respond and react very differently to the inherent contradictions in their role.

Complaints Manager Interviews - Sampling

In-depth telephone interviews were carried out over the two-month period, July and August 1999 with a sample of thirty NHS complaints managers[7] which is in accordance with the objectives of qualitative research, namely, to work longer, and with greater care, with a few people than more superficially with many of them. In other words the purpose of the qualitative interview is not to determine how many, and what kinds of people share a certain characteristic; it is to discover how particular individuals interpret their world (See McCracken 1988: 17). Twenty-one complaints managers were from NHS Trusts, and nine were from Health Authorities in the London/South East, although the vast majority were in London. Interviews lasted approximately one hour. These were taped and fully transcribed during September 1999.

The sampling frame used was the North Thames Directory 1998/99 and the South Thames Directory 1998/99 (published by the NHS Executive). As well as Inner and Outer London, the directory contained home county areas.[8] Letters were sent to Chief Executives *asking them to pass the letters on to the designated complaints manager* in their organization, as it was felt that this would increase the likelihood of response (respondents would have received indirect approval to participate in an interview, from the Chief Executive). A form was attached to the letter with a stamped addressed envelope, to be returned by complaints managers stating they were/were not prepared to be interviewed.

Letters were sent to seventy-nine Trusts and Health Authorities, of which twenty-nine were in the *South Thames* region (six Health Authorities and twenty-three Trusts), and fifty in the *North Thames* region (twelve Health Authorities and thirty-eight Trusts). The sample was restricted to London by limiting letters to Trusts and Authorities with local London phone number codes.

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[7] See Appendix for case details for each complaints manager.

[8] Exact locations and geography have been omitted to preserve the anonymity of the respondents.

Letters were sent out in three phases, until a response rate of thirty complaints managers was achieved. Letters were initially sent to Chief Executives in all the London Trusts and Health Authorities. However, in order to increase the response rate, letters were also sent to three additional Health Authorities close to London.[9]

Characteristics of the sample[10]

This section contains some basic details relating to the sample of complaints managers used in this study. In terms of personal characteristics collected, eighty per cent of complaints managers were female. In terms of work background there was no particular pattern. Twenty respondents had worked in the NHS prior to their complaints manager post. Four respondents had specific backgrounds in nursing. The average amount of time spent in the post was 3.3 years.

Complaints managers' posts were far from homogeneous. The sample included twelve Acute Trusts, seven Mental Health trusts, One Community trust, One Ambulance trust and Nine Health Authorities. In relation to job status, the NHS Executive states that the complaints manager is likely to be either a senior manager reporting to the Chief Executive, through another director, with personal access to the Chief Executive when appropriate; a senior manager reporting directly to the Chief Executive; or the Chief Executive (NHS Executive 1996: 11). This sample of complaints managers consisted of sixteen 'third tier' posts; two 'second tier' posts; and ten 'junior' posts.[11] With reference to job title, seven respondents had the title 'quality' somewhere in their posts. Only six respondents were described as the 'complaints manager'/ 'complaints co-ordinator'. There were four complaints managers who had a 'customer services' or 'consumer relations'/ 'consumer affairs'

[9] These additional Health Authorities were accessed from the North and South Thames directories, although they were not actually in London.

[10] Also see brief case details of complaints managers in the Appendix of the thesis. A small number of respondents did not provide information for all the criteria covered in this section. This may have been due to reluctance to reveal what they considered to be confidential information, for example the level of their post in terms of status in the organization.

[11] As mentioned above, a small number of respondents did not provide information for all the criteria covered in this section.

in their job title. There were also four complaints managers who were described as Patient Liaison Managers/Patient Services Managers. In addition, there were four posts with complaints and litigation/ legal in their job titles. In relation to complaints manager tasks, job descriptions[12] indicated that thirteen out of twenty-five complaints managers spent a significant proportion of their time doing 'non-complaints' tasks, with six out of twenty-five spending a third or less of their time on the actual handling of complaints.

Complaint Managers Interviews - Data Collection

The use of qualitative interviews

It was decided that the interview was the best qualitative method to use because the interview is a useful method of gaining access to people's understanding of the worlds in which they live and work (Rubin and Rubin 1995: 3); it enables a rich understanding of other people's lives and experiences (1995: vii); the researcher encourages the interviewee to reflect in detail on events they have experienced (1995: 2). As argued earlier in this chapter, the study concerns how complaints managers make sense of the world and cope with problems presented to them, for example, their perceptions of their role, their assessment of their own behaviour, their perceptions of the fairness and justice of the complaints system, and their responses to organizational constraints.

The study then focuses on matters such as experiences, attitudes and emotions. The fundamental principal of qualitative interviewing is to provide a framework within which respondents can express *their own* understandings in their own terms (Patton 1990: 290). Thus what distinguishes qualitative interviewing from the closed interview/ questionnaire, typically used in quantitative research, is the ability to capture the complexities of respondents' individual perceptions and experiences. In contrast, as alluded to earlier, structured questionnaires effectively oblige respondents to fit their knowledge, experiences and feelings into the researchers categories (Patton 1990: 290).

[12] Twenty-five of the thirty complaints managers interviewed supplied job descriptions.

The use of telephone interviews

With reference to the conducting of interviews by telephone, methodological appropriateness (See Patton 1990: 39) pointed to a research design that was rigorous, yet time and cost effective. After undertaking two face-to-face pilot interviews, it was decided that for this particular study, telephone interviewing was a logical alternative to face-to-face interviewing in light of the time and financial constraints experienced during the period that the data was collected.

Telephone interviews significantly facilitated gaining access to complaints managers, as it was possible to cut out travel time. Complaints managers had very busy timetables and sometimes they only had one free afternoon or morning for several weeks. Telephone interviews made it easier to fit in with their diaries, and it was possible to conduct three or four interviews in one day. This would not have been possible if travelling had been involved (even in the London region, the various Trusts and Authorities could be considerable distances from each other). It was now viable to interview a complaints manager at 9. 30 am in Croydon, followed by another complaints manager at 11. 00 am in Barnet. Occasionally there were three or four interviews on one day, and then no interviews for a whole week.

Telephone interviews also made financial sense; travelling was expensive and the full schedule of interviews was beyond my available financial resources at the time of data collection. Postage for the project (including stamped addressed envelopes) had involved significant costs, so conducting the interviews by telephone cut additional research costs significantly. Using the example given above, travelling to Croydon, (would have cost £4.70 return with a travel card off peak and £10.20 return peak time), whereas the telephone, while not cheap, meant that almost all calls were billed under local London numbers, still considerably cheaper than rail fares.

Limitations were that rapport may have been more difficult to achieve, and there would also be a lack of visual cues. However, this is compensated for by the likely

reduction of interviewer effects[13] on responses (See Robson 1993: 241 and Frey 1983: 47). Frey argues that interviewer effects on responses should be reduced when researchers are removed from the face-to-face situation, and placed in a telephone situation (1983: 47). Similarly, Bampton and Cowton (2002, paragraph 17) have drawn attention to the possible advantages of separation of the interviewer from the respondent inherent in 'e-interviews' (email interviews), which is also applicable to telephone interviews. Further, it could be argued that because of the particular sensitivity of complaints research, complaints managers may have responded more freely with the more anonymous environment of the telephone interview; in this more private atmosphere, respondents might have been more willing to disclose, for example, any reservations, doubts, or worries they may have had about the complaints system.

The use of semi-structured interviews

Qualitative interviews tend to be either semi-structured or un-structured (See Rubin and Rubin 1995: 5). Robson (1993: 227) describes the semi-structured interview as 'a commonly used middle ground' where the interviewer has specific objectives, but seeks to achieve them through some flexibility in phraseology and the order of questions. An unstructured interview schedule would have involved suggesting the subject for discussion, but with few specific questions in mind (Rubin and Rubin 1995: 5). At the other end of the spectrum, structured interviews are more generally associated with predetermined, set questions, with the responses recorded on a standardized schedule (generally associated with a quantitative approach) (See Robson 1993: 230). A semi-structured interview schedule was deemed to be best suited to the complaints managers study, as the interviews would have the flexibility of a qualitative approach, but would be focused enough to provide specific information (See Rubin and Rubin 1995: 5). In other words, there would be a list of questions or topics to obtain responses from, but with greater freedom in the sequencing of questions/wording, and in the amount of time and attention given to

[13] For example, visual and non-verbal cues, or status differences between interviewee and interviewer (Selwyn and Robson 1998: 4).

different topics than would have been the case with a structured interview (See Robson 1993: 237).

The aim of the interviews

In line with the research questions, the complaints manager interviews were designed to capture:

- The *contradictions and conflicts* in the role of the NHS complaints manager.
- The way in which complaints managers *responded/ reacted to the contradictions in their role* (in terms of behaviour, attitudes and emotions) with particular reference to the implications of their response in terms of *organizational orientation* versus *complainant orientation.* This would in turn determine the potential for the experience of tension in the role. For example, if a complaints manager's response or reaction to a particular situation/ issue was consistent with complainant orientation, would this response indicate a tension in the role due to a conflict with the organizational agenda?

With reference to the *contradictions or conflicts inherent in the role of the complaints manager*, it was necessary to investigate the complaints manager's situation in broad terms of the limits of complaints manager impartiality. In addition, it was necessary to specifically look at particular situations, for example, negotiating with staff in relation to complaints investigations; constraints to investigating practice complaints; constraints to being proactive in using complaints to improve service quality; and withholding information from complainants.

With reference to *complaints managers' responses/ reactions to the contradictions* in their role, a key aspect of the interviews was the examination of complaints managers' behaviour, attitudes and emotions. For example, were complaints managers personally affected by any of the complainants' experiences?

Additionally, it should be noted that at this stage of the study, the notion of *different types of complaints manager* (the third research question), had not yet emerged. Thus, questions *specifically* relating to this research question were not included in the

complaints manager interviews (although the typology of NHS complaints managers set out in chapter six of the thesis was generated from the complaints manager interview data).[14]

The interview topic areas[15]

The first part of the interview dealt with the basic details of the complaints managers post and was designed to take no more than two or three minutes.

The second section concentrated on the complaints manager's perceptions regarding *complainants* and their *behaviour with complainants*. Supporting/advising patients was one of the few areas where complaints managers had some level of discretion and questions on this issue aimed to find out which complaints managers kept strictly to the job description, and those who went out of their way to help complainants. For example, it could be argued that, the more 'supportive' complaints managers might experience tension, if they felt the complaints system was failing to meet complainants' needs. Other questions were designed to encourage complaints managers to discuss their general attitudes to complainants, as this could have a bearing on whether they would experience tension in the post. For example, it is feasible to suggest that complaints managers who identified less with complainants would experience less tension than a complaints manager who identified more.[16] One set of questions on attitudes was designed to uncover attitudes in an indirect way (questions on unrealistic expectations and unjustified complaints). Another set of questions aimed to collect similar information, but was phrased in a more direct way (questions on identifying with the complainant versus the organization, and a question relating to whether complaints managers were ever personally affected by their posts).

[14]The third research question relating to types of complaints manager, emerged as a result of the data analysis of the complaints manager interviews. See the section relating to the data analysis of the complaints manager interviews, later in this chapter.

[15] See the Interview Guide in the Appendix.

[16] In an organization where the complaints system is weighted against the complainant.

The third section examined the complaints manager's *perceptions about the organization* and their *behaviour with other actors in the organization.* Communicating with complained about staff required considerable diplomacy. This group of questions aimed to generate information on any difficulties in extracting information regarding complaints. How did complaints managers, for example, deal with the probable defensiveness of complained about staff? This question is particularly pertinent in NHS Trusts as complaints managers had *direct responsibility* for the coordination of complaints investigations. Not surprisingly, these questions tended to be even more sensitive than those of the previous section because they required complaints managers to *discuss conflicts with members of their own organizations* (as opposed to complainants). Hence, these questions required considerable care and were designed to be as non-threatening as possible. For example, the following question explored a positive aspect of the complaints manager's role in order to encourage them to talk about any problems with complaints investigations:

> Do you need special skills to obtain necessary information regarding complained about staff?

In addition, questions were phrased in a variety of ways in order to encourage complaints managers to talk freely. For example, with regard to questions on being proactive in using complaints to improve service quality, one question used a *direct approach* to ascertaining how restricted the complaints manager felt as a result of organizational constraints:

> Do you ever feel you would like to be more proactive about complaints than your job/the rules/regulations allows? Do you ever feel your hands are tied?

A second question used an *indirect route* to obtaining information on whether complaints managers perceived the organization to be learning lessons from complaints:

> Does the organization have a mechanism by which lessons are learned by complaints i.e. the quality of the service is improved through complaints monitoring and analysis? Do you think this is enough?

It could be argued that the above approach to question design constituted a sort of triangulation (See Robson 1993: 256) in that *a number of questions* were asked for *similar types of information*, in order to establish the complaints manager's attitude to the issue of conflict with the organization. This technique was also used in the questions outlined earlier on unjustified complaints/ unrealistic expectations (indirect questions) and questions on identifying with complainants versus the organization (direct questions).

The fourth section dealt with some 'miscellaneous' issues. One question was designed to obtain complaints managers' perceptions of the fairness and justice of the complaints system, giving the respondents the opportunity to reflect on the complaints system from the complainant's point of view. An additional question examined respondents' perceptions of the role of stress in the post. [17] Finally, two questions were included for the Mental Health Trusts only, to examine how the mental health aspect of the complaints affected complaints handling.

The sensitive nature of the interview process

As mentioned in the Introduction to the thesis, complaints research is particularly sensitive. This study required access to an area, which is particularly difficult to research. In her study on incompetent doctors, Rosenthal (1995:10) reports that a number of respondents[18] found the interviews awkward. Rosenthal notes:

> Several found the interview uncomfortable; the overwhelming majority were surprisingly frank and forthcoming despite the obvious delicacy of the subject.

Simons (1995: 15) has made the point that complaints research is almost certainly going to involve issues that are sensitive for the authorities concerned. This remark is

[17] Although a question was included on stress, stress as a concept was not the focus of the thesis. This question was included for the reason that stress was likely to have a relationship with 'conflicts' and 'tensions', the focus of the thesis, and thus had the potential to generate additional information.

[18] Hospital consultant surgeons and senior general practitioners were interviewed about their incompetent colleagues.

pertinent with regard to the organization's complaint handlers as the complaint handler almost certainly would be required to demonstrate some kind of loyalty to their organization.[19]

Two issues were particularly sensitive to the respondents in this study: discussing emotional reactions to complaints and discussing conflict with other NHS staff members. With reference to discussing emotions, questions on identifying with the complainant versus complained about staff could be awkward. Some respondents were uncomfortable with the word 'identification,' and chose to describe their feelings with words such as 'empathy' and 'sympathy'. Some respondents simply found it awkward talking about emotions. For instance, in response to the question, 'Do you ever identify with the complainant?' Freda Steele (Quality Development Manager, Acute Trust) first replied:

> Yes - I mean - often things have gone wrong, and they have a poor deal.

However, when questioned further (Question: 'Roughly how often?') she protested:

> That's such a hard question to answer ... because it's a job at the end of the day – I don't run on my emotions. All these are terribly emotive questions.

Related to the questions on identifying with the complainant versus the complained about staff, was a question on whether complaints managers were ever personally affected by their posts. Some respondents were very resistant to answering questions such as this, with a strong emotional component. In response to the question, 'How often do you have a particularly bad case?' (A follow up question to: 'Are you personally affected by any of the complaints - If you hear a particularly bad case?), Sybil Fisher (Assistant Director, Public Affairs, Health Authority) refused to give a direct reply:

> It depends, because it will depend on how I feel on a particular day, so again I can't quantify it - I can't put figures to it.

[19] Thus, in order to preserve the anonymity of the respondents, complaints managers were given pseudonyms.

Matthew Andrews (Head of External Relations, Acute Trust) also responded with irritation to my questions on emotional reactions to complaints. In reply to the question, 'Are you personally affected by any of the complaints - if you hear a particularly bad case', he answered curtly: 'No. Can't afford to be.' In response to a follow up question, 'How do you manage to stay detached', he exclaimed:

> Well it's my job! I see too many complaints to get myself personally involved. I think that would be a very bad thing because I couldn't be objective if I was too dramatically involved.

With reference to discussing conflict, in their study concerning managers as third-party dispute handlers in complaints about hospitals, Mulcahy and Lloyd-Bostock (1994) noted a level of defensiveness in all the managers interviewed (1994: 206). In addition, they found that in most instances, managers were keen to play down conflict (1994: 204). With regard to this study, some of the complaints managers appeared to play down conflict; others spoke very openly. It could therefore be argued that there may have been more conflict than the interviews revealed, although the interviews as they stand, revealed significant conflict. One particular question asked: 'Are there occasions when you get conflicting stories from the complainant and the complained about staff? How do you feel about this?' This was a difficult issue for many respondents perhaps because it made them more conscious of the implications of working for the complained about organization and the resulting question mark about impartiality and fairness to the complainant. Some questions were especially delicate in that they required complaints managers to openly discuss conflict with members of their own organizations. Questions on conflict between complaints managers and other NHS staff were particularly sensitive, for example, 'Are there occasions when you have come to a conclusion about a complaint, but another/other members of staff do not accept it? A number of respondents who said 'no' gave the impression of being defensive. When asked the above question Matthew Andrews replied firmly:

> I don't have any arguments with my staff as to how to do it.

The following respondent refused to give a direct response to the question, 'How often would you say that staff are difficult?' Sybil Fisher responded with exasperation:

> Oh God - I'm sorry, I can't answer that - because you ring somebody up, and they might have a surgery full of screaming people or whatever - and they can't talk - and they might be quite abrupt - and then you ring them ten minutes later, when they are away from it all - they have had a fag, they have got a cup of coffee in front of them, and they're fine ... do you know what I mean! It's not that they are necessarily being difficult - but they might be stressed about what's happening, and the last thing they need is the Director of Complaints at the Health Authority after them - do you know what I mean?
>
> ... I can't ... I'm sorry.

As a final point, it is noteworthy that the most challenging respondents tended to be the complaints managers who fitted into the type of 'Institutionalized Person'.[20]

Obtaining informed consent

In line with the general principles of informed consent, respondents explicitly indicated their willingness to participate in the study. Formal consent was obtained from participants as explained earlier by using a form which was attached to the letter requesting the interview, to be returned by complaints managers stating they were/were not prepared to be interviewed. Also, with regard to information supplied to respondents, subjects were made aware of the purpose of the study, the extent of their involvement (i.e. the approximate time required to conduct the interviews) and the proposed use to which the findings would be put (i.e. that the study was related to the researcher's PhD thesis). Additionally, in relation to issues of confidentiality and anonymity, it was made clear to respondents that all information provided by them would be treated as confidential and no individual organization would be identifiable. It was emphasized that anything said by the respondents would be reproduced in an anonymized form in the PhD thesis. In addition, respondents were asked whether it would be acceptable to tape the interview before the interview began.

These principles of informed consent were similarly applied in relation to the conducting of the email interviews (described later in this chapter). With regard to the collection of job descriptions and person specifications, these were initially

[20] See later section in this chapter and Chapter Six of the thesis for information relating to 'the institutionalized person'.

requested from respondents immediately after conducting the telephone interviews. As an adjunct to the telephone interviews, accordingly, these ethics relating to informed consent were automatically applicable when the job descriptions/person specifications were first requested (although in this instance the request specifically relating to job descriptions/ person specifications was made by telephone). In addition, many job descriptions needed to be actively pursued some time after the interviews had taken place, and for that reason further consent was obtained via a letter reiterating the nature of the study, with assurances of confidentiality and anonymity (see the section relating to the documentary analysis of complaints managers' job descriptions and person specifications for further information in relation to obtaining these documents).

Complaints Manager Interviews - Data Analysis

On the one hand, there are particular 'schools of thought', or theoretical approaches to qualitative data analysis (Lacey and Luff 2001:6). On the other hand, there are some common processes, no matter which approach is taken, for example, organization and indexing of data for easy retrieval and identification; identification of themes; development of categories (2001: 3-4). Indeed, much qualitative analysis falls under the general heading of 'thematic analysis' (2001: 6). Robson (1993: 373) too notes the shared aims by methodologists of different ideological persuasions. Furthermore, while Tesch (1990: 77) identified twenty-six different approaches to qualitative research, she stresses that there is not necessarily a one-to-one correspondence between qualitative research approaches and qualitative analysis procedures. Without a doubt, many analysis techniques are shared within the different qualitative research types (1990: 299). For Tesch (1990: 300), the commonalities between the different methods inform us what is important in qualitative research; beyond that, organizing qualitative data during analysis is an 'eclectic' activity; 'there is no one "right" way' (1990: 96). In a similar vein, Olesen *et al* (1994: 126) draw attention to the importance of being flexible and of being open to mixing analytic styles and modes. Moreover, Patton (1990: 372) argues that since each qualitative study is unique, the data analytical approach used will similarly be unique. In short then, it is possible to

be systematic without being rigid (See Olesen *et al* 1994: 126). In this vein, the data analysis of the complaints manager interviews (and the two subsequent methods of data collection) was not guided by a specific analytical approach although the analysis of the complaint manager interviews shares some of the features of grounded theory analysis. Rather the data analysis evolved in response to the development of the work in progress. Nevertheless, in keeping with the *general* purpose of qualitative data analysis, the aim was to make sense of the data produced by reducing the volume of information, identifying significant patterns, and constructing a framework for communicating the essence of what the data revealed (See Patton 1990: 371-372).

The interplay between empirical data and conceptualization

The three propositions[21] generated by the complaints manager interviews were generated both *inductively using the empirical data* and *deductively by drawing from the conceptual framework* (explored in Chapter One of the thesis). These three propositions were as follows:

- The complaints manager's role encompasses inherent contradictions, regardless of the personal style or individual approach of the complaints manager;
- Complaints managers exhibited opposing stances (that is very different responses/ reactions) to the inherent contradictions in their role in relation to 'organization orientation' versus 'complainant orientation';
- There were different types of complaints managers in terms of their responses and reactions to the inherent contradictions in their role with particular reference to organization orientation versus complainant orientation.

With reference to the first two propositions, the initial coding system was not developed from the conceptual framework, but developed inductively from the interview transcripts; rather than deducing the initial coding system from the conceptual framework, a conceptual structure was induced; concepts were developed as a result of thinking about the empirical regularities observed (See Worsley 1987:

[21] Note that these propositions relate directly to the three research questions and the three themes of the thesis i.e. proposition one corresponds to research question one and theme one and so on.

88). However, the initial sub categories generated from the interview transcripts were subsequently placed into broader general categories, which *evolved from interplay between the conceptual framework and these initial sub categories* (See Bulmer1983: 248). Thus, these broader general categories were grounded in *both* the data that had been collected and the conceptual framework of the study (See Mason 1994: 92). Accordingly the processes of induction and deduction were closely intertwined (See Worsley 1987: 88). In common with the grounded theory approach, the process of data analysis for the complaints manager interviews was cumulative and involved frequent revisiting of data in the light of the new analytical ideas that emerged as data collection and analysis progressed (See Lacey and Luff 2001: 7). Indeed, ideas relating to the third proposition (concerning types of complaints managers) emerged later, after the complaints managers' interviews had been conducted, and is dealt with separately from the first two propositions. (Thus, the following analysis relating to sub categories and general categories concerns *only the first two propositions.* The third proposition is explored subsequently). Although the data analytical approach did not involve linear stages as such, the following box illustrates key points in the analysis.

Box 3.1 The interplay between empirical data and conceptualization

Empirical data (complaints managers interviews)
↓
Generated initial categories (sub categories)
↓
Initial categories (sub categories) were considered in conjunction with the conceptual framework
↓
Generated broader categories (general categories)
↓
Generated propositions one and two of the thesis

The generation of initial categories (sub categories) from the interview transcripts (relating to propositions one and two)

In relation to the generation of sub categories, data was sorted out corresponding to each *question/ issue*, that is, by categorizing all thirty complaints managers' responses by question. For example, for question fifteen (WHAT DO YOU THINK OF THE COMPLAINTS SYSTEM IN TERMS OF FAIRNESS/JUSTICE FOR THE COMPLAINANT?), responses were listed thus: R1 (respondent one response), R2, R3, R4 and so on). A synopsis was then made of all the responses to each question. In common with the grounded theory approach, after familiarization with the material, certain ideas emerged in the transcript (See Lacey and Luff 2001: 18). It was then possible to draw out a number of patterns. For instance, analysis of all the responses to the above question generated a number of patterns relating to the fairness and justice of the complaints system (see the box below). For example, in giving views on the fairness and justice of the complaints system, one pattern that emerged was that some respondents felt certain aspects of the complaints system were unfair. The different patterns in turn generated the sub category of FAIRNESS AND JUSTICE IN THE COMPLAINTS SYSTEM - DIFFERENT VIEWS (see the box below).

Box 3.2 Generating a sub category[22]

QUESTION: WHAT DO YOU THINK OF THE COMPLAINTS SYSTEM IN TERMS OF FAIRNESS/JUSTICE FOR THE COMPLAINANT?

Categorizing all 30 complaints managers responses by this question

R1 - Response
R2 - Response
R3 - Response
R4 - Response and so on

↓

Generating a smaller group of patterns in the data

Views that aspects of the system were unfair
Views that it was a fair system in general
Views that their own organization was fair

↓

The above patterns generated the sub category of
FAIRNESS AND JUSTICE IN THE COMPLAINTS SYSTEM - DIFFERENT VIEWS

Fitting the sub categories into appropriate broader categories (general categories) (relating to propositions one and two)

The next stage of data analysis involved fitting all the *sub categories* (generated from the interview transcripts) into appropriate *general categories* (generated from the conceptual framework in conjunction with the sub categories as explained earlier). The linking of sub categories (drawn from the empirical data) to general categories (generated from the conceptual framework and empirical data) in this way directly relates the empirical findings to the conceptual framework.[23] All the sub categories

[22] While some questions generated more than one sub category (e.g. the question on withholding information from complainants), conversely, one sub category could be generated from more than one question (e.g. the sub category relating to emotional reactions to complainants and complained about staff). Thus the above box represents the *basic* framework for generating a sub category.

[23] The research questions were related to the conceptual framework earlier in this chapter.

fitted into one of two (now familiar) general categories/ themes, which have been highlighted throughout this chapter. These were:

- The inherent contradictions and conflicts in the complaints manager's role.
- Complaints managers' responses and reactions to the contradictions in their role.

Box 3.3 Sub categories corresponding with general category one

GENERAL CATEGORY ONE - THE INHERENT CONTRADICTIONS IN THE COMPLAINTS MANAGER'S ROLE

SUB CATEGORIES

The limits of the complaints manager's impartiality
Negotiating with staff in relation to complaints investigations in trusts
The complexity of mental health cases in trusts
The constraints on the health authority complaints manager's participation in the practice complaints procedure
Constraints to being proactive in using complaints to improve service quality in trusts and practices
Withholding information from complainants in relation to trust and practice complaints

Box 3.4 Sub categories corresponding with general category two

GENERAL CATEGORY TWO - COMPLAINTS MANAGERS' RESPONSES AND REACTIONS TO THE CONTRADICTIONS IN THEIR ROLE

SUB CATEGORIES

Advising/ supporting complainants - different approaches
Investigating complaints - different experiences
'Unjustified complaints' - different views
Being proactive in using complaints to improve service quality - different views
Fairness and justice in the complaints system - different views
Mental health cases - different views
Withholding information from complainants - different views
Complaints managers emotional reactions to complainants and complained against staff - different emotions

Generating the third proposition

As Kluge (2000, paragraph 1) points out, in many qualitative studies, 'types' are constructed in order to comprehend, understand, and explain complex social realities. In relation to this study, the idea of a third proposition came about during analysis of the empirical data relating to the first two propositions (described earlier) essentially through a growing awareness that there seemed to be 'different types of complaints managers'. This then led to a search of the literature for explanations. Both the empirical data and the theoretical literature indicated that there were different types of complaints managers in terms of their personal approaches to complaints handling. This proposition, then, was developed inductively and deductively in the sense that the idea for types of complaints managers came from the empirical data, which led to drawing on typologies from public administration literature, which corresponded with the empirical data.

Accordingly, drawing from the empirical data and the literature, a construction of types of complaints managers was conducted in two ways:

- There was a construction of types of complaints managers *in terms of a continuum of organizational to complainant orientation.* Three out of the five types of complaints managers could be specifically distinguished using this method. This method was used because the continuum of organization-complainant orientation was a very strong theme in the interviews and also the literature in relation to the conception of different types of organizational actors.
- There was a construction of types of complaints managers *in terms of grouping similar attributes of complaints managers* (see Kluge 2000, paragraph 9). Two out of five types of complaints managers were distinguished using this method although all five types could be distinguished this way. It was decided to use this second method because two types of complaints manager were identified which did not fit as readily into the above organization oriented /complainant oriented continuum. However, the responses of these two additional types of complaints managers were still conceptualized essentially in terms of organizational orientation versus complainant orientation (as can be observed in Chapter Six of the thesis).

It is worth emphasizing that the third proposition evolved differently from the first two propositions discussed earlier. For example, the idea of types of complaints manager as a research question emerged much later in the research process, and

interview questions were not put to complaints managers regarding types of complaints managers (although this issue was put to complaints experts as demonstrated later in this chapter). Consequently, this third proposition/ theme/ research question does not relate to the aforementioned sub categories (drawn from the complaints manager interviews), as is the case with the two other propositions. Additionally, whilst the analysis relating to the first two propositions, in effect, considered the complaints manager interviews in an *aggregated* form as described earlier, the generation of the third proposition required an examination of the complaints managers' interviews on an *individual* basis.

A construction of types of complaints managers in terms of a continuum of organizational to complainant orientation

With regard to the generation of types of complaints managers in terms of organizational versus complainant orientation, the following types of complaints managers emerged: 'Institutionalized Person', 'Complainant Oriented Accommodator', and 'Reformer'. These three types of complaints managers showed the most dramatic differences in terms of their level of organizational orientation versus complainant orientation. They emerged through an analysis of complaints managers' individual interviews in relation to how far the responses were complainant oriented or organization oriented, and drawing on the public administration typologies described in Chapter One of the thesis. In broad terms, 'Institutionalized Persons' represented the most organizationally oriented complaints managers, 'Reformers' represented the most complainant oriented complaints managers, and 'Complainant Oriented Accommodators' represented a 'middle-of-the-road approach' to complaint handling.

'Organization oriented' responses to interview questions were those responses that indicated a bias in favour of the organization and/ or against complainants by the complaints manager. 'Complainant oriented' responses to questions were those responses deemed to indicate a desire to take duty to complainants seriously. The two examples provided below illustrate how responses were assessed in terms of organizational orientation versus complainant orientation.

Box 3.5 Organizational and complainant oriented responses: unjustified complaints

COMPLAINTS MANAGER	EXAMPLE
Matthew Andrews (Organization oriented response)	... there are so many reasons why unjustified complaints are made. Some people are looking for money; some people are being a little bit vindictive because perhaps they didn't get on very well in hospital with a particular member of staff, and therefore they decide to complain about that member of staff; sometimes they want cash. Increasingly we are becoming a litigious society. And often a complaint is the beginning of a road down which the complainant wishes to go, at the end of which is a pot of gold.
Sonia Rose (Complainant oriented response)	Actually I don't think that any complaint is unjustified.

Box 3.6 Organizational and complainant oriented responses: identification with complainants versus staff

COMPLAINTS MANAGER	EXAMPLE
Matthew Andrews (Organization oriented response)	The people I do feel sorry for are ... members of staff who are sometimes accused by a complainant of bad behaviour ... sloppy medical practice or whatever, and we find that probably the complaint was not justified. Then you have to support those members of staff because they get to know about these complaints during the investigation.
Sonia Rose (Complainant oriented response)	I probably would be more sympathetic to the complainant, if I really thought about it, because, quite often, a lot of the complaints we get could be avoided if staff had spent a bit more time.

In relation to the first example, Matthew Andrews (Head of External Relations, Acute Trust) shows a clear anti complainant ethic and is organizationally biased. In contrast, Sonia Rose (Consumer Relations Manager, Acute Trust) shows a commitment to complainants in her view that no complaint was unjustified. In relation to the second example, Matthew Andrews emphasizes his identification with staff, thus showing an organizational orientation. In contrast, Sonia Rose exhibits a primary identification with the complainant in her response.

A construction of types of complaints managers in terms of grouping similar attributes of complaints managers

With regard to the second method of generating types of complaints managers, types were established in terms of *distinctive traits* shown by certain respondents. The two types of complaints manager generated in this way were the 'Indifferent Accommodator' and the 'Split Personality'. They emerged through an identification of distinctive traits during the analysis of individual interviews, in conjunction with the public administration typologies described in Chapter One of the thesis.

The category 'Split Personality' was used to categorize those complaints managers who showed a dramatically strong identification with *both* complainants and the complained about organization. All these respondents appeared to be especially emotionally affected by their role as complaints manager. The category 'Indifferent Accommodator' was used to group complaints managers who literally seemed to be 'indifferent' to the contradictions in their role, and in this sense exhibited a significant contrast from other complaints managers; in essence they were the complete opposite of the 'Split Personality.'

A consideration of the typology

It is important to bear in mind that the types generated in this typology are not as neat as the discussion implies. I do not claim that this typology signifies 'pure' types of complaints managers, and indeed six complaints managers did not particularly fit into any specific groups (Gordon Evans, Moira Foster, Shona Thornton, Ethel Yates, Angela Keith, Vanessa Farley), although they could all be described as kinds of 'Accommodators'[24] in that their approach was generally a 'middle-of-the-road' approach. In general, these respondents were difficult to pin down in terms of a consistent stance, attitude, or approach. For example, Gordon Evan's responses showed a stance, which was on one hand, very complainant oriented, and on the other hand, it was possible to detect a significant anti complainant ethic in his interview.

[24] See Welch (1994).

Similarly, Shona Thornton was emphatic that the complaints system was a 'nonsense' in terms of fairness to the complainant, yet, like Gordon Evans, she showed a clear anti complainant ethic in her views. Like so many of the respondents that *did* fit into obvious types, the complaints managers that did not correspond with any particular categories, displayed what could be described as considerable ambivalence to their role.

Ultimately, this typology is an attempt to demonstrate that complaints managers had very different personal styles in their handling of complaints in terms of resolving the conflicts/ contradictions in their role, and broadly fell into different types. The key traits of the five types of complaints managers generated by this study are outlined as follows:[25]

- The Institutionalized Person showed a high degree of organizational orientation differing noticeably from the other groups in this respect. *Every respondent* in this group showed a marked level of emotional detachment from complainants' predicaments.[26]
- The Indifferent Accommodator was generally 'indifferent' to many of the contradictions in the role. This group was easily distinguishable from the Institutionalized Person in terms of the absence of an anti complainant ethic.
- The Complainant Oriented Accommodator combined empathy and detachment with complainants, and showed a significant amount of complainant orientation.
- The Split Personality generally became very emotional about their job and about complainants and staffs predicaments in particular.
- The Reformer was extremely complainant oriented and essentially tried to reform the organizational agenda.

The Documentary Analysis of Complaints Managers' Job Descriptions and Person Specifications

The aim of the documentary analysis of job descriptions and person specifications was to assess the structural/objective constraints placed on managers and to relate

[25] For a comprehensive analysis of these types, see Chapter Six of the thesis.

[26] All the complaints managers in the other groups showed at least moderate empathy for complainants.

those to the discourses of managers produced through interviews. It is important to note that the documentary analysis of complaints managers' job descriptions and person specifications was a peripheral part of the research strategy. The complaints managers' interviews focused on the primary focus of the thesis: the conflicts and tensions in the role of the NHS complaints manager; hence, the job descriptions and person specifications were used in this study as a supplementary method to the main research data. Another noteworthy point is that this aspect of the data collection does not relate to the research questions corresponding to the complaints manager interviews;[27] it is used here to address a 'complementary research question', namely, *the role of the complaints manager*. This was not explored in interviews as it was considered that questions should concentrate on conflicts and tensions; I wanted to maximize the interview time (one hour) to cover the key issue of the thesis, that is, conflicts and tensions in the complaints manager role.

There were a number of advantages in using documentary analysis. First, this method was relatively low in cost and unobtrusive. Second, as Prichard (2000: 205) argues, documentary sources are useful in providing information regarding the 'official' discourses in an organization. Indeed, the job descriptions uncovered areas of responsibility, which were not talked about in the interviews, for example, the complaints manager's role in independent review administration, complaints policy, and complaints training.[28] Thus, job descriptions highlighted what were considered *officially* to be important tasks. This provided a useful background for assessing any potential discrepancies in what complaints managers were expected to do and what they were able to do. For example, complaints manager job descriptions paid significant attention to the notion of using complaints to improve the quality of NHS services, demonstrating that this goal was considered *officially* to be an important aspect of the job. However, a number of complaints managers' interviews demonstrated that in *practice*, it was difficult to address this goal in a meaningful way, in terms of the complaints manager post.

[27] Outlined earlier in this chapter.

[28] See Chapter Four of the thesis.

While, job descriptions and person specifications alone could not be relied upon to produce a complete account of the role of the complaints manager, when used *in conjunction with* the complaints manager interviews, job descriptions and person specifications were important in providing an official source of data relating to the job remit of the NHS complaints manager.

Sampling, data collection and data analysis

This section provides an account of sampling, data collection, and data analysis in relation to the documentary analysis of job descriptions and person specifications. The sampling frame used for the job descriptions and person specifications was *the thirty complaints managers originally interviewed* as it seemed logical to gain access to documents relating to the individuals I had already interviewed. Twenty-five complaints managers out of the thirty provided a job description. Fifteen complaints managers provided a person specification.

Data collection was initially conducted by requesting a job description and person specification after the complaints manager interview. In theory, this approach seemed relatively straightforward. However, in practice these documents were time consuming to collect and generally difficult to obtain. Only a handful of the complaints managers sent me the documents after the interview, as they had agreed. It frequently took follow-up telephone requests and/ or letters to the complaints manager in order to obtain some job descriptions/ person specifications. These difficulties were consistent with Bell's observation (1993: 69) that it cannot be assumed that because documents exist, they will be available for research. Difficulties may have occurred for a number of reasons. First, job descriptions were often being rewritten when they were requested. Second, perhaps complaints managers did not wish to supply a job description because they considered this to be too confidential. Third, if complaints managers did not have a copy of their job description, the only option would be to contact the personnel department. Some complaints managers said they did not have the time to chase up the personnel department, but I was free to do so. Other complaints managers did not wish me to contact personnel. Fourth, complaints managers had extremely busy schedules as described elsewhere; some complaints managers may have felt that they had already

gone to enough trouble by participating in an in-depth interview. Fifth, person specifications were particularly difficult to obtain. Many of the complaints managers who supplied me with job descriptions, reported that they did not appear to have person specifications. A possible reason for the scarcity of person specifications was the fact that these documents tend to be associated with the recruitment process. Thus complaints managers who had been in the post for longer periods may have been less likely to have person specifications on their files.

With reference to data analysis, undoubtedly when compared with the complaints manager interviews, the level of data collected was substantially smaller. As such, there is less emphasis on the process of data analysis than with the complaint manager interviews. All the same, the *general* approach to data analysis was similar, for example, the reduction of the volume of information and the identification of significant patterns (See Patton 1990). Essentially, the job descriptions and person specifications were used to establish categories of what seemed to be the key complaints manager tasks and skills. This was achieved by concentrating on *complaints handling* tasks and skills. Tasks were included if they were mentioned in three or more job descriptions/ two or more person specifications. '*Non-complaints tasks*' were left out. Analysis of job descriptions and person specifications then, enabled categories to be generated in relation to key complaints manager tasks and skills.

The data generated four general categories:

- *Complaints manager tasks* required in both Trusts and Health Authorities.
- *Complaints manager tasks* required in Trusts.
- *Complaints manager tasks* required in Health Authorities.
- *Complaints manager skills*, (which were generated from the person specifications) required in both Trusts and Health Authorities.

Box 3.7 Job description and person specification categories

Category One: Complaints Manager Tasks Required in Both Trusts and Health Authorities

Advising complainants
Advising staff
Independent review administration
Health service commissioner liaison
Production of quality reports
Complaints training

Category Two: Complaints Manager Tasks Required in Trusts

Coordinating the investigation of complaints
Producing a final response letter to complainants
Quality action duties
Complaints policy

Category Three: Complaints Manager Tasks Required in Health Authorities

Provide assistance to primary care practitioners in relation to complaints handling
Mediation and conciliation

Category Four: Complaints Manager Skills Required in Both Trusts and Health Authorities

Tact/ sensitivity/ diplomacy
Ability to handle conflict
Influencing /negotiating skills
Promoting a positive image of the organization
Keeping to the timescales of the complaints procedure

The 'Complaints Experts' Interviews

Email interviews were carried out with 'complaints experts' as a way of further validating the complaints managers' interviews. Thus, the aim of the interviews with complaints experts was to address issues raised by the *principle research questions* outlined earlier in this chapter. Would complaints experts give similar messages to the interview data obtained from complaints managers? In other words, would the perceptions of experts cross-validate or uncover discrepancies with the complaints manager interviews?

Complaints experts were identified as people who were likely to come into contact with *many complaints managers* and who may hear about their experiences and problems. It was decided that 'regional complaints leads' and their assistants would be the best people to speak to since they monitored complaints at a policy level, and their responsibilities could include organizing training events for complaints personnel in Trusts and Health Authorities.[29] Essentially, they had regular communication with a variety of complaints managers.

Like the documentary analysis of job descriptions and person specifications, this part of the research strategy was peripheral to the principal research data, that is, the complaints manager interviews. Because the data generated from the expert interviews was naturally radically smaller than the data generated from the complaints manager interviews, the aim of the complaints experts' interviews was to *confirm* complaints manager findings rather than form a significant body of knowledge.

An account of the procedures of sampling, data collection and data analysis is provided below.

Sampling

The interviews were conducted with five complaints experts (three experts were interviewed between October and December 2001 and two additional interviews were conducted between October and December 2002). With regard to the first three respondents, the sampling frame consisted of all fifteen regional leads/ assistant leads (who worked in the NHS Executive offices),[30] and additionally two complaints trainers who were chosen for the same reason as the regional leads, that is, their job provided them with a knowledge of the complaints manager role, and they had regular

[29] They worked in the Department of Health's eight regional offices. From April 2003, the eight NHS Regional Offices were abolished and replaced by four Directorates of Health Social Care (DHSC). DHSCs provide the link between NHS organizations and the government (See Department of Health 2003e).

[30] The NHS Executive offices included: NHS Executive: Eastern, NHS Executive: South West, NHS Executive: London, NHS Executive: South East, NHS Executive: North West, NHS Executive: Trent, NHS Executive: Northern and Yorkshire, and NHS Executive: West Midlands Bartholomew House.

communication with a variety of complaints managers. Because of the small number of regional leads/ assistant leads, the sample took up the whole sampling frame. The fourth interview was obtained via a new sample of seven regional complaints leads/ assistant regional leads the following year, as there were some new post-holders available at this time (October 2002). The fifth interview was obtained from a further anonymous complaints expert who had similar credentials to the other respondents.

Letters were written to the potential respondents and they were asked to fill in a return slip if they were willing to be interviewed. Stamped Addressed Envelopes were supplied.

Data collection

Data collection was conducted using semi-structured email interviews. The interviews could be described as semi-structured in that I had worked out a set of questions in advance but was free to modify their order based on a perception of what seemed most appropriate in the context of the interview. For example it was possible to change wording, give explanations, leave out particular questions which seemed inappropriate with a particular interviewee, or include additional ones (Robson 1993: 231).

With regard to the use of email interviews, this was considered to be a useful option to collect data from complaints experts in that these interviews were added at a much later stage of the project and due to a lack of time, it was necessary to find a relatively quick method of data collection if this additional research was to be feasible. Conducting email interviews meant that there was the practical advantage of having 'ready-transcribed' data (Selwyn and Robson 1998: 1) which saved a significant amount of time. Similarly travel time was saved in that most of the potential respondents were not accessible locally. Further, travel funds were not available at this stage of the study. Thus it was considered that interviewing by email would remove both time and cost constraints.

Like telephone interviews, the main limitation of this method[31] is that the tacit information that would be conveyed in a conventional interview situation is lost (Selwyn and Robson 1998: 4). However, for the same reasons given for telephone interviews, I consider this shortcoming was compensated for by the fact that the email helps in overcoming the usual biases that come about in interviewing such as the problem of interviewer effect, (for example, visual and non-verbal cues or status differences between the interviewee and interviewer) (Selwyn and Robson 1998: 4). Additionally, because this research method is relatively unobtrusive (Selwyn and Robson 1998: 1), potential respondents can respond when and how they feel comfortable (1998: 2).

With reference to the content of the interviews, the interview questions put to complaints experts were very similar to those put to complaints managers. The main difference was that complaints experts were asked to comment on their *perceptions of many complaints managers* whereas complaints managers were asked *directly about their individual situation.* Thus questions on *direct perceptions* of complainants and complained about staff were naturally omitted in the expert interviews. In addition, there was a question added to explore the experts' perceptions of the concept of different types of complaints managers.

Gaining access to regional complaints leads and assistant leads

Gaining access to regional complaints leads was not easy. At least three regional leads/ assistant regional leads said that they did not consider that they came into contact with complaints managers enough to comment on the issues. Perhaps some regional leads/ assistant regional leads were less involved with complaints managers than others. Three regional leads/assistant regional leads sent back the reply slip stating they would be willing to be interviewed, but on receiving the interview did not reply. With the exception of one respondent, all the interviewees who did reply, sent their responses about a month after receiving the interview.

[31] Another potential criticism of email interviews is that the sample would be biased towards the kinds of people who had access to email (See Selwyn and Robson 1998: 2). However, this did not apply to this study as all the individuals in the sampling frame had email addresses at their workplace.

I consider that the main reasons for difficulties in gaining access to regional leads and assistant leads were first, the small sampling frame,[32] and second the sensitivity of the research. With reference to the sensitivity of complaints research, some potential respondents may have felt they would not be anonymous enough due to their small number, and that it might be possible to work out who said what. Further, respondents may perhaps have preferred not to disclose any concerns they might have had about complaints managers since this could have implied that they should be addressing the issue. A Community Health Council officer had remarked to me that it would be difficult to persuade regional leads to comment on the issues pertaining to the study because it was a sensitive subject. A comment one respondent made illustrates this possibility:

> I have been very honest in my replies. I hope it does remain anonymous!

Moreover, another respondent made obvious her disapproval of the following question, 'As employees of the complained about Trust/ Health Authority, how realistic is the aim of being fair to both complainants and complained against staff?' She responded as follows:

> ... The process is designed to be fair to both parties and should be if properly implemented ... I do not think that assumptions can be made that complaints managers will be biased in favour of clinicians/complained against. In some circumstances, it is possibly the other way round, depending on the complaint in question. I have not seen evidence that complaints managers are routinely biased in their handling of complaints.

Data analysis

As with the complaints manager interviews, data was initially coded in relation to each question, that is, by categorizing all the responses by question. Following this, a summary was made of all the responses to each question. It was then possible to draw out a number of patterns in relation to the particular question, as outlined in the section on the complaints manager interviews. Sub categories and general categories (relating to the first two research questions) had already been established in relation to

[32] There were only eight regional leads and seven assistant regional leads in the UK (although an additional seven were added to the sample a year later).

the complaints manager interviews, and as questions put to experts were broadly on the same themes covered by the complaints manager interviews, the patterns that emerged from the expert interviews logically fitted into some of the sub categories and general categories established through analysing the complaints managers interviews.[33] The following example demonstrates how data from the complaint expert interviews could be related to sub categories and general categories already established through analysing the complaints manager interviews.

[33] The reader is reminded that the third research question did not involve the sub categories and general categories described above. In actual fact, complaint experts' responses usually correlated with the first research question (is there an inherent contradiction and conflict in the NHS complaints manager's role?) rather than the second and third research questions. Thus, in practice the data analysis of the complaint expert interviews is generally related to the first research question.

Box 3.8 Fitting data into existing sub categories and general categories (generated by the complaints manager interviews)

QUESTION: AS EMPLOYEES OF THE COMPLAINED ABOUT TRUST/ HEALTH AUTHORITY, HOW REALISTIC IS THE AIM OF BEING FAIR TO BOTH COMPLAINANTS AND COMPLAINED AGAINST STAFF?

Categorizing the 5 complaints experts responses by each question

R1 - Response
R2 - Response
R3 - Response
R4 - Response
R5 - Response

↓

Generating a group of patterns in the data

Comments that there was bias against complainants in complaint handling; there should be no pretence that complaints managers are neutral.
Comments that complaints managers would not be biased.
Comments that there was bias against staff in complaint handling.

The above patterns in the data fitted into the previously developed sub category of

THE LIMITS OF THE COMPLAINTS MANAGER'S IMPARTIALITY[34]

↓

This sub category fitted into the general category:

THE INHERENT CONTRADICTIONS IN THE COMPLAINTS MANAGER'S ROLE[35]

The complaints experts' interviews generally confirmed the findings of the complaints manager interviews in terms of there being inherent contradictions in the complaints manager role (first research question). There were less specific comments from complaints experts' interviews relating to the second research question (responses/ reactions to the inherent contradictions in the role) and the third research question (relating to types of complaints manager) although two complaints experts commented that complaints managers varied in terms of their individual approach.

[34] See data analysis of the complaints manager interviews.

[35] See data analysis of the complaints manager interviews.

A Consideration of the Methods used in the Study

Three issues will be considered in this section. First, the fact that the methods used in this study are unconventional in two respects: *telephone interviews* are used as the principle method of data collection; and an even more innovative method was used as an adjunct to the principle data, that is, the *email or E interviews*. Second, I consider the issue of bias in the research process. Third, I consider that the research was invariably affected by the sensitivity of the topic.

With regard to the use of unconventional methods, the methodological approach of this study is in keeping with Michael Patton's (1990:39) argument for the rejection of methodological orthodoxy in favour of 'methodological appropriateness' as the primary criterion for judging methodological quality. Patton (1990: 39) states:

> The issue then becomes not whether one has uniformly adhered to prescribed canons of either logical-positivism or phenomenology but whether one has made sensible methods decisions given the purpose of the inquiry, the questions being investigated, and the resources available.

In addition, despite being a relatively new research tool, qualitative telephone interviews are increasingly being used in the academic arena.[36]As expected qualitative email interviews are still relatively uncommon.[37] However, it is anticipated that this will change. In their groundbreaking book, *Internet Communication and Qualitative*

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[36] For example, Walshe *et al* (University of Birmingham) recently (2001) conducted a study on quality improvement in health care organizations, using qualitative face-to-face interviews and qualitative telephone interviews with senior managers, clinicians and members of a regional clinical governance review team. See Walshe, K., Wallace, L., Freeman, T., Latham, L., and Spurgeon, P. (2001) 'The external review of quality improvement in health care organizations: a qualitative study,' *International Journal for Quality in Health Care,* 13 (5): 367-374.

Also, Sue Ziebland, Anna Graham and Ann McPherson (1998) conducted a study of GPs concerning prescribing and deregulating emergency contraception using qualitative telephone interviews. See Ziebland, S., Graham, A., and McPherson, A. (1998) 'Concerns and cautions about prescribing and deregulating emergency contraception: a qualitative study of GPs using telephone interviews,' *Family Practice* 15 (5): 449-456.

37 An example of academic usage of qualitative email interviews is research conducted by Roberta Bampton (Leeds Metropolitan University) and Christopher Cowton (Huddersfield University Business School) concerning ethics in the teaching of management accounting in higher education in the UK. See Bampton, R. and Cowton, C. (2002) 'The E-Interview', Forum: *Qualitative Social Research* [On-line Journal], 3(2).

Research: a Handbook for Researching Online, Chris Mann and Fiona Stewart explore how the communicative power of the Internet can be utilized to advance qualitative research (Mann and Stewart 2000). It could be argued that both qualitative telephone interviews and email interviews are likely to become valued alternatives in the qualitative research toolkit in the twenty-first century. It is hoped that this study will have further advanced the usefulness of these methods as qualitative research tools (See Bampton and Cowton 2002, paragraph 27).

With regard to the issue of researcher bias, it is acknowledged that this thesis takes the stance that an in-house complaints handler such as the NHS complaints manager *should be neutral*, that is, an in-house complaints handler should not be more oriented towards the organization or complainant; complaints managers should take their duty to complainants as seriously as their institutional obligations. Insofar as *the potential for bias against complainants has been emphasised in this thesis*, it could be argued that there is a 'researcher bias', which suggests a 'complainant orientation' from the viewpoint of the researcher. Nevertheless, given the transparent testing procedures outlined in this chapter, the findings have been evaluated against objective evidence (see Bilton *et al* 1987: 609).

The final issue I would like to draw attention to is that the sensitivity of the research was a limitation inherent in the study. Essentially the delicate nature of the topic would have influenced complaints managers' responses. The issue of sensitivity affected the complaints manager as a respondent in a number of ways. First, *complaints* by their very nature are awkward, sensitive, and potentially emotive, particularly in the case of the NHS. The first page of *A Practical Guide to Complaints Handling* (Gunn, 2001: xi) draws attention to the personal and emotional aspects of complaint handling. Second, I was investigating the *conflicts and tensions* in the role of the respondent, which again, in essence has negative implications. Third, I was linking up these two potentially delicate issues *in the context of the complaint manager's work environment.* In other words, respondents were being interviewed in their official capacity as complaints managers. Undoubtedly they would have been very conscious of 'saying the wrong thing', particularly as the interviews were being taped. Thus, reticence may have camouflaged the full extent of the tensions experienced by managers as a result of the inherent contradictions in their role.

Conversely, many respondents in fact were easy to interview; they were talkative and needed very little probing. Indeed, several of the interviewees responded to questions with remarkable frankness and honesty. And generally speaking, the more 'difficult interviewees'' responses to certain questions were particularly illuminating. As has been mentioned earlier, there were clear patterns of resistance to talking about particular issues, with unmistakable consistency in the case of some individuals. For the most part, 'difficult interviewees' unwittingly imparted information about their adaptation to their role. Despite the sensitivity of the topic, then, the complaints manager interviews generated exceptionally rich data.

Chapter Four: Inherent Contradictions in the Complaints Manager Role

Introduction

This chapter first gives a description of the role of the complaint manager. It then turns to its principal focus, *the inherent contradictions in the role of the complaints manager.*[1]

The findings illuminating the inherent contradictions in the complaints manager's role, presented in this chapter, relate to *Theme One* explored in Chapter One of the thesis, that is, the proposition that *in-house complaints handlers occupy a role, which encompasses inherent contradictions.* For example, the socio-legal literature explored in Chapter One points out that while complaints handlers are expected to be impartial in theory, this is not necessarily the reality; socio-legal literature casts doubt on the impartiality of in-house complaints systems, and draws attention to the conflict of interest confronting complaints handlers who are employees overseeing in-house complaints systems. Public administration literature showed the potential for the complaints manager to be affected by the conflict between the organizational agenda (organizational loyalty/ organizational constraints) and duty to the public. Additionally, public administration literature emphasizes the predominance of the organizational agenda, which places great pressures on organizational actors to be organizationally loyal and to adhere to organizational constraints. Moreover, sociological literature, with reference to role theory and the concept of 'role conflict', can be used to explain the situation whereby an employee's job may in reality, be in conflict with the organization's expectations and demands (See Salaman 1980: 133). In addition sociological literature has provided the concept of 'sociological

[1] The 'inherent contradictions' element of the chapter commences with the section on 'the limits of the complaints manager's impartiality' and continues for the remainder of the chapter.

ambivalence', which illustrates how a role can require the expression of incompatible norms. [2]

In accordance with the conceptual framework, the empirical findings demonstrate that the complaints manager's role encompassed inherent contradictions; in a whole range of tasks complaints managers are caught between organizational loyalty/ organizational constraints and duty to complainants. In this chapter, a number of 'inherent contradictions' in the complaints manager's role are considered in turn. First, there is a consideration of the limits of complaints manager impartiality in broad terms, that is, general problems in maintaining impartiality. Second, the process of negotiating with staff in relation to complaints investigations in hospital trusts is explored, which demonstrates the contradiction in the complaints manager's role in terms of overseeing complaints investigations whilst being an employee of the complained about organization. Third, the section on the complexity of mental health cases in trusts shows that the conflict between the organizational agenda and duty to complainants is intensified in mental health cases. Fourth, there is an exploration of the constraints on the health authority complaints manager's participation in the practice complaints procedure, which is a specific cause of conflict relating to health authority complaints managers. Fifth, constraints to being proactive in using complaints to improve service quality in hospital trusts and practices, was a source of conflict for many trust and health authority complaints managers. Finally, there is a discussion on the issue of withholding information from complainants, which again causes a conflict for complaints managers in both trusts and health authorities.

[2] See Chapter One of the thesis, which explores the conceptual framework.

Having alerted the reader to the general applications of the conceptual framework to the findings, it should be noted that I have drawn on a *selected number of concepts and propositions* to discuss the findings. Thus every applicable concept generated by the conceptual framework in Chapter One of the thesis has not been applied to every contradiction in the complaints managers' role, as this would have been unnecessarily repetitive.

The NHS Complaints Manager's Role

The complaints managers' role in hospital trusts and health authorities

Each Hospital Trust and Health Authority[3] in the NHS is required to have a designated complaints manager who is readily accessible to the public. The primary role of the complaints manager is to administer the complaints procedure and the complaints manager is the one person in the organization with an overview of the entire complaints system (NHS Executive 1996: 10-11). The complaints manager has a specific role in the *local resolution* stage of the procedure (the first stage of the procedure).

An analysis of job descriptions indicated a number of key tasks relating to the role of the NHS complaints manager in both Hospital Trusts and Health Authorities. These were: advising complainants, advising staff, independent review administration, health service commissioner liaison, production of quality reports, and complaints training.

First, in relation to *advising complainants*, job descriptions referred generally to the provision of advice, information, and support, and demonstrated that the complaints manager's role may well involve meeting with complainants, as required, to resolve issues (Trust and Health authority). In the case of Trusts, this may perhaps involve meeting with patients and family members on wards and clinical areas to deal with enquiries and informal complaints that could be locally resolved.[4] Additionally, complaints manager interviews revealed that providing advice to complainants was a key aspect of the post. A number of respondents considered that while they could advise, there were limitations to what they could do in terms of support, because of being required to maintain impartiality. Some of them made the point that their role involved supporting complained about *staff*, as well as complainants; they drew

[3] As noted in Chapter Two of the thesis, Health Authorities were abolished from 1 October 2002 (See Department of Health 2003b). Health Authority duties relating to operating parts of the complaints procedure transferred to Primary Care Trusts on 1st October 2002 (See Department of Health 2003d).

[4] Interestingly, only eight job descriptions referred specifically to advising complainants.

attention to the requirement of being fair to staff as well as complainants, as set out in the NHS complaints procedures. A number of respondents stressed that the role of the complaints manager with regard to advice and support of complainants was simply to ensure that everyone understood the procedure and the various stages. On the other hand, the complaints manager interviews, overall, showed that there was no uniformity in the level of support provided by complaints managers. Some complaints managers talked about providing emotional support, visiting complainants in their home if appropriate, and assisting complainants with letters in instances where they felt complainants were incapable of writing their own letters. Other complaints managers felt quite strongly that drafting letters for complainants was not their role; this was a task that should be referred to the Community Health Council. Many complaints managers stressed the limitations of their role and were emphatic that they were not advocates.

Second, with regard to *advising staff*, in Trusts, this might involve supporting staff to deal with complaints arising from services within their departments, for example, liaising with directorate managers regarding investigating and responding to complaints. This could require supporting staff in responding to complaints both face to face (early resolution) and in writing. In Health Authorities this might entail assisting primary care practitioners in dealing with complaints at the local resolution stage, including the provision of lay conciliators.

Third, job descriptions placed a great deal of attention on the complaints manager's administrative role in the *second stage* of the complaints procedure, *the independent review*,[5] although the complaints manager is not in fact officially involved at this stage. Job descriptions showed that the complaints manager's role in this respect typically involved co-ordinating requests for independent review which usually consisted of liaison with the NHS Executive Regional Office; engaging the services of a lay chairman; providing relevant background papers for the lay chairman and the trust convener; providing other administrative support as required by the convener; advising and supporting the convener; and arranging the independent review panel (for example payments made to panel members).

[5] This was mentioned in seventeen job descriptions.

Fourth, job descriptions indicated that complaints managers had the responsibility of liaising with the Health Service Commissioner (Ombudsman) in the event that the Health Service Commissioner decided to investigate a complaint.

Fifth, job descriptions placed a good deal of emphasis on the *production of quality reports*.[6] Quality reports essentially dealt with trends of complaints and described lessons learned by the complaints. Generally, complaints were to be listed, along with a description of actions taken to ensure that the incident in question was less likely to happen again, with lessons learned being fed into the report.

Finally, job descriptions put a significant emphasis on the provision of *complaints training*.[7] Job descriptions referred to the setting up of training for staff in handling complaints and training to assist staff in avoiding complaints.

Skills required in trusts and health authorities

An analysis of the complaints manager person specifications indicated a number of key skills relating to the role of the NHS complaints manager in both Hospital Trusts and Health Authorities. These were: tact/ sensitivity/ diplomacy; the ability to handle conflict; influencing /negotiating skills; promoting a positive image of the organization; and adherence to the timescales of the complaints procedure.

First, with reference to tact, sensitivity and diplomacy, person specifications indicated that complaints managers required the ability to be supportive to both staff and complainants in distress. They also needed to have the necessary diplomatic skills to avoid becoming drawn into siding with complainants or staff. This is linked with the capacity to be sympathetic whilst remaining impartial.
Second, person specifications highlighted the need for *conflict handling skills* as complaints managers frequently are required to cope with angry, distressed or bereaved complainants, and thus need the ability to stay calm under pressure.

[6] Twenty-one job descriptions stated that the complaints manager's role entailed producing quality reports. The emphasis on quality is reinforced by the fact that seven respondents had the word 'quality' in their job title.

[7] Sixteen job descriptions mentioned complaints training in relation to the complaints manager's role.

Third, person specifications outlined a requirement for *influencing and negotiating skills* in terms of persuading staff to cooperate in complaints resolution and in terms of persuading staff to use complaints to improve services. With regard to the former goal, this might involve convincing staff and managers across the organization to work collaboratively to assist in the successful resolution of complaints. With regard to the latter goal, influencing and negotiating skills could be linked to the need to demonstrate assertiveness and tenacity in relation to using complaints for bringing about change and improvements to services. In other words, complaints managers need to be capable of persuading colleagues and senior managers of the need for change identified via the complaints procedure; it is necessary to have influencing and negotiating skills in order to engender a proactive approach in making improvements to the service.

Fourth, some Hospital Trust person specifications stated *the need to promote a positive image of the Trust*. On one hand, this could be interpreted as an indication of a requirement to show ones allegiance to the organization. For example, a complaint might perhaps threaten the public image of the trust as is demonstrated in a complaints manager's anecdote in Chapter Five of the thesis. If this interpretation is taken, the implication may be that the image of the organization takes precedence over an impartial handling of the case. On the other hand, the need to promote a positive image of the Trust might also indicate that complaints managers need to put an effort into satisfying complainants by providing a sympathetic, sensitive service.

Lastly, the need *to work under pressure to tight timescales* was emphasized in a large number of person specifications; it was essential to be able to work to deadlines without compromising quality.

The complaints manager's role with particular reference to hospital trusts

An analysis of job descriptions indicated a number of key tasks relating to the role of the NHS complaints manager specifically in relation to Hospital Trusts. These were: coordinating the investigation of complaints; producing a final response letter to

complainants regarding the outcome of the complaints investigation; quality action duties; and dealing with complaints policy.

With reference to the *co-ordinating of complaints investigations*,[8] complaints managers consulted with staff and managers affected by the complaint. They then obtained reports regarding the complaint from relevant staff, and prepared a response to the complainant based on this information. It was important for them to ensure that *all issues raised by the complainant were fully addressed.* Thus, a frequent aspect of the complaints manager role seemed to be filling in gaps in the information provided to them, for example, requesting evidence to corroborate staff accounts of the situation.

Second, the complaints manager was responsible for producing a *final response letter* (on behalf of the Chief Executive) to complainants regarding the outcome of the complaints investigation. Thus investigations (at local resolution stage) were usually brought to an end with the final response letter.[9] Complaints managers were required to ensure that responses were made within the stipulated timescales wherever possible.

Third, a disproportionate number of Trust complaints manager job descriptions referred to responsibilities, which could be described as 'quality action' tasks compared with Health Authority complaints managers job descriptions.[10] Quality action tasks generally included maintaining a complaints database to facilitate the monitoring and analysis of complaints, and attending meetings to discuss quality action plans relating to issues arising from complaints analysis. Similarly, in the

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[8] The investigation *itself*, was generally undertaken by senior staff such as service managers (directors of services/ general managers of services/ business managers) and sometimes Medical Directors or Directors of Nursing.

[9] Interestingly, while the production of the final response letter according to interviews, seemed to be a standard complaints manager task, it was only mentioned in nine job descriptions.

[10] *Quality Action* was mentioned to a lesser degree in Health Authority job descriptions than in Trust job descriptions. One health authority job description referred to coordinating the follow-up of practice complaints, in accordance with the principals of clinical governance, ensuring that service improvements were identified and implemented as appropriate for practice cases. In actual fact, quality action was particularly difficult to implement with primary care complaints as demonstrated later in this chapter.

complaints manager interviews, most respondents referred to groups or panels that met at least once a quarter to monitor complaints and consider how changes could be implemented.

Finally, Trust job descriptions itemized responsibilities, which could broadly be described as *complaints policy*. In general, complaints managers were expected to regularly review the trust complaints procedure, and make recommendations for developing and improving the procedure where necessary.

The complaints manager's role with particular reference to health authorities

It is important to emphasize that in the case of Practice complaints, as alluded to in Chapter Two of the thesis, the local resolution stage (the initial complaint handling stage associated with the complaints manager) does not involve a coordination of the complaints investigation by the Health Authority complaints manager but by *the Practice itself*. Family Health Practitioners are required to nominate one person to administer the complaints procedure and identify that person to patients and clients.[11] The Health Authority complaints manager's role then, involves *less direct contact with complained about staff and complainants* than Trust complaints managers due to the fact that the Health Authority is in effect one stage removed from the Practice. Complaints Managers' interviews demonstrated this more 'disconnected' experience of complaint handling by revealing that communication with complained about staff was frequently by letter, which enabled complaints managers to distance themselves from the situation to a greater degree than was possible in the Trusts; in Trusts, the complaints manager and complained about staff could easily be in the same building, while this was not the case for Health Authority complaints managers. For this reason, some complaints managers in this study felt that Health Authority complaints managers were able to be more impartial than Trust complaints managers. Thus, Health Authority complaints managers were *facilitators* rather than investigators or coordinators at local resolution level and thus did not personally investigate or

[11] The nominated person is generally referred to as the *Practice Complaints Manager* (not the subject of this thesis).

coordinate Practice complaints.[12]

In terms of health authority complaints managers' actual participation concerning practice complaints procedures, first, job descriptions referred to the need for complaints managers to assist primary care practitioners with local resolution, and to work together with Practices to improve systems for dealing with complaints. Thus complaints managers were required to provide advice, support and training to Practices. In accordance with job descriptions, some complaints managers talked in interviews of the importance of building up good relationships with practices. Second, job descriptions revealed that responsibilities might consist of providing a mediation service for complainants who did not wish to use the Practice based complaints procedures, and also may perhaps involve arranging for lay conciliators to try to resolve particular complaints. This is consistent with official guidelines, which stipulates that the Health Authority complaints manager is authorized to *assist* both complainants and the practitioner to resolve the complaint at practice level if contacted by a complainant (NHS Executive 1996: 11).

The Limits of the Complaints Manager's Impartiality

This section on the limits of the complaints manager's impartiality broadly demonstrates the inherent contradiction in the complaints manager's role in that complaints managers are expected to be impartial, while, findings showed that this was not necessarily the case.

Thirteen of the complaints managers in the sample felt that maintaining neutrality was problematical. Moira Foster (Patient Services Manager, Acute Trust) felt that although in theory they aimed to provide an impartial service, this was not always possible:

> You don't want to take sides, but inevitably it does happen. Yeah the conflict of interest can be

[12] However, Health Authority complaints managers *did* investigate in-house Health Authority complaints, for example, complaints about purchasing decisions, which are beyond the scope of this thesis.

quite difficult.

Gordon Evans (Complaints and Litigation Manager, Acute Trust) took a similar line:

> I often use the expression on the phone to patients, saying 'well look, you know, what you have to realize is that I am paid by the Trust, so I cannot claim to be impartial.'

One regional lead had particularly strong views on this issue:

> I do not think people can serve two masters and so complaints staff working for Trusts/PCTs[13]/Health Authorities will of necessity be on the side of their employer ... NHS complaints staff should treat complainants courteously, fairly and openly but there should be no pretence that they are neutral.

Another regional complaints lead acknowledged:

> '... Many Trusts are openly saying [to me] that they don't tell the complainant they have the right to request an IRP[14] in the final letter from the Chief Executive, which signs off local resolution. My personal feeling is that they are not doing this to protect the staff but to try to ease their workload. I have of course strongly advised them that they must tell the complainant they have a right to request IR.[15] [16]

One respondent drew attention to the fact that it was difficult dealing with complaints about members of staff one knew and liked. Situations like this were liable to make impartiality a real problem:

> In a sense we are trying to provide an impartial service, but at times we are not going to be - and I don't think you can be - you can try and do your best, but I think there are going to be times when particularly now I've got to know members of staff - and there are members of staff I get on really well with - that I would find it very difficult if people phoned up sort of saying that this person was aggressive or 'I didn't like this person', because you are in a sense going warm

[13] PCTs refers to Primary Care Trusts

[14] IRP refers to the Independent Review Panel, the second stage of the complaints procedure.

[15] IR refers to Independent Review.

[16] This comment corresponds with research by WHICH (1997:18) who discovered that more than half the respondents in their survey were not informed of their right to request an independent review.

> towards the member of staff. You then have to try and make sure that personal preferences don't get in the way of the complaint.
> (Moira Foster)

Margaret Brown (Complaints Co-ordinator, Community Trust) too, referred to circumstances in which one was acquainted with a complained about member of staff. She remarked:

> ... you feel like saying, 'oh, that's my friend you are talking about!'

It is important to note that a number of complaints managers maintained that they *did not* experience problems in maintaining neutrality.[17] Some complaints managers commented that the Community Health Council was available if complainants wanted additional support. Two respondents (Liz Ellis, Head of Quality, Mental Health Trust) and Jason Bradley (Corporate Services Manager, Community and Mental Health Trust) considered complaints managers *were* independent, because they were not the actual staff being complained about/ or service staff (who may well be line managers of the complained about staff); thus, they were able to be neutral. Some respondents felt particularly positive about neutrality. Indeed, Jackie Waterman (Patient Services Manager, Health Authority) had left her previous job (at a Community Health Council) because she disliked having to represent the patient; she felt more comfortable in the more neutral role of complaints manager. Freda Steele (Quality Development Manager, Acute Trust) argued that she could support both sides without necessarily agreeing with one or the other:

> I think the issue is that you have to maintain a neutral line - you have to support the staff, but you have to support the patient - and it's quite possible to do both without agreeing with either of them - and I think you have to take that path. You can't sympathize with one or the other more.

Nevertheless, as demonstrated in this section, a significant number of complaints managers considered that there were problems with their impartiality. This finding was consistent with the socio-legal literature cited in Chapter One of the thesis which

[17] This theme of opposing/ differing viewpoints is explored in depth in the next chapter.

casts doubt on the impartiality of in-house complaints systems, and draws attention to the conflict of interest for complaint handlers who are employees of the complained about organization.

Negotiating with Staff in Relation to Complaints Investigations in Hospital Trusts

Negotiating with staff regarding complaints investigations had the potential for considerable difficulties for complaints managers. Ten complaints managers acknowledged they experienced problems with complaints investigations, that is, nearly half the Trust complaints managers. Perhaps not surprisingly both person specifications and the complaints manager interviews indicated that it was important to have influencing and negotiating skills in order to encourage staff to cooperate in complaints investigations. Furthermore, complaints manager interviews revealed significant conflict between complaints managers and consultants; complaints managers and investigating staff;[18] and complaints managers and Medical Directors/ Directors of Nursing. Thus generally this was very much an area where complaints managers were caught between two sides:

> ... If they [complained about staff] feel very strongly that the complaint is not justified, you are then being caught between the two sides like on the one hand you've got the complainant who feels that their complaint is justified, they expect a full, detailed, response from the Trust - so you are trying to balance that as against a member of staff who feels equally strongly that they have done what was appropriate - that they have nothing to apologize for - so yes it can be stressful ... just trying to kind of balance fairness really between the two parties.
> Cath Garcia, Patient Liaison Manager, Acute Trust

Sonia Rose (Consumer Relations Manager, Acute Trust) believed she got as much resentment from staff as from complainants:

> Actually there is friction from both sides - I always say you are the 'meat in the sandwich.' You receive the complaint and obviously you've got to go to the person who has been complained about, or the department that has been complained about - and here's a department that have

[18] Investigating staff might well be the line managers of the complained about staff.

> been working very, very hard, under very difficult circumstances, with limited resources, feeling they are doing the very best they can - and someone's complained, you know, and obviously they get defensive - so obviously you have to take the right approach when you deal with the staff too. You can get as much flak from the staff as you can from the complainant! So you have got to be very balanced. You are really sort of the negotiator, and you are trying to appease both sides.

Additionally, the issue of the status of the complaints manager in terms of overseeing investigations was a pertinent one.[19] A complaints expert made the following comment in relation to problematic investigations:

> If the senior staff are not on board it creates problems - if the [complaints] manager is of sufficiently high standing in the organization these can be overcome.

Complaints managers' interviews, too, demonstrated that the status of the complaints manager was a significant issue in relation to complaints investigations. Freda Steele alluded to the idea that difficulties in negotiating with health service staff might be influenced by status or the way the complaints manager was perceived by other people in the organization. It is possible to speculate that higher status complaints managers were possibly less likely to come into conflict with staff over decisions they had made due to their status in the organization. Gordon Evans, a high-level complaints manager (deputy chief executive) supports this argument:

> ... What will happen with my staff is that we'll talk about it, and we'll agree a way forward. If it's necessary, I will use my executive authority in the end and say 'right, we're going to do it this way'.

Moreover, relationships with senior staff in the organization also impacted on the complaints manager's ability to negotiate with staff. For example, Sonia Rose believed that she was fortunate to be a position where she had a good working relationship with relevant staff. Indeed, this chapter shows that the job of the complaints manager was often made more straightforward if the complaints manager had a good relationship with line managers and/or the Chief Executive. Thus, senior

[19] The Audit Commission (1993: 44) drew attention to problems with complaints officers and investigations when complaints officers were junior to the staff under investigation.

staff had an important role to play in enabling the complaints manager to do their job, for example, by putting pressure on consultants to cooperate. Sonia Rose explained:

> I have to say that I am really lucky that most people will rely on what I am saying. If I go to the Chief Executive and say, 'look, I smell a rat with this one - I think that this, this and this needs doing', then, they'll trust me. For example, we got a complaint recently, where I felt there should be an internal inquiry, and I went to the Medical Director and said, 'I really think this is bigger than the complaints procedure' - and he recognized that, and said that he had heard about the problem, and that he had considered an internal inquiry, and that's the conclusion that was reached - so I think that they trust that I will go to them if I need assistance. Having said that, sometimes, I don't get help and I will go away feeling very frustrated.

In short, the particular process of negotiating with staff in relation to complaints investigations demonstrates the inherent contradictions in the complaint manager role brought about by the requirement that the complaints manager oversees complaints investigations while being an employee of the complained about organization. Accordingly, it could be argued that negotiating with staff to conduct an impartial investigation can put the complaints manager into direct conflict with the organizational agenda. This section explores these conflicts or contradictions with particular reference to difficulties with consultants, difficulties with non-medical staff, and dealing with conflicting accounts.

Difficulties with consultants

In keeping with some of the observations made above pertaining to the status of the complaints manager, a number of complaints managers remarked that communicating with complained about staff was made especially difficult if there were marked differences in hierarchy between the complaints manager and the complained about staff. Ten Trust complaints managers (nearly half the trust complaints managers) referred to the problems associated with difficult hospital consultants.[20] Sandra Jarvis (Consumer Relations and Legal Affairs Manager, Community and Mental Health Trust) remarked:

[20] The uncooperative behaviour of consultants is consistent with research carried out on doctors' responses to complaints. Mulcahy (1996) reports that a number of consultants felt that it was not a manager's place to handle complaints about clinical matters (1996: 404) and thus managerial input to complaints was often made impossible (1996: 409).

> ... I think the seniority of the health staff involved is an issue. You have got a very senior old school - lets say consultant. They are horribly rude - to everybody. This goes beyond - you know, clash of personalities. There is an element amongst service managers who have difficulties managing that behaviour - how do you go to a sixty-year-old consultant and say, 'I think you ought to go on a customer care course.' I think that's tough for ... you may be quite a young manager - a lot of managers are.

Michael Price commented:

> ... There's still a couple [of consultants] who are defensive and do bury their head in the sand - and I have terrible trouble actually getting a response out of them.

Sonia Rose linked the attitude of some consultants with the culture of the medical profession:

> ... probably a quarter [of consultants] I have a problem with - but then they are probably a problem for everybody!...There is such a big change in the NHS - and even just in health care generally - I mean years and years ago, you never questioned the doctors word - and I think its very, very hard for doctors now ... they are more answerable... and I think some of them have a real difficulty in being answerable.

The issue of the arrogance of consultants is illustrated in Emily Fowler's (Complaints Manager, Acute Trust) remark regarding complaints about consultants' attitudes:

> If it's about attitude - it's very personal - they will just swear and say, 'of course I wasn't like that,' either completely refuting it, or a handful of doctors would say, 'yes, that's just the way I am - they can like it or lump it' - and there's not a lot you can say to that really.

It emerged from interviews that complaints managers often dealt with consultants more easily if the complaints manager had a reasonably high status in the organization. For this reason, some respondents felt that complaints managers and investigating staff needed sufficient clout to obtain information from complained about staff. Gordon Evans, a 'high level' complaints manager (also the deputy chief executive) explained:

> You will see ... that there is a requirement that there is a designated complaints manager, and that complaints manager is at a sufficient level in the organization to carry some clout - either reporting directly to the Chief Executive, or pretty close. I think if you had somebody who was sort of in an admin grade and maybe was pretty young and inexperienced - I think it could be quite daunting, especially when you are dealing with consultants. I mean they can be very arrogant and difficult creatures, and I'm of sufficient status and age and experience - I talk to them at the same level, you know...

However, most complaints managers were not in posts at the level of the aforementioned respondent. Accordingly, complaints managers often sought help from senior staff when complained about staff obstructed investigations. Some respondents spoke of enlisting the help of Medical Directors if communicating with complained against staff proved problematic. Emily Fowler, (a young complaints manager) had approached consultants directly in relation to complaints investigations when she was first appointed to the job. However, when this proved difficult, she enlisted the help of more senior staff:

> If it was a complaint about the attitude of one of the consulting staff, I would definitely go to the Medical Director. I would not confront them at all. Attitude and communication issues I find are the touchiest complaints to discuss ... when I was first here ... I would go and speak to staff about it directly. If you put yourself in my shoes, they had this young girl coming to talk to them about their attitude - and I would be pissed off with someone doing that to me. I just became very nervous about doing that. I was young - I put consultants and doctors up on a pedestal - I thought, 'this is awful - I can't do it.'

She acknowledged that she would find the job impossible without support from the Medical Director. When asked what she thought it would be like for complaints managers who did not have sympathetic Nursing Directors or Medical Directors, she replied with feeling:

> It must be awful - if I was in that position, I don't think I would stay - It would be incredibly difficult I am sure - I think you would have to be a very strong person to be able to stand up to that every single day.

As mentioned above, Michael Price, too acknowledged that he had a particularly hard time obtaining responses from a few consultants. He also enlisted the help of the Medical Director:

> I put the Medical Director on to them - they're scared of him because he's a bit of a terrier - he doesn't mince his words, which is great - it's really helpful for me.

Moira Foster also approached the Chief Executive or Medical Director in order to obtain information from difficult consultants:

> It can be difficult, particularly if it is a senior member of staff - because obviously they have a lot of power and so on, and we have a particular problem with a consultant who doesn't want to give a statement. But there are ways of going around that. You can try the nice approach, by reminding them - and if they don't do that, then we would take the matter up with someone senior like the Chief Executive or the Medical Director.

Difficulties with non-medical staff

The difficulties with 'non-medical' staff explored in this section refer to difficulties in obtaining information relating to complaints investigations, and more general differences of opinion between the complaints manager and other staff, in relation to aspects of complaints handling.

First, in relation to difficulties in obtaining information relating to complaints investigations, as mentioned previously, ten complaints managers admitted that they encountered difficulties in obtaining facts pertaining to complaints investigations. Sometimes statements came back from investigating staff, which had omitted important information. This might be due to the failure of investigating staff to ask important questions to complained-about staff and /or the absence of evidence required to corroborate staff explanations. Requesting further information, then, was common, in order to fill in the gaps in details obtained by investigating staff. Angela Keith explained:

> .... often the letter that the services have drafted, or the investigations that they have done doesn't address half the points in the complaint ... I then have to go back and ask specific questions.

These findings correspond with Simons' findings (1995), in a study on social service complaints procedures. Simons discovered that some complaints officers felt that investigations by operational managers were 'variable' in quality (1995: 83); some complaints officers felt that their colleagues did not always attach the same priority to dealing with complaints as fully and fairly as they did (1995: 86).

Second, in relation to differences of opinion between the complaints manager and other staff concerning aspects of complaints handling, ten of the complaints managers acknowledged differences of opinion of *how to handle complaints* with other staff. Complaints managers frequently had differences of opinion on handling particular complaints, with senior management staff, for example, the Director of Nursing and the Medical Director. Michael Price spoke candidly about his plea for an independent investigation being refused by a Director of Nursing:

> ... I've had a couple of differences with say the Director of Nursing ... a couple of times when I've said, 'I think this ought to go out for an independent investigation to whoever', and she's disagreed with me and overruled me - but that's OK - it happens. There was one particular one I was very concerned about - I wasn't happy at all - and I said to the Director of Nursing ... 'I would like an independent report from such and such a person.' She said, 'no, I don't think we need to do that ...'

Additionally, two complaints managers spoke of difficulties or awkwardness with staff (both service managers and complained about staff) with regard to producing letters to complainants with appropriate apologies, due to staff opposition to apologies.[21] Diane Salter reported staff resistance to incorporating an apology into the 'acknowledgement letter' to complainants. She, personally, felt strongly that the letter should include an apology, and insisted on its inclusion, despite staff objections; she considered that it would be unethical to omit an apology 'for any distress that you feel you has [have] been caused' in the acknowledgement letter. She went on to reveal that she had in fact been responsible for reforming this procedure:

> A lot of staff get very upset about us putting an apology in the letter. In our acknowledgement letter, we apologize for any distress that they feel they have been caused. We apologize for

[21] For a discussion of the issue of apologies in hospital complaints, see Lloyd-Bostock 1992 and Lloyd-Bostock and Mulcahy 1994.

what they feel has happened initially. In the acknowledgement letter, a lot of staff get upset that we apologize 'for any distress that you feel you has been caused.' They feel we shouldn't put that in. When most people write in, a. they are looking for somebody to say they are sorry - they want an apology - they want to know that something's been done about it, and they want to know basically that it's not going to happen to anyone else. And I think to acknowledge it without putting in some form of apology would actually make people very angry because they would think, 'well, they just don't care.' ... When I first came and sort of changed a lot of the letters - I feel very strongly that people should have an apology - and so I was very adamant about that - and that went in and that stayed in.

In a similar vein, in relation to 'final response letters', Angela Keith (Complaints and Litigation Manager, Community Trust) explained:

I feel, for me, I need to be able to put myself in the position of the complainant, and write a response that deals with every issue in a sympathetic way, even if the staff who have done the investigation have said, 'well this is a totally ridiculous complaint and of course things didn't happen like that.' When I write it, I obviously write things in a way that I would like to read something that somebody had written me, and we do say things like 'I am sorry if your perception was...' or 'if you felt that'... and often - yes ... staff criticize that. They feel that what we're writing is more for the patient than for them ... because we always say 'sorry'. In fact what we apologize for is 'if something happened' - and staff can't understand that a lot of the time - and I don't actually think managers explain that enough. I mean I am criticized for doing it by staff - and I think a lot of the senior managers - not a lot - but a couple of the senior managers I can think of, actually won't feedback the final letter to staff, because they'd rather we didn't say the things that we said - even though they understand why we do it - they feel that it's not supportive of their staff.

Dealing with conflicting accounts

Complaints investigations invariably generated conflicting accounts from both sides which, placed complaints managers into an automatic dilemma. As Ethel Yates explained:

... It's very difficult when it's a conversation that's been had without witnesses, on a one to one basis, and the complainant is saying one thing, and the nursing staff are saying another thing.

Vanessa Farley (Associate Director of Quality and Risk Management, Community Trust) tried to handle this problem by asking the relevant services manager's opinion of the general behaviour of complained about staff. She implied that she might back the complainant, if for example a member of staff had a reputation for rudeness.

Fourteen Trust complaints managers acknowledged that there were occasions when they doubted whether they were receiving the complete picture of the circumstances of the complaint from complained about staff and/ or investigating staff. In this situation, complaints managers are confronted with significant dilemmas in that they are coordinating complaint investigations while being a member of the organization complained about. Do they reluctantly accept the staff account, or do they try to influence relevant persons to ensure an impartial investigation? The question of what to do, in the event of conflicting accounts from the complainant and complained about staff, could be argued to be at the heart of the impartiality issue; for if the complaints managers' role was truly impartial, would they simply accept the staff's version of events, especially if they doubted whether they were receiving the complete picture of the circumstances from the complained about staff and/ or investigating staff.

Accepting the complainant's account of events

Cooper (1990: 192) has highlighted the pressure to conform in organizations. He observes that any employee who attempts to exercise ethical autonomy by placing loyalty to the greater public good above the orderly operation of the organization is invariably viewed as a troublemaker.[22] Empirical findings illustrate this issue. Interviews revealed that accepting the complainant's story could make one unpopular. Cath Garcia (Patient Liaison Manager, Acute Trust) observed:

> Sometimes you have to come to a conclusion that staff may not necessarily like ... I am sure I wouldn't win any popularity contests in the Trust!

The following account sheds further light on the dynamics of accepting the complainant's version of events. Michael Price effectively challenged Trust protocol

[22] See Chapter One of the thesis.

to put what he saw as duty to the complainant before organizational loyalty. In effect, he ignores a ward manager's response in relation to a complaints investigation, and writes a final response letter, incorporating what he considers to be an honest and moral response. This action resulted in the suspension of the ward manager, disciplinary action, and compensation being awarded to the complainant; it also made Michael Price unpopular with certain staff:

> There's one particular ward manager, who had a lot of complaints about her two wards, and I obviously highlighted this to those who need to know. I got a complaint from a guy who actually came to see me, about his wife - about the fact that she had developed a huge pressure sore, through poor nursing. So by the time I saw the complainant, she had developed a huge pressure sore, and she had fallen out of bed, and refractured her leg, which she had fractured some weeks earlier, and the response I got from the ward manager would imply that everything was hunky dory, and everything had been done to try and prevent this. Now fortunately I'd had a response from this ward manager before which was a pile of crap ... So I wrote, for the Chief Executive, a totally honest final response back, saying, ' we have let your wife down; we have let her develop a pressure sore; we are really sorry,' which resulted eventually in us paying out eleven thousand pounds as an ex gratia payment for all the distress, and the delay it caused in her recovery - and the ward manager was suspended - so a disciplinary thing resulted out of a complaint. That's the only time that has happened to me - so that has made me very unpopular in that area with the nursing staff ... they see me as the villain of the piece ... the bottom line is this old integrity thing - I am a nurse, and I know that lady should not have developed that pressure sore, and I know that was crap nursing care - any nurse would agree with that. [23]

Acceptance of the complained about staff's account of events

Denhardt (1988) contends that organizational reward systems encourage loyalty to the organization, and promote identification with the organization (1988: 96). The 'organizational participant' is likely to suppress personal and social values when this conflicts with the norms encouraged in the organization (1988: 97). The empirical findings were consistent with this argument. Respondents rarely mentioned accepting the complainant's point of view. Many of the responses showed that complaints managers sided with staff, if there was a lack of evidence to validate complainants' claims. Out of the seventeen trust complaints managers (from the sample of twenty

[23] This complaints manager had a nursing background.

one trust complaints managers, who acknowledged that there could be conflicting accounts from complainants and complained about staff), eight made it clear directly or indirectly that, ultimately, they would support staff.[24]

Some complaints managers were quite open about siding with staff in the event of conflicting stories:

> It's a thorny one ... the bottom line is - you give staff the benefit of the doubt in the absence of other information, because if you don't give them the benefit of the doubt, you have to take them through a disciplinary. If you take them through a disciplinary, and you don't have sufficient evidence, then you are potentially shafting someone's career.
> (Robert Chatfield, Quality Manager, Mental Health Trust)

Emily Fowler was equally frank:

> ... We have to say, 'this is what our staff are saying, and we are sorry if you are saying something different' - but we have to represent our staff as well as the patient - we work for the hospital. It is very, very difficult. It causes us quite a lot of tension and stress, trying to be fair to all people - but - I suppose at the end of the day, we would come down on the side of staff. You don't want to be seen to not be backing up your staff. Sounds awful that - doesn't it?

She went on to express further unease about this stance:

> ... I don't know what we can do about that - it's actually something I'm starting to think more and more about at the moment, and its something that I don't know what we can do - but it's something I would like to try and get to the bottom of - try and do something about.

One of the commonest methods of dealing with this situation seemed to be an apology for any distress caused, while making it clear that there was no available evidence against complained about staff. Matthew Andrews (a 'high level' complaints manager) recounted an occasion where he strongly suspected that staff had been lying:

> I have interviewed members of staff who have been complained about, and I have thought to myself, 'you're lying to me' but I can't say that they are - I can't accuse them of lying - that is

[24] The other nine were non-committal on this rather sensitive issue.

not right. But that's when you have to go back to a complainant and say, 'we are very, very sorry, but we can't either support or deny what you have told me. You have said x, the staff have said y; I am very, very sorry; please accept my humble apologies; we will certainly make every effort to ensure this type of thing will not happen in this hospital; if I find that it did happen, even at a later stage, then I would take disciplinary action against the member of staff - but in the meantime, I cannot say one way or the other, and I apologize for that.'

The same respondent then went on to further clarify why he felt that there were limits to what he as the complaints manager could do in the event of conflicting accounts:

I had a classic incident a couple of weeks ago, where a complainant came in - it was a complaint about an elderly relative, who the complainant said had been slapped. Now we investigated - we spoke to every one on that ward - no one was able to say that there had been an incident involving a slapping. Now you may say, naturally, they wouldn't. But what else can you do? Can you call them liars? Just because a complainant has said that an elderly relative said that he had been slapped ... might be that the elderly relative was a bit confused - perhaps the elderly relative was under medication ... but whatever - I couldn't reply to that complaint and say, you know, 'yes, we found the person, and we've disciplined them' ... all we can say is: 'we have investigated; we have been unable to find anyone who witnessed or was aware of, or even admits to this incident of slapping; we are therefore very, very sorry; we do assure you that if we ever find that this had happened, then we would take immediate disciplinary action against the member of staff. In the meantime, we are very, very sorry.' And that's about as far as you can take a complaint like that - because if you have investigated honestly and properly, and if you have found no one who is prepared to say 'I saw it', or 'I heard of it', or 'I did it' - then there is not a lot you can do - because I do not believe that it is right or proper to say to somebody, 'well, the complainant says that the elderly relative was slapped - therefore the elderly relative was slapped - therefore one of you lot did it.' You can't do that - that is unreasonable, and it's actually outside of the complaints procedure, which does say that the new procedure was set up for fairness to staff, as well as fairness to the complainant.

Some complaints managers said that they apologized in final response letters to complainants, irrespective of who was right or wrong because something had clearly upset complainants. Many complaints managers used the word 'if' in their final response letters (as shown in the example below), perhaps as a way of appeasing complainants. It could be argued that this was a way of moderating what was ultimately an implicit message that they had accepted the staff account. Ethel Yates explained:

> I think that all you can do is explain what has happened as far as you have been told, and explain that you are really sorry if that's not their perception of what happened - and try to word it in such a way that they don't feel that you're saying 'we don't believe you', but just to say that 'it is very difficult, and we are really sorry if your perception is different to that of the nurse.'

Some respondents mentioned altering the wording of information to be incorporated into final response letters to make them more acceptable to complainants, illustrating a more subtle means of 'reform'/ rebelling against organizational norms. Michael Price spoke of changing the wording of consultant reports to make them more acceptable to the complainant:

> The majority of them will answer it reasonably well, although they might be defensive or slightly aggressive - the sentences in their letter - which I just leave out - to be honest.

It was often the complaints manager who had to deal with the consequences of the acceptance of the staff version of events. Michael Price indicated that he frequently received telephone calls as a result of final response letters, which had disappointed complainants. Diane Salter observed that:

> ... Sometimes if a business manager has made a decision that they [complainants] don't like, I'll maybe have to deal with the consequences of that or the patient's consequences of that.

Angela Keith talked about the awkwardness, which arose when an investigation had been carried out and complainants were unhappy with the outcome. The respondent felt that at this point, complaints managers needed to stand back, and make it clear that they were sorry but could not assist the complainant any further.

These findings on the ultimate acceptance of staff accounts in conflicting stories is in keeping with the administrative ethics literature on the predominance of the organizational agenda.[25] These findings are also consistent with findings from the Public Law Project (1999) concerning the views of complainants about initial complaint handling in relation to serious complaints, in which complainants generally considered that issues had been covered up; staff had been protected; and no one was

[25] See Chapter One of the thesis.

prepared to take responsibility (1999: 22). As a final point, relating instances of acceptance of the complained about staff's account of events was a potentially awkward issue for respondents perhaps because it required them to consider whether impartiality worked in practice. Essentially, it possibly made them recognize the difficulty of working for the complained about organization *and* ensuring an impartial investigation.

Summary

This section has looked at complaints managers' experiences of negotiating with staff regarding complaints investigations with particular reference to difficulties with consultants, difficulties with non-medical staff, and dealing with conflicting accounts. The particular process of negotiating with staff in relation to complaints investigations highlights the inherent contradictions in the complaint manager role brought about by the task of overseeing complaints investigations, *while being an employee of the complained about organization.* Negotiating with staff to conduct an impartial investigation can put the complaints manager in direct conflict with the organizational agenda. Whether it is coping with difficult complained about staff such as consultants; conferring with senior hospital managers; or grappling with an organizational culture, which seemingly requires that one must ultimately back the organization in the absence of substantial evidence, complaints managers are acutely caught between organizational loyalty and duty to complainants.

The Complexity of Mental Health Cases in Hospital Trusts

It could be argued that complaints relating to mental health issues make the aforementioned problem of conflicting accounts between the complainants and complained about staff particularly difficult to deal with. Complaints from those diagnosed as mentally ill come from a very vulnerable section of patients; when mental health is an issue, there is a clear disparity of power between professionals and patients. In this situation, it is likely that the staff account of events will be given even more precedence, than with non mental health complaints as the fact that a

complainant is diagnosed as mentally ill appears to automatically cast doubt on their account of events.[26] Findings suggested that the notion of mentally ill complainants making invalid complaints was very embedded in the culture of the NHS. Angela Keith observed that a consultant might perhaps say that a complaint is an indication of a patient's 'psychopathology'; however, she considered that the complaint still needed to be investigated. In effect, there could be a conflict between what medical staff were saying, and the impartial implementation of the complaints procedures:

> ... What does become complicated, is for example in mental health, where people might make complaints because they are very ill, and a consultant might have a view which says 'well actually this complaint is a symptom of their illness', and we say 'well yes, but we do need to do some response ...'

Sandra Jarvis's comments highlight the huge disparity in power between mentally ill complainants and the complained against staff. She felt strongly that there needed to be an additional independent dimension in the complaints system to act as a 'safety check' for complainants labelled as mentally ill:

> The problem is ... that these are professional people that we are dealing with on one hand - but on the other hand, things *do* happen, and things do *particularly* happen when you have a group of vulnerable people, where the professionals involved have a lot of power as to where they can go, and what people think about what they say - and that to me I think, is inherent in the dynamics between mental health professionals and their patients. I would have thought that wanting to have an additional safety check would be as much safety for them, as it was for patients themselves - and I know people think, 'we're being questioned, and we're being singled out that we'd be more likely to abuse people,' ... that certainly isn't the case - I don't think they are more likely to - than any other professional - but these are people who can't leave, and whose judgments are questioned - so they have less power.
>
> ... I actually think that that is one of the big things about the complaints process that needs to change - is that we need to have something tailored for those who have got mental health problems - because I don't think the system works for them ... I think in terms of things being investigated internally ... our systems would be more - foolproof - if we were to add an additional layer for certain inpatients.

[26] As Perkins and Repper (1998: 5) have pointed out, the views of mental health service users are often disregarded as an indication of their psychopathology.

It should be noted that there were very different viewpoints on this subject; not all complaints managers were sympathetic to the predicament of mentally ill complainants. For example, some complaints managers doubted the validity of complaints from mentally ill complainants.[27]

In short, this section has shown how the task of handling mental health complaints is another manifestation of the conflict between organizational loyalty and duty to complainants. Should the complaints manager submit to pressure from organizational norms, which may interfere with, or perhaps restrict the rights of mentally ill complainants, or do they strictly adhere to their duty to complainants? In line with Cooper's (1990: 85) analysis, dual responsibilities (in this case organizational loyalty versus duty to complainants), which demand incompatible actions, can lead to the individual feeling torn between the two sources of authority (1990: 85). Additionally, it could be argued that mental health issues make the contradictions/ conflicts in the complaints manager's role more pronounced than with non mental health complaints because there are additional dynamics, which discourage impartial investigations.

Constraints on the Health Authority Complaints Manager's Participation in the Practice Complaints Procedure

Health Authority complaints managers were faced with constraints to their involvement with Practice complaints in two respects. First, in theory, Health Authority complaints managers were not involved in the investigation of Practice based complaints, and complainants were expected to take their complaint *directly* to the Practice.[28] Thus, Health Authority complaints managers were confronted with the contradictory role of providing advice to complainants, and assisting with mediation and the provision of conciliation in Practice complaints (as described earlier in this chapter), *whilst simultaneously being excluded from complaints investigations.*

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[27] This issue will be taken up in the following chapter (chapter five of the thesis).

[28] The Health Authority was permitted to become involved in practitioner complaints only if the practice procedure did not appear to meet the national criteria or if asked to do so by the complainant and/ or the practitioner; if both parties agreed, the Health Authority could act as 'honest broker' between the complainant and the practitioner, to settle the complaint at practice level. Health authorities could also provide lay conciliators as a service to complainants and practices (NHS Executive 1996: 19-20).

Second, complaints managers were constrained as to how far they could monitor the Practice's management of the complaint procedure. Consistent with the previous point, Health Authority complaints managers were confronted with the contradictory role of being simultaneously involved and excluded from the procedure.

With reference to Health Authority complaints managers' exclusion from the investigation of Practice complaints, this meant that complainants were expected to complain directly to the practitioners they were criticizing (See Public Law Project 1999: viii). The Public Law Project has argued that in this respect, the complaints system fails to take sufficient account of the disparity in power in the health professional-patient relationship, and does not acknowledge how difficult it could be to complain (1999: 10). With reference to this study, complaints managers spoke of the problems related to explaining to complainants that they were required to return to the Practice they were complaining about. Because complainants were often reluctant to return to the practice unaided, this was a particular source of conflict for complaints managers in Health Authorities, especially since the previous complaints procedure *did not* require complainants to 'face' the Practice single-handedly. In short, the public often incorrectly assumed that complaints managers were able to take charge of this initial complaints handling stage. The following comments of complaints managers highlight this issue:

> I think the most friction is with the bureaucracy of the system ... Sometimes patients get extremely frustrated, with our having to go through the procedural issues, for example, having to go through what's called 'local resolution'. Some patients say this is so serious that they want to go on to stage two - 'don't send me back to the practitioner - that's ridiculous' - but we have to go through the regulations - so some patients get annoyed with that.
> Tamsin Wilkinson, Complaints Manager, Health Authority

> About eighty per cent of the people who complain to us ask us to mediate - and I think that does indicate their concerns about Practice based procedures and the impartiality of it ... Certainly we are aware that if there is a complaint against a GP's member of staff - that invariably the practitioner will accept the employees word and do very little to see if there is any evidence to prove it one way or the other.
> Pat Gates

Ruth Carroll was concerned about the situation surrounding complainants' reluctance to go back to the Practice single-handedly with their complaint, without an independent investigation:

> ... Often complainants say, 'I don't want to go to the Practice - I want to take it further - I want to bring it to the attention of the powers that be.' ... I think you've got to accept that patients do want a sort of independent investigation quite early on, and they don't really want to thrash it out with the practice.'

In terms of being constrained from being able to monitor the primary care complaints procedure, the Health Authority could only work to encourage and support Practices; not enforce the procedure. Some complaints managers felt that local resolution needed to be monitored more closely. For example, Pat Gates had observed that Practices who reported that they had the most complaints, conversely tended to be the better practices. She worried about the implications of this; if the worst practices reported fewer complaints, perhaps these questionable practices were making it difficult for people to complain:

> One of the most worrying things to come to our attention, is that there is another doctor - I think he was second on our league tables for the most complaints he used to get against him under the old system - has consistently since the new complaints procedure told us he has had no complaints at all - and we just don't believe that his attitude and his clinical practice has improved so much that that is the case. We suspect that people are possibly attempting to complain, and not being able to do so because they have to complain to his Practice Manager - his wife! - Or that they are dissuaded at all from doing it because of the way the system works and they feel, 'what's the point of trying to complain to the practice manager, when its his wife!' I hate to think that that's across the board, but it's noticeable that the Practices that tell us they have had the most complaints are the Practices that we normally consider to be good Practices - where they are actually encouraging people to voice their complaints, and using complaints to try and improve their service.

These examples highlight the contradictions relating to the fact that Health Authority complaints managers are overseeing only *part* of a procedure. Findings illustrate Denhardt's (1988: 82-85) proposition that the division of labour in bureaucracies, namely, the practice of working on only one part of a task, in effect prevents responsibility for the task as a whole. Thus individual responsibility and moral duty

are weakened.[29] The Health Authority complaints manager's dilemma can also be understood in terms of the concept of 'sociological ambivalence', that is, the role requires advising complainants and thus *involvement in part of the procedure* and *detachment from another part of the procedure*. Consequently, this role requires 'incompatible normative expectations of attitudes, beliefs, and behaviour' (Merton and Barber 1976: 6);[30]on one hand the complaints manager is expected to advise/ support complainants; at the same time they are effectively excluded from the investigation and monitoring of Practice complaints.

Constraints to Being Proactive in Using Complaints to Improve Service Quality in Hospital Trusts and Health Authorities

Using complaints to improve NHS services and performance is considered to be an important aspect of the complaints procedure (as indicated in Chapter Two of the thesis), and complaints manager job descriptions paid significant attention to what could be described as 'quality action' tasks. Conversely, many complaints manager interviews indicated that the implementation of the quality enhancement goal has been less than satisfactory, and that complaints managers were under considerable constraints with regard to pursuing this goal. The findings from this sample of complaints managers are consistent with Simons' study (1995) reviewed in Chapter One of the thesis, which found that some complaints officers were concerned that opportunities to learn some of the wider lessons from complaints had been missed. The findings of this study were similarly consistent with results from the Public Law Project (1999), which demonstrated that there was a widespread lack of confidence in the independent review processes ability to effectively bring about improvements to services as a result of complaints (1999: 71).

In short, while official job remits, as indicated by interviews and job descriptions, paid considerable attention to the goal of using complaints to improve service quality, in reality, this goal was subject to constraints, as indicated by a number of interviews.

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[29] See Chapter One of the thesis.

[30] See Chapter One of the thesis.

It could be argued that these constraints on using complaints to improve services represent another contradiction in the complaints manager role. In other words, complaints managers were officially encouraged to be proactive regarding using complaints to improve services, but in practice were constrained from pursuing this goal.

In this study, interviews revealed that eleven complaints managers felt that they could be more proactive in using complaints to bring about improvements to services than they were able to be.[31]Complaints managers offered a range of reasons for barriers to being proactive, namely, the bureaucracy of the NHS; a lack of resources; local Trust policy; difficulties emanating from the fact that trust complaints managers were generally not part of any directorate or department; the status of the complaints manager; and particular difficulties concerning Practice complaints.

With reference to the bureaucracy of the NHS, complaints procedures were very formalized and complaints managers were obliged to follow a set path according to Emily Fowler:

> Maybe one of the reasons we can't [be proactive] - is because of the bureaucracy of the NHS and the very formalized procedures you have to go through. You can't just step in if you see something that you want to do something about. You have to follow the set path - that sort of thing.

Another reason given for constraints on the complaints manager's ability to be proactive was a lack of resources. For example, more resources for additional complaints staff would enable Trusts to carry out more complaints analysis, which accordingly would enable complaints staff to put pressure on directorates to improve quality of services.

In addition, it was considered by some complaints managers that the local Trust Policy had a significant impact on the level of follow up action on complaints. Cath Garcia explained:

[31] See Chapter Five of the thesis for further analysis of this issue.

> ... I think generally, we are not very good at actually learning lessons from complaints, and you do find repeated situations occurring, and you kind of wonder what difference they [complaints] really do make ... I am very conscious that we are not anything like as proactive as we could be. But that's as much to do with local Trust policy and practice as opposed to the actual complaints procedure.

Cath Garcia drew attention to another possible barrier to using complaints to improve service quality. She pointed out that it was difficult to act on one's own initiative as complaints managers were generally not part of any directorate or department. She considered that their role was basically advisory, that is, their job was to *suggest* ways of improving services. Thus, they were constrained in terms of *implementation*, which was generally the responsibility of individual service managers and clinical directors. Consequently, her ability to be proactive in using complaints to improve service quality was very dependent on the attitudes of directorate staff (as well as the Chief Executive and Trust Board as indicated above in terms of trust policy):

> I don't have direct line authority over any department or members of staff - all I can do is point out the area, make the manager aware of the problem - but I can't instruct them to do something about it ... there are occasions when you feel that a manager is not really going to tackle a particular problem, or a Clinical Director is not really going to tackle the problem ...

In a similar vein, Paul Hogg (Complaints Manager, Ambulance Trust) made clear:

> We as a department have no power to make sectors do anything about it because it is their staff, not my staff. If they choose not to do anything about it - they choose not to do anything about it ...

The relative seniority of the post also affected complaints managers' ability to be proactive in using complaints to improve service quality. Paul Hogg was emphatic that he needed more clout to be proactive. He stressed the necessity of being able to demand results rather than merely ask for change. Furthermore, he pointed out that in terms of actual follow-up action, he had no authority to ensure improvements had been implemented:

> The only thing I would like, is the opportunity to demand rather than ask ... it would be much easier for me in terms of making sure that we did things differently, after the complaint was

> resolved. Do you see what I mean - I am in a position of asking, rather than saying, 'I've written this resolution letter for the Chief Executive, and we have undertakings to the following', but I have no way of saying, 'has it been done?' You know, I make queries, and I ring round, but I have got no means of demanding it and saying 'I want to see a report on my desk on', you know, 'on the first Monday of next month'. I haven't got that sort of clout ... and I think it's a mistake.'

He went on to say:

> I do think the grading level is important - from my point of view, I actually think - in philosophical terms - my grading is too low - because it means that I have to ask operations managers - I have to ask directors for things rather than demand. But essentially, that's what I am doing - demanding - so that can cause practical problems on a day-to-day basis. Some people respond, and some people don't.

A complaint expert's comments also illustrate this issue of status in the complaints manager role:

> I think it's difficult for complaints managers to do this [be proactive]. From what I have seen, complaints managers are not paid very well and therefore are quite junior in the organization. Trusts need to make these posts far more senior to give them the 'assertiveness and tenacity' this type of post requires.

Finally, Health authorities in particular, did not seem to have the teeth to be proactive in using complaints to improve service quality. The concerns of some Health Authority complaints managers were consistent with recent research by the Public Law Project (1999:x), which demonstrated that the NHS had only weak mechanisms in place for improving services and performance.
Shona Thornton (Health Authority) 'hoped' that lessons were being learned at Practice level, because she did not consider it was happening at Health Authority level. Pat Gates (Health Authority) believed that there was very little scope for the Health Authority in following up independent review recommendations. Rhonda Parker observed:

> The power of Health Authorities are sometimes quite limited in what to do about Practices or doctors that they have concerns about.

Sybil Fisher (Assistant Director, Public Affairs, Health Authority) explained:

> What limits us is the powers that the Health Authority has, and that's laid down in statute. Say for instance, where we were talking about sexual assault - I would desperately want to suspend somebody and not allow them to practice until that case had been heard - that's when I don't think it is fair to patients ... we are limited by the law - we don't employ them [GPs] - if they were employees, then we could - but they are independent contractors; they are private businesses; they run their own business; and we do not have the ability to do that - it's not part of our remit.

On one hand, then, NHS organizations appear to *officially* pay significant attention to the idea that using complaints to improve service quality is an important goal, however, as a number of complaints managers' interviews have indicated, in *practice* this goal is often far from possible. The contradictions/ conflicts implied by this situation can be understood with reference to the 'sociological ambivalence' framework as outlined in the previous section on Health Authority complaints managers (in relation to constraints on their participation in the Practice complaints procedure). In short, the complaints manager's role requires incompatible normative expectations (Merton and Barber 1976), since complaints managers are expected to play a part in using complaints to improve service quality, but in practice are often constrained from effecting any significant improvements.

Withholding Information from Complainants in Hospital Trusts and Health Authorities

With regards to complaints that are referred for disciplinary action, complainants have no right to be informed of the outcome of such action except in general terms (Public Law Project 1999: xi). The Public Law Project has drawn attention to the fact that this means that complainants may be denied information about one of the key outcomes they seek in making a complaint, namely, that corrective action has been taken to address failings in care for the benefit of future patients. Without such information, a common perception is that NHS staff are not accountable for their actions (Public Law Project 1999: xi). If we bear in mind that complaints managers are expected to be empathetic towards complainants, yet are not permitted to disclose

information which may provide 'closure' for many complainants, this issue of withholding information is another example of the moral dilemmas and contradictions inherent in the complaints manager post. It could be argued that a disciplinary hearing is confidential in that it is a member of staff's private proceedings and for that reason complainants do not have a right to this information. Nevertheless, in line with the Public Law Project's observations described above, complaints managers often appreciated the complainant's need to know whether action had been taken against a member of staff. Indeed ten complaints managers said that they did not think this was a fair regulation.[32] Mrs Woodward (Consumer Affairs Manager) explained:

> For the complainant, they feel, 'I've gone through local resolution, independent review - I've got this panel report - it doesn't look good for the practitioner - and the Health Authority has done nothing' - because we are unable to say - because of the regulations and confidentiality issue ... 'this is what we have done' - my personal feeling is yes, it needs changing.[33]

The concept of sociological ambivalence (as referred to in some previous sections) is useful in understanding the complaints manager's dilemma in relation to withholding information from complainants, as this is another example of how the role requires incompatible normative expectations (Merton and Barber 1976). On one hand, complaints managers are expected to be empathetic with complainants; at the same time they are bound by regulations to withhold what is arguably fundamental information from complainants. Thus, this issue of withholding information from complainants, is clearly another example of the contradictions inherent in the complaints manager role.

Conclusion

This chapter has described the role of the complaints manager and explored the contradictions inherent in their role.

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[32] See Chapter Five of the thesis where differing viewpoints from complaints managers on this dilemma are explored.

[33] The viewpoint of this complaints manager on this particular issue differs markedly from her general outlook as can be observed in Chapter Six of the thesis.

Thirteen complaints managers in the sample felt that generally maintaining neutrality was problematical. With reference to negotiating with staff in relation to complaints investigations, the findings showed that complaints managers' deal routinely with the defensiveness of complained about staff, inadequate investigations, and disagreements with staff about complaints handling, as well as the dilemmas of conflicting accounts, which were particularly difficult to deal with when related to mental health care. In general, when there were conflicting accounts, in the absence of further evidence, decisions were biased in favour of staff. Essentially, trying to negotiate an impartial investigation while being an employee of the complained about organization caused a conflict of interest and contradiction in the role.

In addition, Health Authority complaints managers were faced with the contradictory role of giving advice to complainants, and assisting with mediation and the provision of conciliation in relation to Practice complaints, while being excluded from practice investigations and the monitoring of Practice complaint handling.

Also, findings showed that while complaints managers' job descriptions displayed the rhetoric of using complaints to improve quality, in practice there were considerable constraints to being proactive on behalf of complainants.

Moreover, complaints managers were not permitted to disclose disciplinary information, which may arguably go towards providing 'closure' for many complainants. At the same time they were expected to be empathetic towards complainants.

As a final point, while in theory and indeed practice, it has been argued that the complaints manager's role is beset with contradictions, the complaints manager interviews suggested that complaints managers did not necessarily find the contradictions/ conflicts in their role to be a source of *tension*. This issue is considered in the context of complaints managers' responses/ reactions to the contradictions in their role in the next two chapters.

Chapter Five: NHS Complaints Managers' Responses and Reactions to the Inherent Contradictions in their Role with Reference to Key Conflict Variables

Introduction

While the previous chapter (Chapter Four) considered a number of contradictions or conflicts in the complaints managers' role with reference to the structural aspects of precisely how the contradiction manifested itself, this chapter explores how complaints managers *respond and react* to their contradictory role with regard to *key conflict variables,* namely behaviour, attitudes and emotions, which illustrate complaints managers' responses/ reactions to the contradiction in their role, with particular reference to *organization orientation versus complainant orientation.*

Findings suggest that in certain situations the complaints managers' outlook will point to complainant orientation. In other situations, the outlook would suggest organization orientation. With reference to complainant orientation, some complaints managers might believe the system was unfair; they might have doubts about the validity of some investigations; they might become distressed over some complainants' experiences, suggesting an outlook, which conflicted with the system in relation to these issues. It could be argued that such an outlook would promote tension in the role. On the other hand, with reference to organizational orientation, some complaints managers might believe the system was fair; they might have faith in investigations; they might be able to remain detached from complainants' predicaments, suggesting an outlook, which was 'in harmony' with the system in relation to the issues. It could be argued that such an outlook was unlikely to promote tensions in the role.

Thus, organization orientation and complainant orientation are important in that it could be argued that a complaints managers' individual outlook is likely to affect their

adjustment to their contradictory role; their outlook is a viable indication of whether or not a complaints manager would experience tensions on the issues in question.

With reference to the conceptual framework, the findings in this chapter relate to *Theme Two* explored in Chapter One of the thesis, that is, literature suggesting that complaints handlers will exhibit a variety of responses and reactions to their role with a strong pull towards organizational orientation. Thus, the findings in this chapter can be related to concepts, models, and theories (described in Chapter One of the thesis) on actors' reactions/ responses to sources of conflict in terms of organization orientation versus complainant or client orientation, drawn from socio-legal studies, public administration, sociology and social psychology.[1]

In relation to the structure of the chapter, a number of conflict variables[2] are considered in turn. First there is an exploration of complaints managers' behaviour/ experiences, with regard to ways in which complaints managers (1) advise/ support complainants and their experiences of (2) investigating complaints. Next, there is analysis of the attitudes complaints managers with reference to (3) 'unjustified complaints'; (4) being proactive in using complaints to improve service quality; (5) attitudes to fairness and justice of the complaints procedure; (6) attitudes to mental health cases; and (7) attitudes to withholding information from complainants. Finally there is (8) a consideration of complaints managers emotional reactions to complainants and complained against staff.

[1] The author is aware that it would be possible to draw from many more concepts, models and theories from Chapter One of the thesis (the conceptual framework) to frame each conflict variable. However, in order to make the presentation of the findings in this chapter manageable, I do not draw on all the relevant literature mentioned in relation to every applicable finding.

[2] Some of these conflict variables overlap with issues explored in the previous chapter.

Advising/ Supporting Complainants - Different Approaches

As the previous chapter has shown, complaints managers are in a position where their loyalty to the organization and organizational constraints often conflict with their duty to complainants. Advising/ supporting complainants is a 'conflict variable' in that complaints managers have a duty to advise/ support complainants whilst being an employee of the complained about organization, which causes a potential contradiction in the role. How did complaints managers resolve this contradiction/ conflict? Interviews illustrated that while some complaints managers adhered closely to their job descriptions in their 'advice/support role', other complaints managers went out of their way to be helpful to complainants.

One group of complaints managers emphasized the 'support' aspect of their role, with some respondents acknowledging providing more support than was stipulated in their actual job remit. The following comments illustrate this kind of approach:

> What happens on paper and reality is quite different ... in reality, part of my role has turned into, rather unwittingly, a sort of patients advocate/ counsellor at times, which I am very happy to do... it's not actually in the job description - it's evolved ...
> (Michael Price, Patient Liaison Manager, Acute Trust)

Sonia Rose (Consumer Relations Manager, Acute Trust) strongly believed that the level of communication with angry and upset complainants often depended on the attitude of the complaints manager. She commented:

> ...actually if you deal with it properly, people won't be happy, but they will understand the situation.

This respondent described how she always tried to empathize about why someone was angry. Because of her attitude, a number of complainants actually apologized for venting their anger at her:

> I have to say, a lot of it depends on the approach you take - if you are going to start being defensive with people before you even start, you are not going to get anywhere - but we are very

open and helpful and we speak nicely to people, regardless of how they are coming across. I think if you can take control of the conversation and conduct yourself in that manner, then I think that actually does have a calming effect on people anyway. We have a little bit of a strategy here where if someone wants to make a complaint, they are directed to the main entrance reception area, and then the receptionist will call us and we'll go round there and greet them and bring them through to my office. The receptionist always says, 'they come here and they are demanding to see somebody and say they want to make a complaint, and by the time they leave you, they always leave with a smile on their face!' I just think people need someone to listen to them, and just speak to them in an appropriate way. And I think if you get your approach wrong, probably you are going to end up getting more abuse. So perhaps their [complainants] level of communication is really entirely dependent on how you are.

She went on to say:

We need to think why people are angry, and quite often when you think about it, their complaint may be about a loved one, who is in hospital, who may have a serious illness, who may be dying ... and you can imagine that happening to your mother or father or whatever... the anger may be just because they are very frightened about what's happening - they feel helpless - they don't feel enough is being done - you can understand why they have got this anger.

The other thing as well is that they may feel they have to get angry to point their point across. I mean you know if you are going to complain in a shop, you are probably going to psyche yourself up, and get a bit stroppy to get what you want, but actually you don't need to do that. I think once they realize that someone is going to be there and listen to them and everything, they realize that actually they don't need to be angry to make their point.

A second group of complaints managers gave 'general support' to complainants and tended to stress that their role was really one of adviser. They generally emphasized that they were not advocates and they generally directed complainants to the Community Health Council if they wanted more than advice:

We will provide advice to complainants – it's quite a big part of our work. We won't actually act on their behalf. We'll sort of direct them to CHCs to do that.
Rhonda Parker (Advice and Complaints Manager, Health Authority)

In a sense, 'supporting' patients is really a role we would probably refer on to the CHC, but what we would do is if patients have a problem and they want to meet with us ... we go and meet with them to try and see if we can sort out a problem on the spot ...
Moira Foster (Patient Services Manager)

A third group of complaints managers gave little or no support to complainants. Like the second group, they tended to stress that their role was to advise, rather than support. However, this group was particularly adamant that they did not *support* the complainant in any way; these complaints managers emphasized the impartiality and neutrality associated with the complaints manager role. The following extracts illustrate this stance:

What I am not, is an advocate, and I think I have got to be very clear about that, because I am employed by the Trust, and I am always very clear with people about that.
Sandra Jarvis (Consumer Relations and Legal Affairs Manager, Community and Mental Health Trust)

No we don't support patients - that's the role of the CHC. Our role is an impartial one here at the health authority...
Mrs. Woodward (Consumer Affairs Manager, Health Authority)

I don't support patients in that I can't - my role is to be neutral and impartial ...
Jackie Waterman (Patient Services Manager, Health Authority)

We don't support complainants in the way that the CHC do ... When a patient makes a complaint against a doctor, our role is strictly neutral - we can't take sides.
Hilary Bates (Patients Charter and Complaints Manager, Health Authority)

Table 5.1 Patterns of support

COMPLAINTS MANAGERS BEHAVIOUR	NUMBER OF COMPLAINTS MANAGERS
Strong support	5
General support/moderate support	15
Little or No support	7
Non-committal	3
Total	30

The variations in complaints managers' behaviour in advising/ supporting complainants, can be conceptualized by drawing from role theory in terms of individuals responding to roles in different ways. In these terms, individuals can have influence on their roles; they are not completely controlled by structural constraints. Zurcher's (1983: 9) research demonstrates how social actors negotiate compromises between their own individual expectations and the expectations of others:

> Even when a role was rigidly embedded in a highly structured setting, they [actors] found some way ...to put their 'mark' on it.

In varying degrees, this argument could be applied to all the conflict variables in this chapter, for example, investigating complaints, attitudes to fairness and justice of the complaints system. In relation to the current conflict variable (advising/ supporting complainants), there were complaints managers who went out of their way to support complainants; complaints managers who provided moderate support; and the complaints managers who stressed that their role was to advise and not support. It could be argued that the complaints managers who went beyond their job remit to support complainants took a stance, which conflicted with the organizational agenda. In contrast complaints managers who adhered rigidly to their job remits (perhaps providing moderate support or little/no support to complainants), took a standpoint, which was in line with the organizational agenda.

Investigating Complaints - Different Experiences

Investigating complaints could be described as a conflict variable as complaints managers are placed in a contradictory situation in that they have a duty to impartially coordinate complaints investigations, whilst being a member of the complained about organization. This section explores how complaints managers responded and reacted to this contradictory situation. Interviews showed that while some complaints managers experienced problems in relation to complaints investigations, others seemed to find the experience of consulting with staff relatively straightforward. With regard to the latter group, the rigid nature of the complaints procedures was sometimes offered as a reason for no conflicts with staff. Janet Thompson (Acute

Trust Complaints Manager) considered that there was little scope for freedom of choice in investigations as there was a set procedure to be followed:

> ... We don't have lots of scope for people to work on gut reaction; sometimes it would be nice if we could, because sometimes we might be able to wrap them [complaints] up more easily and come across as being more empathetic, but actually the procedure is such that in order for us to be seen to be doing the right thing I suppose, in a sense, that we have to follow procedure. And if somebody deviates from that, they get a very stroppy letter from a very senior member of staff, pointing out to them that this is actually unacceptable, within the procedures that they are supposed to work for, and if they don't stick with it, they would be facing disciplinary procedures.

Hilary Bates took a similar line:

> There is a set procedure laid down and we follow the procedure, so there is not really much for differences of opinion, to be honest.

These responses correspond with Denhardt's observation (1988: 88) that the rules and procedures in bureaucratic organizations allow members of the organization to act without stopping to reflect over what should be done in each situation. Because no deliberation is called for, there is little opportunity or reason for anyone to question the rules or think about the morality of their actions.

Other complaints managers said they found staff to be helpful regarding complaints investigations. Sandra Jarvis commented:

> ... Everybody is so delightful - I have to say, in the main, people are extremely nice, if you are very pleasant to them.

In a similar vein, Matthew Andrews (Head of External relations, Acute Trust) stated:

> All our doctors, especially our consultants, and the more senior of the junior staff like registrars - they are all very, very good - they will give me sensible reaction to complaints - they will always attend meetings with the complainant if I ask them to, where they are very honest and upfront because they have all learned and I have learned, that that is the way for a complaint to go away!

It is worth considering whether these complaints managers who did not experience problems in overseeing complaints investigations, found the process straightforward because they simply did not find any gaps in the information provided/ complaints investigations or perhaps they were not as *concerned* about gaps in the information/ investigations as other complaints managers, possibly because they did not identify with complainants as strongly as they identified with staff, and therefore were not too concerned about the thoroughness of investigations or impartiality (albeit on an unconscious level). The experience of this group of complaints managers is consistent with Serber's (1980) observation, that the complaints handlers in his study took a half-hearted approach to complaints investigations.[3] In short, it could be argued that the absence of any disagreements with staff in the complaint handling process suggests a consensus with the organizational agenda.

Another group of complaints managers were less inclined to simply accept that an investigation would automatically be fair (even if they ultimately accepted the findings of investigating staff). Angela Keith (Complaints and Litigation Manager, Community Trust) said:

> It is just the hardest thing when two people remember things differently or say they do. I just have trouble when people come back and say, 'no, what you're saying is wrong - this happened,' and I think then, I do feel, which way to go from there sometimes - so that's where the conflict comes in, I think. Maybe I've just been doing it for a length of time now that I don't worry about it as much. When I started, I did worry more about the fact that there were two sides to a story, but maybe I'm not that impartial because I've been doing it for a length of time.

If this respondent considered she was not going to get to the truth, she did not pursue the investigation further. However, if the complainant then put pressure on her to find answers, she went further in her investigations. This is consistent with Nader's (1980) propositions that complaint handlers were more helpful to people who were assertive. Nader stated that only the most persistent complainers were satisfied (along with the most blatant cases of unfair treatment) (1980: 38). Additionally, this respondent's revelations that conflicting accounts no longer bothered her due to the fact she had been in the job for some time is consistent with Blau's (1960) findings

[3] See Chapter One of the thesis.

that workers' reaction to tensions produced by their experiences was most often to lose concern with the welfare of clients as a way of avoiding these tensions (1960: 242).

Only one complaints manager went so far as refusing to accept the findings of a complaints investigation, and thus put ethical behaviour before organizational goals. Michael Price (Patient Liaison Manager, Acute Trust) went beyond his job remit to try to get to the truth:

> '... There was a complaint, and it happened to be from a member of staff, and it happened to be from somebody I knew[4]- not very well - but knew ... about a consultant. This member of staff had a tumour - I don't think it was a cancer but it was a tumour in her face. A general consultant surgeon went in, did an operation, and I would say f***** it up completely. When the complaint came in, the questions raised were totally valid, for example, should the consultant, when he saw it was a tricky tumour, have closed it up and referred her to a neurosurgeon? And there was about six or seven questions like that. When the consultant responded, everything he responded to, just from my background, I completely disagreed with. I genuinely thought the guy was lying through his teeth, and he'd f***** up this woman's face. She has now got a significant facial drop down one side, problems with her eyes, problems with her jaw, you know - I think he did it with the best will in the world, but he got in there and it was nasty, and he wasn't qualified to do it, and he botched it up ... that's what I feel - bearing in mind we're totally anonymous here.
>
> When we got that response from him, I went to the Chief Executive, and Director of Nursing ... Before I did that, I was going to go to a local neurosurgical unit and get an independent opinion of the lead neurosurgeon there - not to sort of shaft our consultant, but just for accuracy of the complaint response.
>
> Was this without speaking to the Medical Director? (CX – Interviewer)
>
> Yes, it was at the time. Unfortunately, the complainant who was a member of staff went to the *Daily Mail* - so all sorts of panic started, so we had to get a response out to her within a day or so - and I lost sleep over this one because I thought the consultant's response was lies. In the end there wasn't time for me to go outside and get an independent opinion, so I had to go to the Chief Executive and the Director of Nursing and say 'look, I don't agree with this, this and this,' told them why, and I said, 'I'll have to pull out of this one', and I did, and they did the final response which went out ... I saw it - and the Chief Executive and a few others had a meeting

[4] The complainant in this case was a member of staff known to the complaints manager.

> with the complainant and her husband - and I refused to go to that as well - it was a response that I thought was a tissue of lies - and I did tell the Chief Executive that, and I think the Director of Nursing that - and they saw my point, but unfortunately, because there was this press pressure, it didn't give us the time to go outside and get an independent opinion. So I was a total coward in that in many ways, because all I did was just pulled out of it. I didn't know what else to do. I obviously couldn't go to the complainant and say, 'I think you've been fed a load of crap' ... I couldn't do that. But I did want to have an independent investigation, and that was denied because of the press interest. So that's the most awful tricky one I have ever had.

From the language used, it is clear from this anecdote, that Michael Price had become emotionally involved by this particular complaint, which is consistent with Blau's (1960: 242) notion of workers becoming emotionally involved with the plight of clients. Additionally, he tries to gain the support of the Director of Nursing, which corresponds to Hall's (1972: 476) observation of redefining the expectations held by other people so that fewer conflicting demands are placed upon the person, with a new set of role behaviours being expected from that individual by members of the role-set. Furthermore, this respondent eventually removes himself from that case, which is consistent with Kahn *et al's* (1964: 29) notion of avoiding sources of stress as a way of resolving role conflict.

It could be argued that the findings indicate that complaints managers took both complainant oriented and organization oriented stances in relation to the issue of investigating complaints.[5] It is possible to speculate that those complaints managers who experienced disagreements with other staff in the complaints handling process (on the complainants behalf), identified with the complainant on the issue in question and in turn, may possibly experience tension in response to the conflict in their role. On the other hand, it could be argued that those who administered complaints investigations, with no apparent difficulties, were likely to be organizationally oriented (and as their experiences have demonstrated) they would probably experience little tension in relation to complaints investigations, since their stance would be in line with that of the organization. For example, it could be argued that an individual such as the aforementioned complaints manager, who was extremely complainant oriented (Michael Price), almost certainly would experience more

[5] See Chapter Four of the thesis on difficulties with complaints investigations.

tension than complaints managers who identified with complainants on a more moderate level.

Table 5.2 Experiences of complaints investigations (trust complaints managers)

COMPLAINTS MANAGERS EXPERIENCES	NUMBER OF COMPLAINTS MANAGERS
Difficulties with investigation	10
No difficulties with investigation	7
Non-committal	4
Total	21

'Unjustified Complaints' - Different Views

The item 'unjustified complaints' is included as a conflict variable in order to explore complaints managers' attitudes on another issue pertinent to the role in terms of organization orientation versus complainant orientation. Complaints managers' viewpoints on the question of 'unjustified complaints' could be categorized into three groups of responses. For some complaints managers there was a general consensus that every complaint was justified. Even if the treatment was found to be appropriate, if the patient was dissatisfied, then the complaint was still justified. Put another way, if a person perceived their care was not good, even if it was found that technically that there had been satisfactory care, communication, for example, may have been poor. In this respect, then, it could be argued that every complaint was justified. Many of these complaints managers had reservations about the actual concept of unjustified complaints. This stance seems to be in accordance with Blau's study (1955) whereby workers who were strongly oriented toward serving clients objected to anti-client norms (1955: 93).

Sonia Rose commented:

> ... There is always an element of truth in a complaint. There is always something that has triggered that complaint off. It may well be that ... even if our investigation reveals that the

> patient had very good care, the person's perception is that they didn't, and so something has gone wrong there, and that may be a communication problem - no one has actually sat down and explained to them what they have had done - what sort of level of care they have received - what they should be expecting - you know - or it may well be that what they got was not what they expected, and so that has to be explored as well - and they need to have an explanation for that - and so actually I don't think that any complaint is unjustified.

In contrast, a second group of complaints managers exhibited what Nader (1980: 44) termed an 'anti complainant ethic'. These complaints managers generally felt that certain types of people wasted NHS resources with regard to complaints. Some complaints managers used terms to label complainants such as 'serial complainant.' This stance is consistent with the remark of a regional complaints lead:

> Complaints managers vary drastically. Some have been in the job a long time and have a certain 'attitude' towards complainants.

These complaints managers tended to condemn what they regarded as the complaints culture. Liz Ellis (Head of Quality, Mental Health Trust) remarked that initiatives such as the Patients Charter had inflated people's expectations, which in her view was not necessarily a good thing. Some complaints managers felt that particular complainants were complaining 'for the sake of it'. Sjobert *et al* (1966: 64-65) have argued that as result of his/her role commitment, the bureaucrat tends to impose his/her own expectations and interpretations of reality upon the client, for example, blaming clients. It could be argued that a number of complaints managers held views that were consistent with this analysis. Sandra Jarvis believed that many complainants did not have a valid complaint but simply wanted someone to talk to:

> '... We have regulars, and one of the things that particularly upsets me I suppose is the fact that I know their problem is not the particular complaint that they have brought to me, but the fact that they are lonely, old, and miserable - and they want somebody to talk to - and I am more than happy to talk to them rather than, you know - waste the time. Part of my role, I guess, I see as allowing people to let off their frustrations. We, actually in this Trust bend over backwards to try and fix things and sort things out for people, but there are some people who actually just like complaining.

Ruth Carroll (Complaints Manager, Health Authority) was particularly scathing about what she regarded as unjustified complaints:

> Normally I feel that we seem to be bending over backwards for patients who are just wasting our time.
>
> ... And I think we live in a complaints culture now, where people have unrealistic expectations of what they can get out of the health service - out of the complaints procedure.'

Matthew Andrews felt the same way:

> Some people are looking for money, some people are being a little bit vindictive because perhaps they didn't get on very well in hospital with a particular member of staff, and therefore they decide to complain about that member of staff - sometimes they want cash. Increasingly we are becoming a litigious society. And often a complaint is the beginning of a road down which the complainant wishes to go, at the end of which is a pot of gold.

Liz Ellis (Mental Health Trust) used strong language:

> ... you get the people who are frankly out for money! And we get quite a lot of those actually, proportionally ... I can forgive people having a sort of ghastly grieving process, but what I can't forgive is .... people who, you know are basically 'saddies' who just want to have a go at people who are not in a position to answer back very often. And what people don't realize is that some allegations, because we take them very seriously, you know - the clinician might be suspended, while an investigation is carried out, and even though a suspension in human resources terms is seen to be without prejudice, it is stigmatising - there is no getting away from it. So yeah, I think there are occasions when things are not justified and actually quite damagingly so.

A number of complaints managers considered that some complaints were made in response to bereavement, for example, they considered that a relative may need to blame something or somebody for the death of a loved one, and thus make a complaint. Liz Ellis believed that what some complainants really needed was bereavement counselling:

> But I think there are people who actually almost don't know what they want. I mean very typically, you have people who are perhaps going through a grieving process - and the tendency to lay blame at the door of the clinician for the death of a loved one is quite a typical response -

> and it's very difficult then to know what that person actually wants from the complaints process - what they actually need is bereavement counselling ...'

Ruth Carroll took a similar line:

> They are nearly always bereavement ... one of our ... ongoing serial complainants had a crusade against a GP who had been treating his late wife and I felt so sorry for this GP. She had done everything she could, and all the thanks she was getting was this vindictive old man just trying to get her struck off - I really felt sorry for her.

The responses to the question on unjustified complaints to some extent depended on the way individual complaints managers defined unjustified complaints. Thus, a third group of complaints managers did not necessarily espouse strong anti complainant views but nevertheless considered the term unjustified complaints as a valid way of judging complaints. Some complaints managers in this group even used the term in their analysis of complaints. These respondents often seemed to define the term 'unjustified' in a sort of 'textbook sense' of whether the complaint was medically valid. Consequently, they deemed complaints unjustified if medical treatment was judged to have been appropriate, thus not allowing for a complaint due to 'poor communication'. One complaints manager remarked that lack of communication was the major reason for 'unjustified complaints'.

It is possible to speculate that an arguably complainant oriented stance whereby a complaints manager regards all complaints as justified may conflict with the organizational agenda (even if organizations pay lip service to the notion that all complaints are justified). In contrast it could be argued that a standpoint whereby the complaints manager takes on an anti complainant ethic is in reality an organization oriented stance and thus is unlikely to conflict with the organizational agenda.

Table 5.3 Attitudes to 'unjustified complaints'

COMPLAINTS MANAGERS VIEWS	NUMBER OF COMPLAINTS MANAGERS
Did not see any complaints as unjustified	13
Had no problem with the term unjustified but without an anti complainant ethic	11
Anti complainant ethic	6
Total	30

Being Proactive in Using Complaints to Improve Service Quality - Different Views

Being proactive in terms of using complaints to improve service quality is included as another conflict variable, which demonstrates how complaints managers' respond/ react to the contradictions in their role in terms of complainant orientation versus organization orientation. [6]

Complaints managers' views could be categorized into three different groups. One group of complaints managers generally felt that their organizations needed to be more proactive. A significant number of complaints managers felt that the culture needed to change, that is, the NHS needed to welcome complaints and see them as a valuable source of information. It was felt that clinical governance was an important step towards this change.[7] Others argued that more robust measures were needed to use complaints to improve quality.

A second group of complaints managers were less inclined to be proactive in using complaints to improve service quality. A few complaints managers remarked that they did not wish their job to be a proactive one. Ruth Carroll pointed out that trying to be proactive could cause problems on an emotional level:

[6] See Chapter Four of the thesis for further detail on this topic.

[7] See Chapter Two of the thesis for further information on clinical governance.

> If you come to this job on a crusade, thinking that you are going to make things better for people, then you are likely to find there is a big gap between your expectations and the reality of the job, and that gap can cause a lot of problems. Once your expectations settle down, and you realize that what you are doing is implementing the NHS complaints procedure as fairly as you can, and that if you find any other information or problems along the way - then you try and refer that on to somebody who is in a position to do something about it - then your expectations are more realistic; they're not so far removed from reality - so that's liveable with.

A number of respondents felt that they were *already proactive* and gave descriptions of problems they had tackled or were tackling. Moreover, a significant minority felt that no further improvements were needed. Robert Chatfield (Quality Manager, Mental Health Trust) said:

> In the vast majority of cases, what's being done is enough because most of the complaints are unique, and response is to specifically those concerns.

In reply to the question, 'Does the organization have a mechanism by which lessons are learned by complaints /do you think this is enough,' Liz Ellis replied:

> I think it probably is - realistically, yes.

In relation to the same question, Hilary Bates answered:

> It's certainly enough as far as the complaints that we receive go - yes.

In view of the significant criticism of the current complaints procedures with regard to the shortcomings of the quality enhancement criteria of the complaints procedure,[8] it could be argued that complaints managers would probably be constrained in being proactive and thus consider they should be *more proactive*. Thus it could be argued that the aforementioned respondents were perhaps surprisingly nonchalant with regard to the situation concerning the application of the quality enhancement goal of the complaints procedure.

[8] See Chapter Two of the thesis.

It is possible to speculate that the attitudes of this group of complaints managers on this issue tended towards organization orientation in that their replies suggest a defence of the organization's stance, and an acceptance of the status quo. Hall's (1972) observations could be applied here; his notion of *personal role redefinition* involves changing the person's *perceptions* of his or her role demands rather than attempting to change the environment (1972: 477). Consequently, it could be argued that this group of complaints managers might adjust their attitudes to being proactive to correspond with the organizational agenda; thus if the organizational agenda is not in reality committed to being proactive, it could be argued that the complaints manager's attitude may perhaps adapt to this state of affairs accordingly.

A third group of complaints managers had ambiguous views regarding the question of being proactive. Some took the attitude that there was only so much that could be accomplished with finite resources which is in accordance with Lerner's (1980: 19) notion of the acceptance of the 'reality of injustice', namely, the acceptance of ones limitations. Some of them made rather ironic responses, in the vein of:

> Well, nothing is ever enough. Things can always be better.
> (Imran Quereshi, Complaints Manager, Acute Trust)

The implication of these kinds of responses was that naturally there was more they could do, but 'was this not obvious?'

Others were simply non-committal. On one hand, Jackie Waterman acknowledged:

> I think more probably needs to be done, and I think some of that is actually about changing the culture ... people are very uncomfortable about complaints, and they don't quite see what they see as small individual complaints can influence and change services.

At the same time she felt that being too proactive could interfere with the doctor-patient relationship:

> I feel reasonably comfortable with the way things are ... sometimes you feel you might like to have a bit more clout to do a bit more, but then you have to be very careful, because we would be making a judgment about the complaint, and we would also be interfering in the relationship

between the patient and their practitioner, and we have to be very sensitive about sort of interfering in that which is why I think that the complaints procedures were changed to give GPs more opportunity to deal with patients complaints, and actually make improvements in their own practice, rather than having a Health Authority sort of getting involved and sort of wading in with heavy boots on.

It could be argued that those complaints managers who wanted to be more proactive were taking a complainant oriented stance and would possibly be in conflict with the organization on this issue. In contrast those who said the organization was performing adequately with regard to being proactive or were philosophical about how proactive an organization could be were more likely to be in line with the organizational agenda.

Table 5.4 Views on being proactive in using complaints to improve service quality

COMPLAINTS MANAGERS VIEWS	NUMBER OF COMPLAINTS MANAGERS
Wished to be more proactive	11
Did not wish to be more proactive	10
Non-committal	9
Total	30

Fairness and Justice of the Complaints System - Different Views

The fairness and justice of the complaints system is another conflict variable that was explored in order throw light on complaints managers' responses and reactions to their role in terms of organization versus complainant orientation. It was possible to divide complaints managers into three groups according to their attitudes to fairness and justice of the complaints system. One group considered that aspects of the system were unfair. A second group considered the system to be fair. A third peripheral group considered the system was fair *in their own organization.*

The first group criticized aspects of the complaints procedure. Some felt the complaints system was generally weighted in favour of the organization:

> I think probably it's more helpful for the hospital; it's easier for the hospital to respond to complaints than for the complainant to be satisfied at the end of it. You've still got this thing of the small complainant and the great big institution, and what the institution says, goes.
> Emily Fowler (Complaints Manager, Acute Trust)

Additionally complaints managers commented that there was a need for culture change, with less defensiveness and more accountability. Ethel Yates (Complaints/Claims Manager, Mental Health Trust) declared that there were always going to be difficulties until there was a total culture change, with less defensiveness:

> I think until get to a total culture change, where everybody puts their hands up and says well I did or I didn't do it, whatever is the truth of the matter - there are always going to be difficulties.

Jackie Waterman believed that people often went through a long-winded process with very little to show for it at the end:

> ... I think ... people often feel that they have gone through a lot of time and effort to pursue a complaint, and they actually haven't had very much to show at the end of it. They don't feel really confident that things are going to change. Sometimes our powers to influence change are limited.

In addition, complaints managers made a number of criticisms specifically regarding the independent review process (the second stage of the complaints procedure). Although participation in independent reviews was not a direct aspect of the complaints managers job remit, the 'fairness/ unfairness' issue was particularly acute in the context of independent review hearings, and many respondents were uncomfortable about the perceived lack of impartiality of the independent review stage of the complaints procedure.[9] Indeed, it is clear that some complaints managers had reflected seriously about this issue.

Sonia Rose made a number of observations, which cast doubt on the impartiality of

[9] As referred to previously in Chapter Two of the thesis, the Government document, *NHS Complaints – Making Things Right* proposes radical reform to the independent review stage (second stage of the complaints procedure) by placing responsibility for it with the new Commission for Healthcare Audit and Inspection (CHAI) (DoH 2003: 3).

the independent review process; first, the panel of clinicians[10] from other hospitals were likely to empathize with the complained about consultants; second, with a small specialty, the specialists in question were likely to know each other; third, lay people were likely to go along with the expertise of the clinicians on the panel; fourth, the convenors[11] were non-executive directors of the Trust, and so realistically speaking, their impartiality was questionable. In Sonia Rose's words:

> I think probably they [complainants] should go straight to the ombudsman[12] quite frankly, because that's somebody who is completely out of the NHS who can be very very independent. Because after all, you're setting up a panel [independent review panel] of clinicians from other hospitals - they may know what it feels like to be on the end of an independent review - they may have been involved in one themselves. Secondly when you have got a speciality which is quite a small speciality, say neurology for instance, it's quite likely that the majority of neurologists know each other, or there is some network ... I mean you know they probably go on conferences together and things like that. So how independent is it? I know there are lay people ... but they are lay people and they are going to look at the expertise or knowledge of the clinical advisors on that panel, so I just wonder ... you know. And the non-executive director - of course they are independent, but they are still on the Trust board of the hospital, and has the hospitals interest as well, you know, in the back of their minds - so I think that's probably unfair to complainants - that part of the procedure.

In a similar vein, Gordon Evans commented:

> I think the independent review process leaves much to be desired. I think it is now fairly well recognized that the independent review process is not really independent and I think a number of patients have recognized this.

For Pat Gates, there was a particular problem with independent review panels being reluctant to make difficult decisions, which she felt was unfair on the complainant:

> I think that the independent review stage - there is a big problem with panels themselves actually being willing to bite the bullet and actually make a decision where there actually is a

[10] As referred to previously in Chapter Two of the thesis, where the convener decides that the complaint is a clinical complaint, the independent review panel will be advised by at least two independent clinical assessors nominated by the regional office (NHS Executive 1996: 29).

[11] See Chapter Two of the thesis.

[12] In this respondents view, complainants should go straight to the ombudsman rather than go through the Independent Review stage of the complaints procedure.

> conflict of evidence. Too often, they will just cop out and say 'well, we can't make a finding one way or the other,' and that is very frustrating for the complainant ...

A second group of complaints managers, in general, considered the complaints system was fair. Some respondents rationalized that the system was fair because they believed that the second stage, the independent review, acted as a safety check:

> The fact that you can take it to a second stage review is a safety valve for actually having an external entity look at it and address what the issues are...
> Liz Ellis

> ... if they are not satisfied, then they can come back to us and ask for an independent review. So from that point of view, I think it is quite fair.
> Hilary Bates

In addition, some complaints managers suggested that there was generally no room for improvement to the system. Jason Bradley (Corporate Services Manager, Community and Mental Health Trust) believed that the system was as fair as it was going to get, giving examples of their advocacy service, the Community Health Council, and patient leaflets. Hilary Bates remarked:

> It's difficult to imagine how any other system could be any better for them really.

Others said the current procedure was an improvement on the old system. Angela Keith considered the Trust procedure was fairer than the Health Authority procedure:

> I think that complaint systems within Trusts are a lot fairer than with GPs,[13] for example when the poor patient feels that they have to write to their own GP to complain about them! At least ours is fairer than that I think.

Sybil Fisher pointed out that in the current system, complaints could be considered about attitude, which had not been possible under the old system:

[13] See Chapter Two of the thesis regarding problems of the primary care aspect of the complaints procedure.

> I think it's not bad. I think it's a lot better than it was under the old system because you can consider a complaint about absolutely anything at all now - under the previous system you couldn't consider a complaint about attitude or whatever. From that point of view I think it's excellent.

Sybil Fisher was particularly committed to local resolution.[14] She had little sympathy for complainants who were unhappy about being referred back to practices:

> Many people don't like going back to the GP and they want my staff to take it over for them; they want somebody else to sort it. And I don't think that's actually helpful, because it's very easy for people to abdicate their responsibility for their own actions.

A third peripheral group felt that the system was fair *in their own organization.* Two complaints managers in this group had put particular efforts into making the system more complainant oriented.[15]

Overall, it could be argued that those complaints managers who felt the system was fair held views which did not conflict with the organizational agenda. In view of the general criticisms about the complaints procedure as explored in Chapter Two of the thesis, it could be argued that these complaints managers might use defence mechanisms such as 'denial' to ignore some of the obvious problems in the system (See Lerner 1980: 20). In contrast, the respondents who criticized the fairness of aspects of the system were arguably in conflict with the organization on certain issues.

Table 5.5 Views on fairness and justice of the complaints system

COMPLAINTS MANAGERS VIEWS	NUMBER OF COMPLAINTS MANAGERS
Aspects of the system unfair	17
Own organization fair	3
Fair system in general	10
Total	30

[14] A highly criticized part of the primary care procedure (see Chapter Two of the thesis).

[15] Two of these complaints managers, Michael Price and Paul Hogg, have been categorized as 'reformers' (see Chapter Six of the thesis).

Mental Health Cases - Different Views

As observed in Chapter Four of the thesis, mental health cases significantly increased the complexity of the complaints managers job in terms of the conflict between organizational loyalty/ organizational constraints and duty to complainants. Thus, this was another useful conflict variable in terms of assessing organization orientation versus complainant orientation.[16]

Complaints managers' attitudes to this issue could be broadly categorized into three groups. First, there were complaints managers who felt that mental health complaints were less valid than other complaints because of the complainant's mental health status. Janet Thompson (Service Quality Manager, Acute Trust) was uncomfortable about treating complainants with mental health problems in the same way as 'normal' people:

> I have a problem in one key area - and that is that we have to treat everyone the same ... remember, I have got a mental health background - sometimes people with mental health problems have not been helped by our handling of complaints, because in a sense, what we have had to do is to accept what they are saying, even though they are, actually, frankly - mentally unwell, and unstable. And then of course, we have had to come back and say, 'well look, you know actually ... you're mad - it wasn't like that at all - you need to see a psychiatrist.'

Robert Chatfield was very emphatic that mentally ill complainants would need to give particularly strong evidence in order for a member of staff to be disciplined:

> The other point and maybe it's more so in mental health - you will get a number of malicious complainants who will complain about what a nurse has said or what a nurse hasn't said, or what a nurse has done or what a doctor has done. So you have to be scrupulously fair to both staff and patients, and on the basis of something that isn't beyond reasonable doubt - I mean it has to be more than beyond reasonable doubt, to say to a nurse, 'right, we are disciplining you.'

[16] Responses to this issue were limited to the complaints managers who worked in mental health trusts and a few other complaints managers who had strong views on this issue, who had come across mentally ill complainants among the general complaints.

The attitude of these complaints managers is consistent with Sjoberg's (1966: 65) notion of blaming clients as a response to conflicting goals. Thus, in a sense, mentally ill complainants were 'blamed' since their complaints were automatically cast as suspect because of their mental health status. This outlook is also reminiscent of Lerner's (1980: 21) just world theory, that one could judge an injured party as being of dubious character in order to deflect blame regarding any unfairness or bias. Accordingly, mentally ill complainants are characteristically regarded as being of a dubious disposition, which enables complaints managers to automatically side with the organization.

Second there were complaints managers who empathized with both complainants and staff. They exhibited dual opinions on this issue and typically were conscious of the possibility that complaints could be a part of a patient's mental illness. However, they equally felt that even it this was the case, it was crucial to establish the issue behind the complaint. On one hand, Ethel Yates argued that any complaint, even if it was medically invalid, was probably a sign of dissatisfaction about something, and thus it was important to determine the route cause of the complaint. At the same time she strongly empathized with the position of mental health staff who were complained about; she pointed out that being a member of staff in a psychiatric hospital could be difficult; she observed that mental health staff often have to do unpleasant things to patients such as administering medication, controlling, and restraining.

> Staff, particularly nursing staff - often have to do things to patients that they don't want done to them. They are the ones who give them the medication; they are the ones maybe that have to control and restrain them; they are the ones that have to tell them things they are saying maybe aren't right - and so they are often seen as 'the baddies' - and it's very difficult for staff. I think they do a very difficult job.

On one hand Angela Keith remarked that all complaints have to be investigated:

> So we try and manage it as best we can but we never say, never, unless it's - there are a couple of examples of what somebody said is really quite mad - we never dismiss something as someone's mental illness - but it can cause problems.

At the same time she empathized strongly with staff:

> ... there are also times when I hear from the staff point of view that this person was particularly difficult, and was particularly hard to manage. It happens a lot within mental health for example when clients within mental health complain that they have been restrained by nurses, but then when you hear about how they were behaving, and the fact that they thumped a nurse first, before they were restrained - in those situations, you can definitely identify with the staff - but you feel sympathetic towards the patients who are in that situation in the first place.

On one hand Vanessa Farley (Associate Director of Quality and Risk Management) acknowledged:

> they are a very vulnerable section of our patients. It would be very easy for people to say, 'he doesn't know what he's talking about because he's daft.' So, no - we are very keen no matter how stupid the complaint might seem, to investigate to make sure there is nothing there.

At the same time her sceptism about these kinds of complaints is illustrated in the following remark:

> I do get vexatious complaints at times but they really all have to be investigated, because you never know when there might be a grain of truth there.

Third, there was only one complaints manager (Sandra Jarvis) who focused on the complainants' predicament, pointing out that mentally ill complainants were particularly vulnerable.[17]

Thus, some complaints managers were organization oriented; some complaints managers espoused both organization oriented and complainant oriented views; and one complaints manager tended towards complainant orientation, with regard to this issue. It could be argued that a complaint manager who was particularly complainant oriented; who was concerned about the predicament of mentally ill complainants, was more likely to experience tensions with regard to this issue than other complaints managers, in that their stance is one which conflicts markedly with organizational norms.

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[17] For further detail on this complaints manager's views on this issue, see Chapter Four of the thesis, regarding mental health complaints. This view on mental health was uncharacteristic of this particular respondent as can be seen in Chapter Six of the thesis and also from her other responses in this chapter.

Withholding Information from Complainants - Different Views

The withholding of information from complainants was also included as a conflict variable as another useful indicator of complaints managers' responses and reactions to their role in terms of organization orientation versus complainant orientation.[18] Essentially complaints managers were not authorized to share a discipline committees report with the complainant who initiated the action in the first place. In relation to this issue, respondents were asked questions concerning the withholding of information from complainants relating to staff disciplinary proceedings.

Complaints managers could be categorized into two groups. First there were complaints managers who were uneasy about withholding information from complainants. These respondents seemed to identify with complainants need to know whether complained about staff had been disciplined. There was a general feeling that morally, complainants had a right to know about outcomes of disciplinary proceedings. Moreover, Cath Garcia (Patient Liaison Manager, Acute Trust) felt that giving the complainants this sort of information might actually make complaints handling easier as complainants would be more satisfied with the outcome of the complaint. Pat Gates held the view that it was unfair to expect complainants to be witnesses and then refuse to make the results of the disciplinary report available to them:

> ... Actually the way the regulations work is that you are not allowed to share the discipline committees report with the complainant who initiated things in the first place. So that's very difficult, and I tend to end up doing it if I have to, off the record, but you can't formally let them know. So that's very unsatisfactory, because we ask them to be a witness for us, to help us to take the case forward, but then they are not really allowed to know the outcome...'

In contrast to his views on other issues, Robert Chatfield also sympathized with the complainant on this particular matter:

> In one sense, looking at it from the complainants' point of view, they will make an accusation

[18] This issue was not pursued with ten respondents due to the question being added later in the data collection process.

against a member of staff - if I went somewhere and was treated appallingly by a member of staff, and complained, I'd kind of feel I had the right to know what's being done about that.

Indeed, as indicated above, some complaints managers bent the rules and used off the record ways to give complainants this information. Gordon Evans also acknowledged:

I think there are off the record ways of dealing with these situations. Especially if you build up a reasonable rapport with the complainant, you can actually say to them over the telephone 'I am not able to say, put in writing what has happened, but I can tell you that this person has been given a written warning' or something like that. I've done that once or twice on an unofficial basis because I felt the complainant deserved it ...

On the other hand, there were complaints managers who had no problems with withholding information from complainants. The general feeling of complaints managers who held these views was that first, it was unfair to staff to reveal this information to complainants; complaints managers had an obligation to staff; and second, that it would be inappropriate to give this kind of information to complainants. Lisa Martucci (Consumer Relations Manager, Acute Trust) made the following comments:

I think some patients can get quite a lot of gratification from knowing that a member of staff's has been pulled over the coals, but at the end of the day, a member of staff is a human being, and that's not fair ... [19]

Janet Thompson remarked:

...actually we have got an obligation to staff, and so we do not say, 'look, this person was disciplined and were given an informal or formal warning and they've been sort of put on a probationary period, blah, blah, blah.' We don't go into that level of detail. That's what patients want or complainants want. But that's not an OK thing to do. What we have to say is, 'look, you have to trust us as responsible employers; we have dealt with this within the context of our disciplinary procedures, and this person's behaviour, or practice or whatever, will be very closely monitored.' But we don't give details. They'll come back to us and say, 'so who gave you the statements? who did this? was so and so asked to give a statement?' They'll say, ' why

[19] While this respondent identified with staff strongly on this issue, she identified strongly with complainants with regard to distressing cases.

> couldn't I have given a statement ? I want to be at the disciplinary hearing ...' ... We don't owe it to our complainants to reveal the details of disciplinary action that has been taken. Sometimes I'll say, 'this person no longer works for the organization' and the complainant will come back and say, 'did you sack them.' Well actually even if we did, we are not going to say that.

Like all the other conflict variables described, this situation is an example of complaints managers exhibiting complainant orientation or organization orientation. It could be argued that the complaints managers in the first group took a complainant-oriented stance and the complaints managers in the second group took an organization- oriented stance. With regard to those who took a complainant oriented stance, it is interesting to note that on this issue a number of complaints managers admitted to rebelling against organizational norms, a direct response to conflict with the organizational agenda.

These opposing responses could be explained by role theory in terms of individuals reacting very differently to situations of role conflict. As Zurcher (1983) pointed out, social actors employ different strategies to resolve any role conflict they are experiencing. For example, they conform to roles, modify established roles, create new roles, and negotiate workable compromises between behavioural expectations they have for themselves and the behavioural expectations they perceive others have for them (Zurcher 1983: 9). Complaints managers seemed to *conform to roles* (willingly withheld information from complainants) or *modified their roles* (gave information to the complainant off the record). Others may have adhered to their role demands and withheld information, albeit reluctantly. In other words they encountered a conflict in their role but tried to meet all the demands of the role and thus may have 'unwillingly' withheld information from complainants. Arguably this latter response would possibly result in significant tensions; Hall (1972) observed that coping with role conflict through this kind of *reactive role behaviour* involved aiming to meet all of the role demands experienced and he argues that this strategy would probably bring about considerable strain on a person's energies as it involves attempting to do everything demanded rather than trying to reduce conflicts and demands (1972: 480).

Table 5.6 Views on withholding information from complainants

COMPLAINTS MANAGERS VIEWS	NUMBER OF COMPLAINTS MANAGERS
Against withholding information	10
In agreement with withholding information	10
Total	20

Emotional Reactions to Complainants and Complained about Staff - Different Emotions

The NHS complaints manager job is a post in which employees are regularly exposed to negative, often disturbing cases. For example, two complaints managers recounted situations where complainants were threatening suicide. This section explores complaints managers' emotional reactions to their job, which is another conflict variable relating to how complaints managers resolved the conflict in their role in terms of complainant orientation versus organization orientation. Two key issues were addressed, that of sympathizing/ empathizing with complainants and sympathizing/ empathizing with staff.

It could be argued that the emotional reactions referred to in this section are indicative of complainant and organization orientation in the same way as the aforementioned behavioural and attitudinal variables (for example, advising/supporting complainants). For example, it could be argued that a coping mechanism which allowed an individual to detach himself/ herself from the complainant's situation might be associated with organizationally oriented behaviour in that this detachment from the complainant would enable the complaints manager to feel at ease in the event of acting against the complainants interests. On the other hand, a reaction involving empathy with complainants, possibly will be linked to complainant oriented behaviour in that the complaints manager may be more likely to try and achieve a favourable outcome for the complainant. In the same way, strong sympathy with staff, could be linked to organization orientation, as staff represent the organization.

Sympathy/ empathy with complainants - different emotions

Complaints managers' emotional responses to complainants' cases seemed to fall into three key groups. One group of complaints managers acknowledged that they became upset or angry by distressing cases and used a number of terms to describe their emotions. Emily Fowler revealed:

> I'm one of those sorts of people that if someone's crying, I might burst into tears as well! So I do find that hard sometimes.

Vanessa Farley said:

> I get very angry sometimes if I hear a particularly bad case. I mean I've been in hospital myself - I got my mother and various other relatives that I don't think have been particularly well treated - but if you hear something that .. you know ... is just not right, then yeah - I do get annoyed.

A number of respondents felt that one would not be human, and indeed could not do the job effectively without some emotion, empathy or understanding of the complainant's position:

> I think that if you didn't have some emotion and some feeling you wouldn't do the job very well at all.
> Ethel Yates

Some complaints managers believed that complainants felt better when they displayed emotion; they argued that being upset was a way of showing genuine empathy:

> ... I wouldn't avoid meeting someone just because I thought I might get upset by it - and in a way ... showing that you are upset by what has happened might make them feel a bit better - might make them feel, 'yeah, I have got some cause - what happened to me was bad - at least there's a human face at the hospital who has listened to me, who has obviously taken in what I have been saying.' I was speaking to the complainant at the end of the week on the phone and talking about how the meeting had gone and he said, 'I could see that you were very upset and thanks - thanks for being human.' So for that reason, I certainly wouldn't avoid it.
> Emily Fowler

> Oh God, yeah, I cry! Definitely! You wouldn't be human if you didn't - and I don't think the complainants mind - sometimes I start breaking up on the phone - they don't mind - they are quite pleased I think, that somebody is affected by it.
> Ruth Carroll

Some complaints managers were badly affected. For example, Emily Fowler recalled:

> ... The meeting I had last week ... that was very upsetting, and I almost burst into tears during the meeting ... it was horrible - very sad. When we have had similar types - well I've felt similarly moved.

It could be argued that complaints managers who became emotionally involved in complainants cases were likely to be complainant oriented in relation to these cases. This is consistent with Blau's (1960: 242) assertion that some workers showed a concern for the welfare of clients and became emotionally involved, thus *linking a concern for the emotional welfare of clients with becoming emotionally involved.*

A second group of complaints managers were personally affected by complainants' cases, but only occasionally. Like the first group of complaints managers, this group of complainants generally showed empathy. However, this group also significantly tended to stress that *ultimately* one could not 'take it home' or 'lose sleep over it':

> You do go away and think about things, and it's hard to listen to particular stories or read particular complaints, and not feel that it's very sad or something like that ... To that extent, then yes, you know, I would say I am affected - but I don't sort of take it home with me and lose sleep over it. Again that's about how you deal with it personally. A lot of complaints managers may give you different responses.
> Jackie Waterman

> One has to be sensitive, and on the other hand you must avoid being so involved that you take the job home. That sometimes happens - it's unavoidable.
> Imran Quereshi

> ... On the whole, I think I've probably got the attitude where once I walk out of the door in the evening, I have a shut-off mechanism. And you have to be like that ... I might discuss a case

> anonymously with my wife or something. But that's it then - and I tend to put it behind me because you know - it's the classic situation of yesterday's case, you know, and you move on to the others.
> Gordon Evans

Some complaints managers felt that they became detached from upsetting cases after they had been in the job for some time. Pat Gates commented:

> It's true you do become hardened to it, and you empathize less, the longer you've been in the job.

Moira Foster (Patient Services Manager, Acute Trust) remarked:

> Some of the really serious cases that you read can be quite upsetting - although to be honest, I think once you have been in the job a while, I suppose you become a little bit detached - otherwise you just wouldn't be able to cope with the job - it's quite stressful.

This phenomenon of becoming emotionally detached as a result of being in the job for some time is in keeping with Blau's (1960: 242) notion of losing concern for the welfare of clients as a way of resolving conflict. In addition, Moira Foster felt that she coped by looking at the situation positively and viewing the complaint as a way of improving the situation. The following extract illustrates this point:

> ... in a sense, you have to adopt perhaps a hard line a little bit - otherwise you wouldn't be able to cope with the job - and I think it's more - right OK it's awful - but what can we do about it? How can we investigate it? So I try and put my energy into that in a sense. I think by and large, we try and focus things on the positive side of what can we do to sort the problem out ... a way of sort of getting over horrific details - if that makes sense.

In short, with these complaints managers, there was a general feeling that one had to be the kind of person who could switch off, and recognize that the world was not a perfect place. A number of respondents alluded to the idea that the job was stressful if one allowed it to be. At the same time there was the implication that one required a certain degree of compassion and sensitivity to carry out the job. Overall, this group of complaints managers' outlook is possibly conceptualized by Blau's (1960: 242)

notion of combining impersonal detachment from clients with a concern for the welfare of clients.

A third group of respondents showed little or no sympathy with the complainant's situation. These complaints managers stressed the need to be emotionally detached. Indeed, some complaints managers held very strong views that it was unwise to become emotionally affected by complainants' cases. Matthew Andrews firmly held the belief that one could not afford to be affected by one's job; if one became emotionally involved, impartiality became problematic:

> I see too many complaints to get myself personally involved. I think that would be a very bad thing because I couldn't be objective if I was too dramatically involved.
> (Also quoted in Chapter Three of the thesis)

Sandra Jarvis indirectly criticized those complaints managers who allowed themselves to become emotionally involved with complainants cases. She argued that it was unwise to make immediate judgments and/or take sides. She felt that the role of the complaints manager was to put things right and not to dwell on how bad a particular situation may be:

> ... If you go into a situation ... with any emotional baggage ... you thinking the patient is right - or whatever ... then I think it's more difficult - and I've certainly seen complaints managers do that ... on a hysterical basis - we've had people taking up the cudgel ... I'll give you an example of a different organization which is somebody [another complaints manager] ringing somebody up as a result of a complaint and saying, 'please will you look into this frankly horrifying situation' - so a lot of prejudging of the issues. It was all about an old lady I think who had got bruises on her arm ... the children had gone off on the deep end - but before an investigation had even taken place, they'd [the complaints manager] already prejudged what the issues were, which, you know, you must never do - until after the event - until we actually know what the situation is - and then it's a matter of putting things right - not dwelling necessarily on how dreadful it all was. Instead of a calm appraisal of where you could improve, there is sort of an emotional fling that I think can get out of hand - and you have to be careful about that.

Work background was cited by some complaints managers as a possible reason for their ability to remain detached. Some complaint managers felt that because in the past they had worked in jobs, which had involved witnessing traumatic events, they

were already fairly hardened to distressing cases. Janet Thompson considered that her work experience and training (mental health nursing) had enabled her become emotionally detached:

> I have got a nursing background - mental health; I am trained as a counselor; I am a trainer - health psychology, you know - I have got a lot of things that have taught me how to look after myself and be my own woman - do you see what I mean - so it doesn't mean I am not touched by them - it doesn't mean I don't empathize with them - but hopefully ... I hope that what it means is that I don't allow my personal feelings to colour my work.

Freda Steele too, was aware that her nursing background had already hardened her to upsetting situations:

> I guess if you ask a complaints officer with a non-clinical background that problem, they may say yes - but I don't think I have experienced anything here that is any worse than my clinical days.

Sandra Jarvis had dealt with emotionally charged cases due to her background as a solicitor:

> I think that I'm probably hardened to it as a result of my background. I used to do a lot of care work, working for families that had had their children taken away from them, as a result of poor standard of living or abuse or whatever ... and that was very harrowing, so I actually find it sort of less harrowing here!

It follows from the above examples that work background may have an impact on how far complaints managers are personally affected by complainants' predicaments. On the other hand, this could simply be nothing more than an explanation offered by the complaints managers themselves. A further example casts doubt on these complaints managers' explanations: Michael Price (see Chapter Six of the thesis) who was particularly affected by distressing cases, also had a nursing background; it could therefore be argued that it was actually the complaints manager's disposition, and not the work background which determined who was emotionally affected by certain cases.

Table 5.7 Emotional reactions to complainants

COMPLAINTS MANAGERS EMOTIONS	NUMBER OF COMPLAINTS MANAGERS
Personally affected by complainants cases	7
Occasionally affected/ rarely affected by complainants cases	12
Unaffected by complainants cases	10
Non-committal	1
Total	30

Sympathy/ empathy with complained about staff - different emotions

Complaints managers fell into three groups with reference to sympathizing/empathizing with the position of complained about staff. One group of complaints managers strongly sympathized/ empathized with staff and were very vocal in their support for staff. Emily Fowler held the view that staff worked very hard, and that the majority did their best:

> ... they work very, very hard; they can't be all things to all people and I think the vast majority of them really do their best and really do care. A small handful have a bad press - maybe justifiably - I don't know - but on the whole, yes, they work very hard - most of them are dedicated - they get faced with complaints, and it's particular areas of the hospital as well that get more complaints than other areas, like A&E. For example, you get a lot of complaints from people who have visited A&E, but probably the A&E doctors and nurses are one of the hardest working groups of people in the country. It must be very soul destroying for them.

Liz Ellis felt that that sometimes staff had been misunderstood:

> ... You get people who just haven't been understood properly, or you know, they've had a hard day and they haven't been chatty, and upbeat and bouncy, and the persons got fed up because that's what they expect from their district nurse or their whoever, and something else goes wrong, and they make a complaint ... You are taking a snatch of dialogue, as it was remembered by somebody. So you do sort of think 'this is a little bit unfair.'

Other respondents drew attention to the fact that staff may have suffered verbal or physical abuse. Shona Thornton remarked:

> Some of them suffer - particularly staff in the front line like the receptionists, or the practice managers - put up with an awful lot of abuse from patients, and I have every sympathy with them.

Still others implied that consumerism in the NHS had gone too far. Liz Ellis commented:

> ... I think the Patients Charter has done a huge amount, unfortunately, to load expectations about rights without the kind of attendant responsibilities about what it is you are asking for, and how you are asking for it, and what you can reasonably expect to have at the end.

Sybil Fisher pointed out that complaints could be very stressful for GPs as well as complainants:

> I think it gets forgotten ... we all want to kind of bang the GPs and screw them into the ground ... sometimes I think it is justified ... but a lot of the time they are human ... they have never had training in communication ... they were taught to be God! - and they find it very difficult - and some of them are trying really hard, and they are also working under very stressful conditions - and I think that can sometimes get lost. It's stressful on all sides - on both sides.

A second group of complaints managers showed a more moderate sympathy/ empathy for staff. For example, Angela Keith remarked:

> ... you can identify with staff - staff do get really personally affected by them [complaints] and I did have somebody make a complaint about the way I dealt with something once - once or twice actually - and I realized how it felt. Yeah, you do.

In a similar vein, Tamsin Wilkinson (Complaints Manager, Health Authority) remarked:

> 'I even get complaints about me personally ... I think it's daunting for almost any member of staff, or any person to receive a complaint about themselves ...

A third group of complaints managers said that they had empathy for staff, but identified more with complainants. Vanessa Farley remarked:

> We're paid to do a job, and you shouldn't bring your problems to work with you - that sort of thing - but I do identify with the staff to a great extent - it's not pleasant to be complained about.

Ethel Yates commented:

> I do identify with the staff very much. I think they have a very difficult job to do. And I am not sure that I could do it. But then I do sometimes think that they bring things on themselves by their poor communication with patients.

Table 5.8 Emotional reactions to complained about staff

COMPLAINTS MANAGERS EMOTIONS	NUMBER OF COMPLAINTS MANAGERS
Strong sympathy/empathy for staff	10
Moderate sympathy/ empathy for staff	10
Moderate sympathy for staff, but more sympathy with the complainant	10
Total	30

Conclusion

This chapter has focused on eight conflict variables: advising/ supporting complainants; investigating complaints; unjustified complaints; being proactive in using complaints to improve service quality; fairness and justice in the complaints system; mental health cases; withholding information from complainants; and complaints managers' emotional reactions to complainants and staff. The theme of organization orientation versus complainant orientation was considered in relation to each variable in terms of how complaints managers' responded/ reacted to the conflicts in their role, which in turn, perhaps indicated, the extent to which the complaints manager might experience tensions in their role.

In general the complaints managers in the sample responded to questions in two or three ways: they gave a complainant oriented response, an organization oriented response, or a 'middle-of-the-road' response some where between the two former stances. It could be argued that an organization oriented stance shows a consensus with the organizational agenda, which is therefore likely to eliminate or at least significantly diminish tensions for complaints managers. However, unless the complaints manager's stance is *consistently organizationally oriented*, complaints managers are in varying degrees showing *some* level of complainant orientation. Whether it is going out of ones way to support complainants; conscientiously chasing up gaps in investigations; becoming emotionally involved by complainants cases; or simply believing that the complainant is getting a raw deal, these types of arguably complainant oriented reactions would be likely to cause at least some tensions, as is apparent in much of the evidence presented in this chapter.

By exploring the interrelations between organization oriented stances and complainant oriented stances, and combining different patterns of behaviour, attitudes and emotions, it is possible to identify five types of complaints managers. This *typology of complaints managers' responses and reactions to the contradictions in their role* is the subject of the next chapter.

Chapter Six: A Typology of NHS Complaints Managers' Responses and Reactions to the Inherent Contradictions in their Role

Introduction

This chapter further develops the ideas considered in the previous chapter. Thus the focus of this chapter is a *typology of complaints managers' responses and reactions* to the inherent contradictions in their role. Essentially, when the different orientations of complaints managers outlined in the preceding chapter are combined in a variety of groupings, they can be categorized into a 'typology of responses/ reactions'. This typology can be seen as a typology of responses/ reactions to the inherent contradictions in the complaints manager's role in that the typology draws from literature, which has a clear theme of resolving conflict, that is, contradictions in the role of organizational actors.

This chapter draws on *Theme Three* outlined in Chapter One of the thesis to explain the findings, that is, *typologies of organizational actors' responses and reactions to the inherent contradictions in their role*. The findings related to this theme in that a typology of complaints managers' responses/ reactions was generated from the complaints managers interviews. It is important to note that in searching the socio-legal, public administration, and sociological literature for suitable typologies to frame the research findings, I draw mainly from public administration literature because the typologies identified in this literature provided the best interpretation of the findings in terms of *organization orientation versus complainant orientation.* It could be argued that such a framework provides the best way of exploring the complaint manager's role for the purposes of this thesis since the key cause of inherent contradictions (explored for this study) is the clash between the organizational agenda and duty to complainants, in other words, organization orientation versus complainant orientation. Accordingly, the chosen framework provides a useful way of framing responses/ reactions to the *contradictions* in the complaints manager's role.

In this chapter, I have drawn from Don Welch's typology in *Conflicting Agendas* (1994), Robert Presthus' typology in *Organizational Society* (1979), Sherman and Wenocur's (1983) typology in the article, 'Empowering public welfare workers through mutual support', and briefly from Kramer (1974) *Reality Shock - Why Nurses Leave Nursing.*[1]

The literature pointed to two 'extreme' types of responses to conflicting agendas (extreme organization orientation and extreme client orientation); and a 'middle-of-the-road' approach (see Klein 1973 and Welch 1994).[2] The typologies constructed by the above-mentioned authors strongly correspond with each other. With reference to extreme organization orientation, Welch's *Institutionalized Person* is consistent with both Presthus' *Upward Mobile* and Sherman and Wenocur's notion of *Capitulation.* In the same way, in relation to extreme complainant orientation, Welch's *Reformer* corresponds with Presthus' *Ambivalent* and with Sherman and Wenocur's conception of *Non-Capitulation.* Moreover, with regard to middle-of-the-road orientation, Welch's *Accommodator* is compatible with Presthus' *Indifferent* and with Sherman and Wenocur's concept of *Functional Non-Capitulation.* I have also drawn on the 'split personality' type, an organizational type developed by Welch, which did not correspond with the above patterns of accommodation.[3]

In short, this chapter examines how different types of complaints managers coped with the contradictions posed by their role in the organization. Drawing from the public administration typologies referred to above[4], it was possible to formulate five types of complaints managers from the empirical data of this study which have been categorized as follows:

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[1] See Chapter One of the thesis. In terms of disciplinary context, Welch and Presthus could be categorized as public administration texts. Sherman and Wenocur's article could also be considered a contribution to public administration literature in that the article considers the role of public welfare workers.

I draw briefly from Kramer (1974) because Sherman and Wenocur made use of Kramer's typology in formulating their own typology.

[2] Both these authors use the term 'middle-of-the-road' in relation to their typologies.

[3]The construct of 'split personality' is drawn exclusively from Welch (1994).

[4] For further detail see Chapter One of the thesis.

- Institutionalized Person
- Indifferent Accommodator
- Complainant Oriented Accommodator
- Split Personality
- Reformer

With reference to the structure of the chapter, this chapter examines each of these approaches in turn, that is, the institutionalized person, the indifferent accommodator, the complainant oriented accommodator, the split personality, and the reformer.

Table 6.1 The focus of chapter six - types of complaints managers[5]

GROUP	NUMBER[6]
(1) Institutionalized Person	9
(2) Indifferent accommodator	6
(3) Complainant oriented accommodator	4
(4) Split Personality	3
(5) Reformer	2
Total	24

The Institutionalized Person

Nine complaints managers fell into the category of *Institutionalized Person,* which draws from Welch's concept of Institutionalized Person, Presthus' (1979) notion of Upward Mobile, and Sherman and Wenocur's (1983) notion of Capitulation (which builds on Kramer's typology [1974]). Broadly speaking, these complaints managers

[5] While this typology is an attempt to demonstrate that complaints managers had very different personal styles in their handling of complaints in terms of resolving the conflicts in their role and fitted broadly into distinct types, it is important to note that as *pure types* these models are artificial and individuals did not *rigidly conform* to these categories (See Welch 1994: 12). For example, two of the complainant oriented accommodators in the sample also had some 'reformer' attributes in their behaviour, attitudes and emotions.

[6] As explained in Chapter Three of the thesis, this typology is based on twenty-four of the thirty complaints managers interviewed for this study.

Although I use quotations from the vast majority of respondents, I have not drawn from the interviews of every single respondent in this chapter.

consistently displayed behaviour, attitudes, and emotions, which showed an organizational bias. The key characteristics of this group included embracing the institutional agenda; conforming to organizational norms and values; identifying with the organization; staying emotionally detached from complainants' predicaments; exhibiting an anti complainant ethic; and being comfortable with the bureaucratic situation.

Thus, institutionalized persons tended to feel the complaints system was fair. Taken in the context of the widespread criticism of the then fairly recently reformed complaints procedures, the following comments suggest a support for the status quo. Jason Bradley (Corporate Services Manager, Community and Mental Health Trust) reasoned:

> ... personally I think it (the complaints procedure) is as fair as it's ever going to get. I don't think there's much more they can do to improve it. We've got the advocacy service; we've got the CHC; we provide patients with leaflets on how to complain - what they need to do, where to send things ... so we give them as much information as we possibly can, and we even encourage them to send in their comments and complaints.

In terms of conforming to organizational norms and values, in line with Sherman and Wenocur's observations, this group of complaints managers assumed little responsibility for what they were not able to do.[7] For example, they tended to have few problems investigating complaints which might suggest that they were less willing to 'rock the boat' when there were uncertainties about the viability of complaints investigations. Additionally, there was the tendency with this group of complaints managers to be in agreement with the regulation of withholding information from complainants regarding disciplinary action against complained about staff, (a regulation which was opposed by a number of complaints managers as being unfair on complainants). Furthermore, this group was less likely to desire to be more proactive in using complaints to improve service quality.

In terms of identification with the organization, with reference to this group's attitudes to staff and complainants, institutionalized persons were prone to empathize

[7] See Chapter One of the thesis.

particularly strongly with staff. Robert Chatfield (Quality Manager, Mental Health Trust) felt keenly that staff should be given the benefit of the doubt:

> ... the bottom line is you give staff the benefit of the doubt in the absence of other information because if you don't give them the benefit of the doubt, you have to take them through a disciplinary. If you take them through a disciplinary, and you don't have sufficient evidence, then you are potentially shafting someone's career.

In a similar vein, Sibyl Fisher (Assistant Director, Public Affairs, Health Authority) felt that a 'softly softly' approach should be taken with complained about General Practitioners. In answer to my question on whether to be stricter with consistently poorly performing General Practitioners, she replied:

> ... If you just come down on somebody like a ton of bricks, and fine them five hundred quid, it puts them under a lot of stress, inevitably, but it's actually unhelpful for them in the long term. And if it's something that you think could be improved by training or support or whatever, and the GP is willing to consider that, then I think that's got to be the best way forward. That's common sense wherever you work, isn't it, if you have got somebody who has made a clanger - wherever it is - if you are working in an office or whatever, you know, you don't come down on somebody like a ton of bricks the first time it happens.

At the same time this group were inclined to remain emotionally detached from complainants' predicaments. Liz Ellis (Head of Quality, Mental Health Trust) was typical of this group. When asked whether she was ever personally affected by any of the complaints, she explained:

> No, because I don't think anything has ever happened which has been so dreadful that ... I can't think of any complaint which I've sort of thought 'Oh my God, this is really terrible.'

Concurrently this group of complainants' managers tended to exhibit an anti complainant ethic (see Nader 1980: 44)[8] in relation to complainants. According to Presthus, acceptance of the organization's goals predisposed this group to conformity and caused impatience with those who dissented (Presthus 1979: 161). With these types of complaints managers, there was a tendency to blame complainants. For example, many of them had no time for 'unjustified complaints' and a lot of them

[8] See Chapter One of the thesis.

doubted the validity of complaints from the mentally ill. As referred to in the previous chapter, Janet Thompson (Service Quality Manager, Acute Trust) was uncomfortable about treating complainants with mental health problems in the same way as 'normal' people. This could be argued to be a standpoint indicative of an anti complainant ethic in that she is casting further doubt on the legitimacy of complaints from an already vulnerable group of patients.

When asked whether she ever identified with complained about staff, Liz Ellis' reply illustrates her irritation with what she saw as unjustified complaints and her sympathy with staff:

> ... you feel that they [staff] are sitting ducks for people to sort of throw things at, and knowing how very hard the vast majority of staff work, and how thankless some of their tasks are, you feel it's a very bitter pill to swallow when somebody makes - particularly the more sort of gratuitous forms of complaints - you just sort of think - you know - 'for Christ sakes, get real'. And I do feel sorry for the staff when complaints are made.

When asked about the implications of conflicting stories between complainants and complained about staff, Sandra Jarvis (Consumer Relations and Legal Affairs Manager, Community and Mental Health Trust) implied it was unrealistic for complainants to demand the facts of a particular case:

> ... it depends what you see the purpose of the complaints procedure. If they see the purpose of the complaints procedure to punish staff who have done wrong, then yes, I can imagine it would be very galling not to have all the facts.

Thus, when these complaints managers experienced frustration, irritation tended to emanate from their dealings with *complainants* rather than the staff. The responses of some complaints managers suggested they felt the complaints system was in fact too far weighted in favour of the complainant. For example, the following comment by Liz Ellis suggests that she feels the complaints of those with mental health problems are taken too seriously:

> With the mental health side of things, if you know that you've got a patient who is actually in our patient wards, and you get a complaint from them, we have to take them seriously, even if they are - you know - what they have written is almost unintelligible - because they are entitled

to the normal patients charter treatment in terms of response to their letters and so on.

The same respondent was also exasperated about the requirements of the complaints procedure in terms of duty to complainants. Her remarks imply that the NHS is unnecessarily lenient on complainants:

> I think this is the thing about the having to deal with these irritating people, writing just pointless letters - demanding another letter in return. I would like to cut the crap and say to them, 'look, we are investigating your thing, and please could you just have the courtesy to wait until we've carried it forward' - because at the end of the day these people are difficult people - and it doesn't help anybody, I believe, in the end, to encourage that kind of mentality.

Correspondingly, Freda Steele (Quality Development Manager, Acute Trust) was critical about the amount of time that was considered necessary to handle complaints:

> I think I feel frustrated, because such a lot of effort goes into some people or some peoples complaints, in my opinion unnecessarily, and it takes up so much of people's time, and it's not just nurses' time, it's management time - whatever.

It could be argued that the above examples of frustrations with complainants somewhat conflicts with Presthus' theory that this group found the bureaucratic situation comfortable and thus could often adapt to the organization with relatively little strain (Presthus 1979: 183). However, it is still feasible to speculate that *compared to more complainant oriented respondents*, this group of managers did in fact adjust to organizational life with relatively little strain. Consequently, it is possible to theorize that these complaints managers were far less likely to experience tensions in their role, as their behaviour, attitudes and emotions seem to represent a desire to protect the organization complained about and thus would be in line with organizational norms and values. Presthus argues that this group's ability to identify strongly with the system is highly productive in personal terms since it qualifies (Upward Mobiles) for the organization's major rewards (1979: 151). Nonetheless, as Sherman and Wenocur (1983: 376) point out, the drawback of such a response is that workers shut down their empathic responses. In Kramer's view, (1974: 161) if individuals rigorously adopt these kinds of values, they find their efficacy diminished;

she argues organizational actors[9] should not be expected to support the whole of the local culture but to inspire essential changes in that culture.

The Indifferent Accommodator and Complainant Oriented Accommodator

Accommodators were complaints managers who in various ways learned to cope with *two value systems* (Sherman and Wenocur 1983: 377; Kramer 1974: 162), that is, their own ideological standpoints *and* that of the organization with regard to client demands. Essentially the complaints managers in this category *accepted* the institutional agenda rather than embracing the institutional agenda (like the institutionalized person). Thus, *they identified with both the complainant and the organization.* Hence this could be regarded as a 'middle-of-the-road' adaptation to the role of complaints manager. Ten accommodators were identified in the sample. Presthus (1979: 184) theorized that this method of adaptation is the most common type of adjustment to life in an organization. Certainly this figure shows that a significant number of respondents took this 'middle-of-the-road'approach to organizational adjustment.[10]

The indifferent accommodator

Six of the ten accommodators could broadly be categorized as *indifferent accommodators*. While, their standpoint was a general mix of complainant and organizational orientation, this group of complaints managers, as their name suggests tended to take an 'indifferent' approach to their role compared with the complainant oriented accommodators covered in the following section.[11] In terms of their key characteristics, indifferent accommodators were often non-committal and ambiguous

[9] In this case nurses.

[10] It is probable that the six complaints managers who did not fit into any of the types described in this chapter (see Chapter Three of the thesis) took on *aspects* of a 'middle-of-the-road' approach in their adaptation to their role.

[11] This group of complaints managers had much in common with Presthus' middle-of-the-road typology (the indifferent).

in their stances. In addition, they were generally emotionally detached from complainants' predicaments although they showed moderate sympathy towards complainants. Moreover, Presthus argues that the indifferent's stance is manifested in an emotional withdrawal from the work arena and a transfer of interest to activities outside work; indifferents pay lip-service to organizational values but do not retain any real interest in the organization (1979: 188).

Thus, with reference to their views, indifferent accommodators were less inclined to give strong opinions; their responses to questions were much more evasive, ambiguous and non-committal than the complaints managers in other categories. For example, Jackie Waterman (Patient Services Manager, Health Authority) emphasized that she was neutral:

> I actually feel more comfortable with the neutral role. I mean one of the reasons I left my CHC post ...I actually found it more difficult to be there representing the patient all the time in every circumstance, than I do to actually be neutral. I think that comes back to perhaps the personality of the individual - the way you as an individual see yourself.

Similarly, Rhonda Parker (Advice and Complaints Manager, Health Authority) stressed:

> ... We're very much sort of in the middle, and our advisory role is sort of in the middle of all interested parties in the complaint and that, I think is a good change from the previous complaints procedure when nearly everybody saw us as being there to advise the complainant ...

Likewise, when asked whether she ever identified with the complainant, Mrs. Woodward (Consumer Affairs Manager, Health Authority) responded:

> Yes, I do, and similarly I feel sorry for the doctor, the dentist, the optometrist or pharmacist.

With reference to emotional reactions to their role, indifferent accommodators acknowledged that complainants' predicaments had the potential to be upsetting, but generally took a non-emotional approach. Mrs. Woodward argued:

> Obviously I have listened to complaints which have been upsetting, but I don't impart that to the

> person I am speaking to ... it's not going to be helpful in a situation where something really horrible has happened such as a child has died, for us to get upset on the phone, because it doesn't help that person at all.

Once again Jackie Waterman emphasized her neutral stance:

> Quite often you do feel sympathetic, because the people who contact you are clearly distressed. You can sympathize with their distress and the fact that they are unhappy with something but that doesn't necessarily mean you feel strongly one way or the other.

These complaints managers typically showed small amounts of empathy with complainants whilst taking an indifferent attitude to possible inequities in the complaints system. While showing some sympathy towards complainants, Tamsin Wilkinson (Complaints Manager,[12] Health Authority) seems to be indifferent to the problems of resolution in primary care raised by other respondents and the subject of debate by policy analysts:

> In terms of local resolution, I think it's a good process - when it works correctly, it's exactly what complaints should be about - trying to put things right immediately - and I think in a lot of Practices, that works absolutely fine.

Likewise, whilst occasionally sympathizing with complainants, Imran Quereshi (Complaints Manager, Acute Trust) felt the complaints system was essentially fair, remarking, 'I think it's reasonable.' Similarly on one hand Margaret Brown (Complaints Co-ordinator, Community Trust) empathized with complainants; at the same time, regarding the complaints system, she stated, 'I think it's fair.'

Indifferent accommodators tended to exhibit empathy with complainants and staff *in moderation*. They differed from institutionalized persons in that there was an absence of intense support for staff and an absence of an anti complainant ethic. They differed from complainant oriented accommodators in that they seemed less likely to 'put themselves out' for complainants. In short, then, this group tended to hold views and experience emotions that were less strong than other groups of complaints managers.

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[12] All the respondents are complaints managers (with the exception of identified complaints experts). However, only a few had the term 'complaints manager' as their job title.

Thus, it is possible to speculate that they were significantly less likely to experience tensions in their role than the more complainant oriented respondents.

The complainant oriented accommodator

Four complaints managers fell into the category of *complainant oriented accommodator*. What sets this group of complaints managers apart from the aforementioned indifferent accommodators is that they exhibited a significant complainant bias. These types of complaints managers tended to be willing to admit that the system was not necessarily fair. In addition, they managed to remain generally emotionally detached from complainants' predicaments whilst showing a moderate empathy for complainants, and also incorporating moral principles into their role. Moreover, this group of complaints managers did not necessarily accept organizational norms and values.

In relation to cynicism regarding the fairness of the complaints system, (when asked whether she experienced stress from not being able to do more), Pat Gates (Quality Services Manager, Health Authority) answered resignedly:

> Yes, although I suppose I have become a little bit more used to that. Once again it's where experience dulls the sting of these things.

Cath Garcia (Patient Liaison Manager, Acute Trust) commented:

> I think there are still concerns about to what extent the trust is truly impartial in investigating a complaint.

With regards to being proactive in using complaints to improve service quality, Sonia Rose (Consumer Relations Manager, Acute Trust) acknowledged:

> I feel that more should come out of complaints.

Furthermore, Diane Salter (Customer Relations Officer, Acute Trust) felt the system was weighted against complainants:

> Patients are still left feeling very vulnerable and at the end of the day, they haven't got the answers or the explanations that they require. I think a lot of people don't pursue them because they think 'it's getting me nowhere,' and it's just a long complicated process that is going to cause more stress and upset for them. The patients don't get a very good deal.

With regard to emotional reactions to their role, although this group of complaints managers tended to be personally affected by complainants' predicaments to a certain extent, they were essentially able to remain detached. Thus, they empathized with the complainant while maintaining the emotional distance necessary to carry out the job. Diane Salter explained:

> We probably hear bad, distressing cases on a daily basis really. But they don't necessarily affect us all ... It's a case of keeping it in proportion and just supporting each other through it. When it personally affects us, it's a couple of times a month I suppose - yeah. You obviously couldn't do the job, if you were getting totally distressed every single day!

While Sonia Rose considered she had more sympathy with the complainants than the complained about, she also felt that she had become significantly detached since starting the job. She commented:

> I probably would be more sympathetic to the complainant, if I really thought about it, because, quite often, a lot of the complaints we get could be avoided if staff had spent a bit more time.

She later said:

> I remember when I was first here - I always say when you go and work in complaints it takes three weeks to get over the shock factor, because you read things that ... you can't believe... you know ... I think probably doing the job makes you less tolerant as a person anyway.

In terms of personal morality, ethical principles had a significant part to play in the role of complainant oriented accommodators. This group of complaints managers tended to hold firm views, for example, about fairness and justice of the complaints system. As Diane Salter explained:

> A lot of staff get very upset about us putting an apology in the letter ... a lot of staff get upset

> that we apologize for 'any distress that you feel you have been caused.' They feel we shouldn't put that in ... I feel very strongly that people should have an apology, and so I was very adamant about that - and that went in, and that stayed in.

It could take a lot of persistence to pursue investigations where staff were reluctant to give full accounts of the situation. Thus it could be argued that those complaints managers who kept persevering with investigations did so because of personal morality. Cath Garcia (Patient Liaison Manager, Acute Trust) stated:

> Frequently you will get statements coming back which avoid asking the difficult questions, or just aren't terribly informative in the way that the information is put across - so that there can be difficulties particularly with a very sensitive complaint or if that member of staff thinks there are going to be consequences for them as an individual if they own up to certain things - so yes it can take quite a lot of perseverance in terms of actually getting the information that you want.

Related to personal morality was the tendency not to necessarily accept organizational norms/ values, and consequently maintain some autonomy of value, personal control, and choice. Typically these complaints managers recognized that external demands would play a role in shaping their decision but insisted that their own personal agenda would also play a part in their decision (See Welch 1994: 116). Unlike the institutionalized person and the indifferent accommodator, they tended to have stronger views regarding duty to complainants. While Pat Gates realized that there was little she could do in achieving justice, this did not stop her trying to influence things:

> At no point is the Health Authority - unless it's a complaint about it's own actions - supposed to be making a judgment - we are there just to facilitate the process - it's either the Practice investigating or it's the Convenor looking at the case, or it's a Panel investigating. That can be quite frustrating, although we do attempt to influence things sometimes if we have strong views.

It could be argued then, that this group of complaints managers chose to *balance* various personal norms against the costs of remaining in the organization (Welch 1994: 117). Similarly Sherman and Wenocur (1983: 376) conclude that this kind of adaptation (functional non-capitulation) is about *managing* conflict rather than resolving it. Equally, Welch (1994: 13) believed that this type of organizational adjustment did not resolve tensions between different agendas. The idea that these

organizational actors are not able to resolve the tensions in their situation is summed up by Cath Garcia's explanation:

> ... On the one hand you've got the complainant who feels that their complaint is justified - they expect a full, detailed, response from the Trust - so you are trying to balance that as against a member of staff who feels equally strongly that they have done what was appropriate, that they have nothing to apologize for - so yes it can be stressful, quite frequently from that point of view, and just trying to kind of balance fairness really between the two parties.

The Split Personality

There were three complaints managers who seemed to correspond markedly with Welch's 'split personality' type (1994). This group consisted of complaints managers who appeared to identify *intensely* with both the complainant and the institution. This group of complaints managers adhered to an institutional agenda, conforming to organizational norms/ values *in spite of* a strong identification with complainants' predicaments. Consistent with Welch's speculation, the acute conflict in their responses/ reactions to the role appeared to result in an 'unstable' adjustment in terms of their role as complaints manager (See Welch 1994: 95). Not surprisingly they seemed to be particularly prone to stress.

In terms of their intense identification with complainants, the following comments illustrate the sensitivity of this group of complaints managers to complainants' predicaments:

> ... having met the relatives, I was just so upset by the whole thing.
> Emily Fowler (Complaints Manager, Acute Trust)

> ... before supervision, it would be at least once a week - something would have upset me or made me angry, or panicked me. Now that I have supervision, I haven't experienced that at all. I find it very very helpful, and very constructive.
> Lisa Martucci (Consumer Relations Manager, Acute Trust)

> Oh God - yeah - I cry! Definitely! You wouldn't be human if you didn't. And I don't think the complainants mind - sometimes I start breaking up on the phone - they don't mind - they are

quite pleased, I think, that somebody is affected by it. I just go, 'Oh God, that's awful!'
Ruth Carroll (Complaints Manager, Health Authority)

At the same time, all these complaints managers felt strongly sympathetic towards complained about staff. It could be argued that the following comments also indicate a clear commitment to the institutional agenda in so far as identification with staff implies identification with the organization and it's values:

... I have to admit that I tend to feel sorry for the staff a bit more than I do the patient.
Emily Fowler

I think some patients can get quite a lot of gratification from knowing that a member of staffs has been pulled over the coals - but at the end of the day a member of staff is a human being and that's not fair.
Lisa Martucci

I think I more often feel sorry for the staff, than for the complainant.
Ruth Carroll

Additionally, these complaints managers continued to follow the institutional agenda (although they were routinely disturbed by some complainants'cases):

If it's evident that there is sort of a vexatious complainant or something, we will almost certainly stand up for our staff and say, 'hang on - enough is enough - this is what happened and we are not going to listen to you anymore.' It's difficult - yeah.
Emily Fowler

Often complainants have unrealistic expectations of the NHS complaints procedure. And they want two things: one is money, and the other one is the practitioner's head on a plate - and the NHS complaints procedures can't provide either of those things. But sometimes I just can't get that through to them, and they just keep on and on about how they won't be happy until the GP is struck off, and I have to explain to them that they are not going to get that.
Ruth Carroll

In response to a question on the fairness of withholding disciplinary information from complainants, Lisa Martucci responded:

But it's a private thing. I think that's reasonable.

These complaints managers sometimes accepted inequity in spite of moral convictions to the contrary. In answer to my question, 'are there occasions when you don't feel you are getting the full picture of the situation from complained about staff/investigating staff,' Emily Fowler spoke frankly:

> I think quite often people [complained about staff] hold certain bits of information back. I do think people hold things back a lot of the time - I can't say how often. I may be completely off the mark - I don't know. But that's just a feeling that you have.
> Emily Fowler

She later acknowledged that the organizational bias towards complained against staff could discourage complainants from complaining:

> ... I am sure a lot of people don't complain full stop for that very reason, [organizational bias] which is a shame ... but that's the way it is at the moment.

Ruth Carroll commented:

> ... there are times when I just think 'this should go straight over to the GMC'[13] and I really do sympathize with the patient, especially when the doctors close ranks, and the LMC[14] say there is nothing wrong with this practice, and the GMC turn it down. I feel for them then - that's the way the process is.

Lisa Martucci remarked:

> I do feel very sorry for some of them, because some things are incredibly sad.

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[13] GMC refers to the *General Medical Council* and is generally known to the public for it's handling of complaints or other information, which casts doubt on a doctor's ability to practise. The GMC takes action when a doctor has been convicted of a criminal offence; when there is an allegation of serious professional misconduct; when a doctor's professional performance may be seriously inadequate; and when a doctor with health problems continues to practice whilst unwell. If there is evidence that patients may be at risk, the GMC is permitted to suspend or restrict a doctor's registration as an interim measure. Lesser problems are expected to be resolved locally, in particular through the NHS complaints procedures (see GMC 2003).

[14] LMC refers to the *Local Medical Committee* which is the organization statutorily recognized by successive NHS Acts as the professional body representing individual GPs and GPs as a whole to the Health Authority, including Primary Care Groups and Trusts. The LMC represents the views of GPs to the NHS Executive and to any other appropriate organization or agency (See Londonwide Local Medical Committees 2003).

Perhaps unsurprisingly, these complaints managers seemed to be particularly prone to stress. Ruth Carroll explained:

> ... dealing with people in extreme - I think you should never underestimate the effect that that has on you.'

Lisa Martucci felt that not receiving any sort of support was bad for complaints staff:

> I think it's potentially quite dangerous because you are dealing with such vulnerable people ... I think it's quite damaging to people doing the job, and quite damaging for people you are trying to help.

Emily Fowler admitted:

> The stress sometimes is bad, and I have burst into tears in the office - it's not easy.

In short, it could be argued that these complaints managers represent the conflict of the employee caught between the organization and the complainant *in the extreme*. Emily Fowler expressively conveyed the sense of simultaneously being caring and detached:

> ... I really do think you have to have a compassionate nature to do the job ... whether that's good for you or not, I don't know, but I don't think you can do the job as effectively if you don't have that compassion really - as long as at the right time when you need to be hard, you can be - you can say 'time to stop this, they [complainants] are making allegations about staff that are completely unfounded ...' ... as long as you can be hard at times like that, then that's fine, but I don't think you can be hard the whole time - I think you do have to show some sympathy towards the patients ...[15]

[15] This example is reminiscent of the concept of sociological ambivalence described in Chapter One of the thesis.

The Reformer

Two complaints managers corresponded to a 'reformer' type. Welch stated that the reformer seeks to resolve conflict by reforming the institutional agenda into one that is more compatible with his/her own (1994: 13). Key characteristics of reformers were as follows: they identified strongly with the complainant; they frequently rejected organizational norms/ values; they tried to change the institutional agenda; and played an innovating role in the organization.

In short, it could be argued that this group exhibited 'extreme' complainant orientation. Michael Price (Patient Liaison Manager, Acute Trust) and Paul Hogg (Complaints Manager, Ambulance Trust) were consistently complainant oriented. The fact that only two reformers were identified is in keeping with Presthus' view that these kinds of organizational actors (in Presthus'terms – 'Ambivalents') constitute a small residual category of individuals in organizations (1979: 228). Both the complaints managers explored here showed clear complainant orientation in all their responses to interview questions, together with accounts of challenge to organizational norms.

With reference to the issue of identification with the complainants, Michael Price was deeply affected by complainants' predicaments. In reply to my question about whether he was personally affected by complaints, he replied:

> Yeah, personally affected, yeah, frequently, it is a very, very stressful role.

Michael Price identified with complainants to such a great extent that he was even empathetic about complainants who shouted at him:

> I sort of emphasize if they're screaming at me down the telephone; they must have had a bad deal somewhere along the line to warrant this. We must have failed them somehow that they are doing this.

The second reformer complaints manager, Paul Hogg remarked:

> ... sometimes this department can be quite hard to run ... some of the things we hear in here and some of the distraught telephone calls we get from people in total anguish, and massive personal pain, because of what happened ... what they believe our role to be in it - we are all affected ...

With regard to the issue of frequent rejection of organizational norms and values, it is possible to speculate that Michael Price exhibited such a stance. For example, he had no qualms about disagreeing with powerful members of the organization if he felt it was in complainants' best interests. He admitted to differences of opinion with the Director of Nursing:

> ... I've had a couple of differences with say the Director of Nursing ... a couple of times when I've said I think this ought to go out for an independent investigation to whoever, and she's disagreed with me and overruled me - but that's OK - it happens. There was one particular one I was very concerned about - I wasn't happy at all - and I said to the Director of Nursing '... I would like an independent report from such and such a person.'

Another example of Michael Price's rejection of organizational norms and values was the fact that he routinely reworded letters that had already been written to complainants to make them more sympathetic (also an action of complainant oriented accommodators):

> I know some of my peers [other complaints managers] - they receive a written final response from say a directorate manager, or a consultant even - and that's what goes out - but I always rewrite what they've done and put it into a sort of user friendly letter.

This rejection of organizational norms and values is consistent with Sherman and Wenocur's (1983: 376) description of 'non-capitulation', that is, a response in which workers reject the values and behaviour of the organization and retain their own values. As outlined in Chapter One of the thesis, workers adopting this stance identify with clients beliefs that the organization creates barriers to meeting clients needs (1983: 376). For example, Michael Price was determined to send out a thorough final response letter to complainants even if this resulted in criticism:

> I sometimes think that the Chief Executive is only bothered about getting the final responses out within that twenty working days. It is monitored, and I think one quarter this year, we did appallingly - I got a lot of flak on that, but I had a lot of particularly difficult complaints, which is very frustrating - you might get a response back - it might take fifteen days to get that

> response back, but when you look at it, it's crap and it's got to go out again. But I'd rather do that and have the complaint delayed, than have an incomplete or inaccurate final response going out. I've got a couple on the go, where again, I've had the response, but I want an independent opinion, so I've had to give it to someone else, and that can take another week or two ...

Linked with the rejection of organizational norms and values is the reformers attempt to change the institutional agenda whereby he/she seeks to resolve role conflict by bringing group expectations in line with his/her personal values (Welch 1994: 97). Michael Price alludes to the fact that his no-nonsense approach to overseeing complaints investigations was having an effect on the consultants in his organization:

> I am ... very particular about getting total clinical accuracy; there have been occasions when some of the consultants have either carefully omitted to answer some of the points, or have been slightly economical with the truth, so because of my nursing background, I am able to go to the Medical Director, Clinical Director, or even outside, to get a second opinion - which I do, and the consultants are actually, learning now, after, a couple of years that they have really got to answer the questions ...

In terms of playing an innovating role in the organization, Michael Price seemed optimistic about playing a major role in transforming the defensive NHS culture to a more open one:

> Myself and the Medical Director have been working quite hard to get them [staff] to understand that this [patient orientation] is part of the culture now. You will get complaints - this is not necessarily going to go legal and you really have to answer them.

Presthus (1979: 228) suggested that this kind of organizational actor has the potential to provide insight and motivation for organizational change and thus could provide an innovating role.[16] This position is consistent with Michael Price's strong desire to be more proactive:

> ... [The consultant] creates complaints, but up to now, nobody's addressed that, which I think is bloody silly! It's complaints we could lose if we could just make this guy behave. But I raised that two years ago and nobody's addressed it.

[16] See Chapter One of the thesis.

Similarly, Paul Hogg's inability to be adequately proactive was a source of irritation for him:

> My frustration is that I can draft and say what I like, but in terms of getting peoples cooperation in that, I have to ask ... and in terms of enforcing what I've said to the complainant, what will happen within the service, I have to ask.... and I find that frustrating. [in the future] I think one of the standards will be, 'how much influence does the complaints manager have on the quality improvement after the complaint has been resolved and lodged.'

Interestingly, Paul Hogg's organization appeared to be willing to make changes in line with his preferences. Thus in some areas, the institutional agenda was consistent with his own agenda. In the following statement he explains that in some respects he had been allowed to pursue his own ideas. In relation to the Chief Executive, Paul Hogg stated:

> He's let me run it pretty well as I think it should be run according to best practice.[17]

He went on to explain:

> ... I know not many Trusts go along with it, but the NHS guidelines in 1996 demand that it [the complaints procedure] should be independent and we have just pursued that so we can get as independent as we can be ... I personally make enormous efforts constantly to assert our independence. I don't really see why that couldn't be achieved in every Trust, I have to say.

He acknowledged:

> ... from my point of view, I would always act on their [complainants] behalf rather than on the Trusts behalf.[18]

On the other hand, Michael Price appeared to be in a more conventional organization. Thus, it is possible to speculate that a reformer in this position would experience strong tensions in his/her adjustment to the role. Indeed he acknowledged:

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[17] This respondent's complaints department seemed to successfully separate itself from the rest of the organization.

[18] This example is highly unusual, and in all probability the typical Reformer's agenda would in fact be in conflict with the institutional agenda.

> ... it is a very, very stressful role, in as much as you are trying to answer things as honestly as possible, but again you are working for the organization and you don't want to be disloyal, so there are tensions, great tensions.

Presthus believed that with this group, there is always a gap between their perception of themselves as independent professionals and the realization that they are really employees (Presthus 1979: 230). Michael Price epitomized Presthus' (1979: 251) description of caring too much and being able to do too little. He told a long anecdote[19] about a case where he strongly suspected there had been a hospital 'cover up.' When it became clear that the Trust were going to defend a consultant he believed was lying, he personally withdrew from the case.

Sherman and Wenocur speculate that before long, the organization would prohibit the reformer approach, and thus this mode of adjustment to the organization was ultimately not viable. They argue that these workers quickly become isolated and identified as dissenters; at best they are dismissed as unrealistic and immature; more frequently they will be forced out if they do not first resign (1983: 376).

Conclusion

This chapter has developed a typology of complaints managers' responses and reactions to the inherent contradictions in their role. Findings generated five types of complaints manager: institutionalized person; indifferent accommodator, complainant oriented accommodator; split personality; and reformer.

At least three of these different types of complaints managers were located on a 'continuum' of extreme organization orientation to extreme complainant orientation, namely the institutionalized person, the complainant oriented accommodator and the reformer. While the two additional types of complaints managers (the split personality and the indifferent accommodator) could not be located on this continuum as clearly as the three former types (See Chapter Three of the thesis), they were still

[19] See Chapter Five of the thesis.

conceptualized essentially in terms of organizational orientation versus complainant orientation as can be observed earlier in this chapter.

For the institutionalized person, organizational loyalty and adherence to organizational constraints clearly came before moral duty to complainants and unsurprisingly there were strong indications that they did not particularly experience tension in their role. On the other hand the reformer consistently put moral duty before the organizational agenda. Predictably one reformer (Michael Price) experienced significant tension in his role. The accommodators typically took a 'middle-of-the-road' approach, that is, they were able to be empathetic to complaints managers without becoming too personally involved. Given their responses, it was highly probable that the complainant oriented accommodators would experience some level of tension in their role, although in general, they seemed to be able to maintain the fine balance between the organizational agenda and duty to complainants in a way that was pragmatic and realistic. They were able to fulfil their organizational and bureaucratic duties whilst at the same time retaining some level of humanity. The split personality was not so much located on this continuum of organization orientation to complainant orientation but simply found adjustment to the contradictions in their role particularly difficult and appeared to experience tensions in the complaints manager role in an almost exaggerated fashion. The indifferent accommodator to a certain extent could be located on this organization-complainant continuum in terms of taking a middle-of-the-road approach. However their chief significance was their indifference to the contradictions in their role when compared with the other types of complaints managers.

On a continuum of extreme organization orientation to extreme complainant orientation, then, it is possible to speculate that in general the institutionalized person (nine respondents) would experience little tension and the reformer (two respondents) would experience extreme tension. However, without reference to this organization-complainant oriented continuum it is also possible to speculate that the split personality (three respondents) would experience extreme tension and the indifferent accommodator (six respondents) would experience little tension. Additionally, it could be argued that the complainant oriented accommodators (four respondents) would experience 'moderate tension'. Ultimately different complaints managers

adjusted to their role very differently. According to this typology, it is possible to argue that a significant minority (nine out of thirty respondents) would experience either acute or moderate tension in their role, that is, the reformers, the split personalities and the complainant oriented accommodators.

Chapter Seven: Conclusions

In this chapter first I provide an overview of the research. I then examine limitations of the research and consider directions for further research. Finally, I set out the research contribution with reference to researchers and policy makers.

Overview of the Research

Inherent contradictions in the complaints manager role

Findings suggested that there was a basic contradiction in the complaints managers' role in that there were limits to complaints managers' impartiality. This assertion is substantiated by the fact that thirteen complaints managers considered that maintaining neutrality was a problem. Secondly, complaints managers' accounts demonstrated specific contradictions in the post (in terms of being caught between being fair to complainants and being loyal to the organization/ adhering to the constraints of the organization) with reference to a range of issues: negotiating with staff concerning complaints investigations in hospital trusts; mental health complaints in hospital trusts; constraints on the health authority complaints managers participation in the practice complaints procedure; constraints to being proactive in using complaints to improve the quality of services in hospital trusts and health authorities; and withholding information from complainants in hospital trusts and health authorities.

In hospital trusts, the contradiction in the complaints manager role manifested itself in terms of a conflict of interest in being *employed by the complained about organization.* In health authorities the contradiction was more evident in terms of a conflict between duty to complainants and *organizational constraints.* This is because health authority complaints managers did not face the predicament of being *directly employed* by the complained about organization in the same way as trust complaints managers, in that health authority complaints managers were more

removed from the front line faced by trust complaints managers. However, a contradiction between duty to complainants and organizational constraints was evident in both trusts and health authorities.

First, in the context of negotiating with staff concerning complaints investigations in hospital trusts, negotiating with staff was a problematic area for several complaints managers. Ten complaints managers acknowledged they experienced difficulties overseeing complaints investigations in terms of cooperation with staff. Respondents spoke of difficulties with a whole range of actors in the complaints process including consultants, investigation staff, nursing directors and medical directors. Ten complaints managers specifically referred to problems with investigations that were caused by difficult consultants and ten complaints managers acknowledged differences of opinion in how to handle complaints with other staff. Additionally interviews indicated that the status of the complaints manager had an impact on the problems of negotiating with staff, in terms of complaints managers often not possessing the authority to persuade the appropriate members of staff to cooperate in investigations. Dealing with conflicting accounts was an especially difficult and complex task for Trust complaints managers. Fourteen trust complaints managers acknowledged there were occasions when they did not feel that they were getting the full picture of the situation from complained about staff/investigating staff. Despite this, eight respondents made it clear directly or indirectly that ultimately they would side with staff in conflicting accounts. It is possible to speculate that when complaints managers have been in the post for some time, they are probably consciously or unconsciously aware that there are limitations to being fair to both complainants and staff. Whatever the complaints manager privately feels, ultimately, they will have to come to terms with the fact that they are employees of the organization with the concomitant limitations to impartiality this status structures.

Second, in relation to mental health complaints, findings demonstrated that mental health issues made the task of dealing with conflicting accounts from the complainant and complained against staff particularly challenging. There seemed to be a conflict between the views of some medical staff about the validity of complaints from mentally ill complainants and the impartial implementation of the complaints procedures by complaints managers. In this context there may be particular pressure

on complaints managers to accept the accounts of staff rather than complainants. Some complaints managers were worried that this aspect of NHS culture put mentally ill complainants at risk of being treated unjustly.

Third, with reference to the particular contradictions in the health authority complaints managers' role in relation to investigating practice complaints, these contradictions manifested themselves in two key ways: being excluded from practice complaints investigations and being constrained from monitoring practice complaints handling. With regard to the former point, some complaints managers reported problems in explaining to complainants that they had to return single-handedly to the practice to complain. With reference to the latter issue, the health authority could only work to encourage and support practices; not to enforce the procedure; and some complaints managers considered that local resolution (the initial complaints handling stage) needed to be monitored more closely. Thus there was a conflict in being expected to advise complainants at the same time as being effectively barred from complaints investigations (at local resolution stage) as well as being prevented from efficiently monitoring these complaints investigations.

Fourth, in relation to constraints to being proactive in using complaints to improve service quality, complaints manager interviews established that there were inconsistencies in the complaints managers' role with regard to their responsibility to be proactive. While job descriptions put considerable emphasis on the objective of using complaints to improve the quality of the service, interviews revealed a gap between this aspiration and practice, in that this objective tended to have a low priority in organizations. Eleven complaints managers felt that they could be more proactive in using complaints to bring about quality improvements than they were permitted to be. A number of reasons were given as to why it was extremely difficult to be proactive. For example, bureaucracy was a major barrier to being proactive in terms of official procedures, rules and regulations. In addition, there were difficulties in being proactive due to a lack of resources. Also, in the case of hospital trusts, the local trust policy put limitations on the complaints manager's ability to be proactive. Additionally, the status of the complaints manager also had an impact on his/ her capacity be proactive in terms of complaints managers often not having the authority to persuade the appropriate members of staff to implement improvements to service

delivery. It was also difficult to act on one's own initiative as complaints managers were often not part of any directorate or department. A number of complaints managers said that they could only *advise* that improvements were made but not implement improvements; this was generally the responsibility of individual service managers and clinical directors. Moreover, Health authorities had particular weaknesses with regard to the emphasis on the informality of the complaints procedures and with regard to ineffective processes in place to deal with serious problems. A number of complaints managers were concerned that effectively their hands were tied regarding poorly performing GPs; there were limits to the Health Authorities powers to bring GPs to account for consistent bad practice.

Fifth, with regards to the regulation of withholding information from complainants relating to staff disciplinary proceedings (for both hospital trust and health authority complaints managers), this was another area, which caused conflict between organizational loyalty/ organizational constraints and complainants interests. Moreover, ten complaints managers identified strongly with the complainants need to know that 'justice had been done' and many complaints managers opposed this regulation. Indeed, some respondents revealed that they found off the record ways to reveal results of disciplinary proceedings to complainants and thus tacitly defied the regulation when they felt the situation merited such action.

In short these findings suggest that the NHS complaints managers' role encompasses in-built contradictions. For example, complaints managers are expected to coordinate an impartial, thorough investigation *and* deal with organizational obstacles to investigations; they are expected to be responsive to complainants *and* staff in the awkward contexts of conflicting stories. They are expected to be proactive about using complaints for quality enhancement without the authority to implement quality enhancement. They are expected to advise complainants and practices, but not to become unduly involved in investigations. They are expected to act with tact and sensitivity, whilst possibly going against their moral values, for example, withholding information from complainants. Thus, complaints managers are conveyed conflicting messages. In line with Sherman and Wenocur's (1983: 375) observations, it could be argued that NHS organizations encourage complaints managers to perform what are

often effectively unworkable tasks and in effect prevent them from succeeding at these tasks.

As a final point, it is important to recognize that not all complaints managers experienced the abovementioned contradictions as *tensions*. For example, many complaints managers did not have difficulties negotiating with staff. Some health authority complaints managers were at ease with the institutional constraints on their role; a number of health authority complaints managers were comfortable with the practice managing their own complaints procedure. Certain complaints managers considered that the regulations relating to withholding disciplinary information from complainants were fair. Thus different complaints managers responded to the post in different ways.[1]

NHS complaints managers' opposing responses and reactions to the contradictions in their role with reference to key conflict variables

Next it was necessary to explore complaints managers' *responses* or *reactions* to the contradictions outlined in the previous section. Complaints managers' responses to key 'conflict variables' reflected the delicate balances worked out between the competing possibilities and constraints imposed on complaints managers by their role in terms of their behaviour, attitudes, and emotions. The notion of the organizational agenda (organizational loyalty/organizational constraints) versus duty to complainants was important in making sense of complaints managers' responses/ reactions to their role.

First, there is a consideration of complaints managers' *behaviour/ experiences*, with regard to ways in which complaints managers advise/ support complainants and investigate complaints. Second there is an analysis of the *attitudes* of the complaints manager, with reference to 'unjustified' complaints; being proactive regarding using complaints to improve the quality of services; fairness and justice of the complaints procedure; mental health cases; and withholding information from complainants.

[1] This is the subject of Chapter Five and Chapter Six of the thesis.

Third, there is a consideration of complaints managers' *emotional reactions* to the complainants and complained about staff.

The behaviour, attitudes and emotions of the thirty complaints managers suggested two key opposing standpoints, which were exhibited in different situations. One approach was an organization oriented response; the other approach was a complainant oriented or citizen oriented response. In other words complaints managers' behaviour, attitudes, and emotions to different issues showed a tendency towards organizational loyalty/ adhering to organizational constraints or a tendency towards duty to complainants. In addition, some responses indicated a 'middle-of-the-road' approach, that is, combinations of organization and complainant orientation.

From a standpoint of *organization orientation*, then, in terms of advising/ supporting complainants, complaints managers tended not to go beyond their job remit to help complainants. With reference to investigations, their experience seemed to indicate that investigations were satisfactory. Displays of organizational loyalty were also exhibited in terms of blaming complainants for having unrealistic expectations or unjustified complaints. In relation to being proactive in using complaints to improve the quality of the service, complaints managers with an organization orientation generally felt that they were doing all that they could possibly do to be proactive. With regard to the complaints of the mentally ill, the organization oriented stance was that complaints from the mentally ill were dubious because of the complainants' mental health status. A number of complaints managers' related incidents of complainants who had made outrageous complaints to justify their viewpoint that complaints from the mentally ill were automatically questionable. With regards to complaints managers' emotions, complaints managers displaying organizational loyalty/ adhering to organizational constraints typically stayed detached from complainants, that is, they tended not to empathize with complainants. Conversely, some of the complaints managers who were able to maintain emotional distance from complainants were markedly sympathetic to the plight of complained against staff. It could be argued that organization oriented responses enabled complaints managers to resolve the contradictions in their role by identification with the organization.

In contrast, complainant orientation may possibly lead to going beyond ones job remit to support a complainant. In relation to investigations it could mean requesting further information from investigating staff rather than automatically accepting the findings of investigations. Some complaints managers enlisted the help of more senior staff during problematic investigations. In relation to the issue of 'unjustified complaints,' complaints managers with a complainant oriented outlook might take the attitude that there was no such thing as an unjustified complaint because if a complainant is dissatisfied, this in itself was sufficient. Similarly, concerning being proactive in using complaints to improve service quality, complaints managers with a complainant oriented stance typically felt they should be more proactive. Complainant orientation in relation to mental health cases was likely to manifest itself in terms of concern that mentally ill complainants were treated fairly. This stance tended to involve awareness of the vulnerability of mentally ill complainants and the fact that the system was unduly weighted against them. In terms of withholding information from complainants, a complainant oriented approach tended to manifest itself as discomfort about this regulation. Finally, in relation to the emotional response of the complaints managers, it is argued that complaints managers exhibiting a complainant orientation tended to identify with complainants and were personally affected by some complainants' cases. They stressed the importance of empathy and of 'being human.' Often, this complainant oriented stance seemed to point to the idea that the system was not necessarily fair. Thus, these complainant oriented behavioural, attitudinal, and emotional responses were another way of resolving the contradictions inherent in the role.

A case could be made that a complaints manager's individual outlook was likely to affect their adjustment to their role; that the complaints manager's stance in any given situation could affect their experience of tension in the role. For example, a complainant oriented outlook might hint at tension in terms of role adjustment in that the complaints manager might believe the system was unfair; they might have doubts about the validity of some investigations; they might become distressed over some complainants' experiences. On the other hand, an organization oriented outlook might suggest a standpoint, which was essentially in harmony with that of the organization on the issues in question; the complaints manager might believe the

system was fair; they might have confidence in investigations; they might be able to remain emotionally detached from complainants' cases.

Ultimately, unless the complaints manager's stance is *consistently organization oriented,* it could be argued that they will at least occasionally experience tensions in relation to various issues. It was apparent that complaints managers were not necessarily consistently organization oriented or complainant oriented on *all issues.* Some responses were organization oriented; some responses were complainant oriented; and some responses were more or less a mixture of the two. As Denhardt (1989: 191) reminds us:

> every true dilemma for public administrators involves a tradeoff of values, and different people make different choices.

Thus, organization orientation and complainant orientation should not be thought of as separate and competing perspectives (See Denhardt 1989: 189). Complaints managers' behaviour, attitudes and emotions manifested itself in combined and often contradictory ways, that is, complaints managers used a *combination of responses/ reactions*, which is reminiscent of Merton's concept of sociological ambivalence (1976).[2] Indeed, I make the case that complaints managers use numerous combinations of the above variables to resolve the contradiction in their role, effectively generating 'different types of complaints managers,' which is the subject of the next section.

A typology of NHS complaints managers' responses and reactions to the contradictions in their role

Complaints managers took on different patterns of adjustment to resolve the contradiction that their role presented for them. In this study I have presented five formulations, which were typical of the ways in which complaints managers did this.

[2] See Chapter One of the thesis.

- institutionalized person;
- indifferent accommodator;
- complainant oriented accommodator;
- split personality;
- reformer.

Four *complainant oriented accommodators* were identified and it is suggested that perhaps these respondents were the best adjusted complaints managers[3] in that they were able to empathize with complainants, yet generally remain emotionally detached. However, their complainant orientation would invariably cause conflict with the organizational agenda on a frequent basis. Thus, these respondents had unresolved conflicts.

In contrast, *institutionalized persons* (nine respondents) generally did not empathize with complainants. At the same time they gave the impression of sympathizing strongly with complained against staff. For these complaints managers, the reality of taking on primary identification with the organization makes the organizations perspective the only standpoint of any importance. Organizational socialization has been so successful that these complaints managers are confident that loyalty to the organization is the only rational response to the contradictions in their role. Some of the complaints managers in this category were unwilling to talk about emotions. For example, when asked whether complainants' cases personally affected them, some complaints managers responded impatiently. This suggested that they assumed that everybody came from their viewpoint of being emotionally detached from complainants' cases.

It could be argued that the institutionalized person did not generally experience tensions, as there was little discrepancy between their views and organizational views in a procedure, which is weighted in favour of staff.[4] On the basis of these facts, it is possible to speculate that as employees of the complained about organization,

[3] In relation to this particular organization situation.

[4] See Chapter Two of the thesis which demonstrates the biases in the system in favour of the complained against organization. In addition, significantly, Department of Health research (2001a: 3-4) showed that the majority of complained about staff were satisfied with the complaints procedure while the majority of complainants expressed a high level of dissatisfaction with the procedure.

identifying solely with staff/ the organization would be less likely to present tensions. Was this a good thing? From the complaints managers' point of view, perhaps it was. However, complaints managers taking this stance may not be fulfilling certain areas of the job remit as stated in person specifications, that is, an ability to work with sensitivity and tact; to be sympathetic (to both complainants and staff) whilst remaining impartial. Such a stance could well compromise any claim of objectivity in handling a complaint. In addition, their overall attitude is almost certainly inconsistent with the spirit of the complaints procedures, which is to be responsive to complainants.

Indifferent accommodators (six respondents) generally appeared to exhibit 'indifference' to the contradictions inherent in their role. Compared to the other groups, they were less willing to express views on key issues and were non-committal on certain questions. In terms of their emotions, they appeared to show moderate empathy with both complainants and staff. Their level of adjustment could be argued to be a general emotional detachment from the difficult issues raised by the job as a way of resolving conflict. Certainly on the surface, this group showed little signs of tension as a response to the inherent contradictions in the complaints manager role.

The study also identified three *split personalities*. Split personalities identified strongly with both the complainant and the institution. These complaints managers were especially sensitive to complainants' distress; they tended to express very strong emotions on the job, going so far as to cry in response to distressing cases. At the same time, they strongly empathized with complained about staff, and in this respect are (perhaps surprisingly) organization oriented. The split personality type of adjustment seemed to exemplify *in the extreme*, the archetypal conflict outlined in this thesis, namely, that the complaints manager is caught between conflicting expectations of the complainant and the organization in which they are employed. Thus is it is possible to speculate that those complaints managers who fitted into the split personality type experienced high levels of tension and adjusted to the role in the least satisfactory way on a personal level.

Finally, there were only two complaints managers who broadly fitted into a *reformer* type in that they seemed to identify with the complainant on virtually all issues. This

approach encompassed a high degree of personal morality. Also, as mentioned previously in the thesis, this type of accommodation to organizational dilemmas can provide an innovating role in the organization.[5] However, as shown in Chapter Six of the thesis, the reformers behaviour is often going to be at odds with the norms of the organization, which is likely to lead to high levels of tension.

It could be argued that reformers, split personalities and complainant oriented accommodators (i.e. nine respondents out of the original sample of thirty) would all experience high to medium levels of tension in their jobs in terms of the way their complainant orientation manifested itself.[6] Thus, these results demonstrate that a significant minority of respondents showed a strong tendency for tension in terms of personal discord with organizational norms.

The patterns of accommodation in this study show some of the possibilities for complaints managers' conflict resolution. They are by no means comprehensive. As has been explained in Chapter Three of the thesis, six respondents did not fit into any of the above-mentioned categories. Additionally, one potential group, omitted from the sample altogether, are those complaints managers who may leave the organization because they cannot cope with the conflicts. This was beyond the scope of the thesis but could be usefully pursued in future research.

Summary

Having established that there was an inherent contradiction in the complaints managers' role, that is, there was a *potential* for conflict, the next step was to consider how complaints managers responded to this situation. Findings showed that the actual *experience* of tensions depended on the way the individual complaints managers responded to the inherent contradictions or conflict in their role. The behaviour, attitudes and emotions of the NHS complaints managers in this study varied considerably. Different complaints managers tended to respond with organization oriented and complainant oriented standpoints with respect to different variables. It

[5] See Presthus (1979: 228).

[6] See Chapter Six of the thesis.

could be argued that a complainant oriented outlook in any particular situation would cause tensions in the complaints managers' role due to a clash with the organizational loyalty required by the organization or organizational constraints imposed by the organization. On the other hand, a case could be made that an organization oriented outlook in a specific set of circumstances would limit tensions in the complaints managers role as the complaints managers behaviour, attitudes, and emotions would concur with organizational norms and values.

Taking analysis one-step further, findings demonstrated that individual complaints managers drew on *combinations* of organization oriented approaches /viewpoints/ perspectives and complainant oriented approaches /viewpoints/ perspectives. Put together, particular blends of different 'stances' (in response to varied situations) seemed to signify distinct types of complaints managers, which in turn suggested that there would be differences in the tensions, experienced by different complaints managers.

Limitations and Further Research

Critique of the adopted conceptual framework

The thesis drew broadly on three different social science disciplines: socio-legal studies, public administration, and sociology. Different perspectives and disciplines were useful in making sense of different areas. The socio-legal perspective was especially useful in examining the *inherent contradictions in the complaints managers role* in the sense that the socio-legal literature cast doubt on the impartiality of in-house complaints handlers and complaints systems (in which NHS complaints managers are employed) and thus pointed to contradictions inherent in the role of complaints handlers who are both *employees* overseeing in-house complaints systems *and expected to be impartial.* The public administration perspective was valuable for looking at these same contradictions in the complaints manager role from a broader angle. Public administration literature (particularly administrative ethics literature) suggests that there are inherent contradictions in the role of public administrators in terms of the conflict between organizational loyalty/ organizational constraints and

duty to the public; and the conflict between bureaucratic values and democratic values. The public administration and sociological literature was important in making sense of the complaints managers' *very different responses or reactions to the contradictions in their role*. In addition I drew from public administration literature to formulate a typology of complaints managers responses to the inherent contradictions in their role since the types of complaints managers that emerged from the research appeared to correspond particularly well with public administration literature as opposed to more legalistic models.

A limitation of the adopted conceptual framework was that because three disciplines were used, it was not possible to pursue one discipline exhaustively. However, as demonstrated above and in the Introduction to the thesis, different disciplines were important in providing a framework for the different themes of the thesis.[7] Ultimately, taking this holistic approach to conceptualizing the situation of the complaints manager using three disciplines has provided a richer understanding of the themes of the thesis and hence the conflicts and tensions in the role of NHS complaints managers.

Possible research design limitations

The research design has been justified comprehensively in Chapter Three of the thesis. However, I will reiterate two points. Some may query certain approaches used in the methodology. One possible criticism is that aspects of the research tools were unorthodox in that I used qualitative telephone and email interviews. In terms of the sensitivity of the research, it is argued that telephone interviews may have been

[7] The three key themes of the study as stated throughout the thesis are as follows:

- The complaints manager's role encompasses inherent contradictions regardless of the personal style or individual approach of the complaints manager;

- Complaints managers exhibit opposing responses/ reactions to the contradictions experienced in their role in terms of organization orientation versus complainant orientation, which may result in tensions for the complaints managers concerned.

- It was possible to generate a typology of complaints managers' responses and reactions to the inherent contradictions in their role.

able to yield richer data than possible with face-to-face interviews. In terms of time and financial constraints, email interviews were a pragmatic alternative to telephone or face-to-face interviews. Furthermore, telephone and email interviews are being used increasingly in qualitative research and it is hoped that this study will help demonstrate the usefulness of these methods and perhaps encourage increased usage of qualitative telephone and email interviews as valuable alternatives to the more traditional methods.

With reference to the issue of bias in the research, Patton (1990: 476) notes that neutrality and impartiality are not easy stances to achieve in research. Bilton *et al* (1987: 592) have remarked that qualitative methods are closely associated with sympathy for the 'underdog'. For example, they observe that the symbolic interactionist approach often appears as a methodology for individual opposition to pressures from powerful institutions. In this vein, the language used to describe the interpretations of the findings may perhaps have come across as being more sympathetic to the complainants' viewpoint than the complained about staff's viewpoint. Ultimately, the *interpretation of the research itself* has been carefully objective. The following example gives a demonstration of this principle: I initially speculated that all complaints managers would experience tensions in their role due to the conflict between organizational loyalty/ organizational constraints and duty to complainants. However, as the study demonstrates, this was clearly not the case. Additionally, I consider that validity was established through a clear exposition of data collection and analysis as recommended by Mays and Pope (2000: 95). The description of the primary research method, namely the thirty complaints manager interviews, incorporated a detailed and transparent account of data collection, and data analysis. I have aimed to be similarly transparent in accounts of the documentary analysis of job descriptions and person specifications; and the complaints experts' interviews.

Implications for future research

There are implications for future research both from an academic or researcher perspective and a policy perspective.

From an academic and research perspective, the thesis touched on certain issues, which could be usefully explored in their own right. For example, the amount of discretion in the complaints manager's role could usefully be explored in terms of how the level of discretion impacts on their role. What are the implications of more or less discretion for conflict in the post? In addition, the relationship between inherent contradictions in the complaints manager's role and job stress could be examined in a further study.[8] As referred to earlier in this chapter, one potential group, omitted from the sample, are those complaints managers who may leave the organization because they cannot cope with the conflicts. This was beyond the scope of the thesis but could be usefully pursued in future research.

Secondly, the conflicts and tensions in the role of in-house public sector complaints handlers in areas outside the NHS could be explored. A series of studies could be conducted on in-house complaints handlers in a range of areas. For example the conflicts and tensions in the role of police complaint handlers could be explored.

Thirdly, it could be argued that the initial complaint handling stage raises major questions about the disposition of complaint handlers (See Partington 1999: 542). In his study of complaints against doctors, Klein considered (1973: 139) that the personal style of the complaints handler (Clerk) unduly affected the operation of the complaints system. In a similar vein, Mulcahy (1999b: 79) asserts that the lower levels of the grievance hierarchy are the places where it is most likely that abuse will occur. Accordingly, there is a necessity for research on the link between complainant satisfaction at the initial stage of the complaints procedure[9] and the individual approach/ personal style of the complaints manager. How far does the personal style of the complaints manager affect the outcome of the complaint and/ or complainant satisfaction?

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[8] It is possible to speculate that experiencing tension in the role could be linked with undue stress. Sixty per cent of the complaints managers in this study considered that the job was more stressful than a typical managerial post. Interviews with complaints managers demonstrated that for many, stress was, without a doubt, a significant aspect of the role. Furthermore, a regional lead commented that there seemed to be a general consensus that two years was the maximum amount of time to stay in a front-line complaints job.

[9] This refers to local resolution, the stage of the complaints procedure in which complaints managers are specifically involved.

From a policy perspective, this study has suggested that the in-house complaints procedure in the NHS encourages a bias against complainants and a bias in favour of the complained about organization; the findings illustrate the difficulties which confront complaints managers due to their consequent lack of impartiality. Is there a need for a change in policy, for example, an independent complaints inspectorate? It could be argued that further research would be useful to explore ways of establishing a more independent complaints procedure at the initial complaint handling stage. The issue of lack of impartiality is even more acute in Practice run complaints procedures and has received much criticism. As explained in Chapter Two of the thesis, Family Health practitioners must nominate one person to administer the complaints procedure (a practice complaints administrator [See Stanton 1997: 106]) and identify that person to patients and clients (National Consumer Council 1997: 7). This area of the complaints procedure has received much criticism, not least because the complaints administrator could theoretically be the GP who is complained against. A further study on the conflicts and tensions experienced by complaints administrators in Practices would be useful.[10]

The argument that the in-house complaints procedure in the NHS encourages a bias against complainants is also linked to the issue of *organizational culture*. The fact that complaints managers are constrained by organizational control mechanisms means that the issue of organizational culture is very important. How does one change the organizational culture and professional culture of the medical profession in order that responses to complaints are neutral and fair to all parties? Research on the impact of organizational culture on complaint handling would useful in terms of targeting what needs to change.

Research Contribution: Implications of the Research for Researchers

This thesis has made three specific contributions in terms of the findings of the study. It has demonstrated that:

[10] This study focused on designated complaints managers in trusts and health authorities, excluding practice complaints managers.

- The complaints manager's role encompasses inherent contradictions regardless of the personal style or individual approach of the complaints manager.

- Complaints managers exhibited opposing stances in response to the inherent contradictions in their role with reference to organization orientation versus complainant orientation

- A typology of complaints managers could be used to explain complaints managers' responses and reactions to the inherent contradictions to their role with reference to organization orientation versus complainant orientation.

Inherent contradictions in the complaints manager role (regardless of the personal style or individual approach of the complaints manager)

I have made the case that all NHS complaints managers are faced with the necessity of reconciling obligations to complainants with loyalty to the organization/ organizational constraints. Thus, complaints managers face inherent contradictions when they try and reconcile complainant's interests with organizational requirements as demonstrated in Chapter Four of the thesis. Organizational loyalty might mean complainants are denied justice through an over-identification of the complaints manager with the employing organization; organizational constraints may impede complaints managers from supporting complainants through the complaints process. Thus, duty to complainants is likely to be at odds with institutional obligations. Essentially I demonstrate that there is a *potential for contradictions or conflict in the role*. Extensive evidence is provided for these inherent contradictions or conflict in Chapter Four of the thesis.

With reference to other work on the topic, comparable studies do not provide the depth of analysis on the inherent contradictions of complaint handlers provided by this study. For example, in his study of the social services complaints procedures, although Simons (1995) provides some detail on situations that could bring about inherent contradictions in the complaint handler's role, he does not conceptualize his findings in terms of inherent contradictions, conflicts or tensions. While Mulcahy and Lloyd-Bostock (1994) drew attention to the fact that complaints handlers being

examined had an allegiance to the organization being complained about and at the same time as public servants also had a duty of care towards the service users to consider their best interests (1994: 205), in terms of Mulcahy and Lloyd-Bostock's *actual findings*, they do not provide evidence for this contradiction. Kolb's (1987) study on ombudsmen states that ombudsmen seem to face an 'inherent tension' in their position between the desire to assist a complainant and the need to represent the best interests of the organization (1987: 675). However, Kolb's findings, too, provide limited evidence for this contradiction (1987: 681). With the exception of Klein (1973), other comparable studies *allude* to a contradiction in the role of complaint handlers, but do not provide evidence for it. While Klein (1973: 136-137) *does* provide some evidence for the inherent contradictions in the complaints handler's role (Clerks),[11] the *focus* of Klein's study is not on complaints handlers but on the professional accountability of doctors. As such Klein does not provide the depth of analysis provided by this thesis.

In short, this study is likely to be the first to provide a *systematic account of the inherent contradiction in the role of NHS complaint handlers,* and as far as the author is aware, the first study to provide a systematic account of this contradiction/ conflict in the role of complaints handlers in public sector services generally. The findings proposed in this section are consistent with the socio-legal conceptual framework explored in Chapter One of the thesis, which demonstrates the contradictions inherent in the role of complaints handlers who are expected to be impartial whilst also being employees overseeing in-house complaints systems. The findings are also consistent with the public administration conceptual framework, which emphasizes the friction between the organizational agenda and duty to the public. Additionally, the findings are consistent with the sociological framework of social actors caught between conflicting expectations and social actors with incompatible roles. In short, the findings of this study support the theoretical propositions that there were inherent contradictions in the complaints manager's role.

[11] Klein's study lends support to the idea of complaints handlers (in this case called Clerks) facing conflicting roles due to the contradictory demands placed upon them by doctors and complainants.

The complaints managers' opposing stances in response to the inherent contradictions in their role with reference to organization orientation versus complainant orientation

The thesis provides extensive evidence for the *opposing* behaviours, attitudes and emotions of complaints managers in response to the inherent contradiction to their role in terms of organization orientation versus complainant orientation; it provides this evidence with specific reference to eight 'conflict variables' as demonstrated in Chapter Five of the thesis. Put another way, complaints managers exhibited very different responses and reactions to the inherent contradictions in their role with reference to organization orientation and complainant orientation. Thus, while the thesis title may suggest that *all* complaints managers experience *tensions* in their role, this was clearly not the case. While the study provided evidence for the existence of inherent contradictions in the NHS complaints managers' role, that is, *conflict* in the role, complaints managers *responded* to these inherent contradictions in very different ways; because many complaints managers responded in organization oriented ways, it could be argued that these inherent contradictions *did not result in tensions* in numerous respondents.

Comparable studies (Mulcahy and Lloyd-Bostock 1994; Kolb 1987; Klein 1973; Simons 1994) do not conceptualize complaints handlers' responses or reactions to their situations in *terms of organization orientation versus complainant orientation.* In Mulcahy and Lloyd-Bostock's study, a completely different approach is taken in relation to the way complaints handlers adapted to their role; the authors found that complaints handlers adapted to their role by taking on multifaceted roles according to *the situation* rather than *different personal approaches* as indicated by this study. In relation to Klein's study, complaints handlers (Clerks) *did* respond to their role in opposing ways, with different personal approaches as 'conciliators' and 'legalists'. Similarly, in Kolb's study, the third-party dispute handlers (in this case ombudsmen) responded to their role in opposing ways, which was indicative of different personal approaches or hinted at different personal approaches, that is, there were 'helping' ombudsmen and 'fact-finding' ombudsmen. However, this thesis' analysis of opposing behaviour, attitudes and emotions is considerably more detailed and

systematic than that provided by Kolb or Klein in that it explores opposing responses to the role of complaints handlers with specific reference to eight conflict variables. In addition, as previously mentioned, this study is novel in providing an analysis of complaints handlers' responses to their situation specifically in terms of organization orientation versus complainant orientation.

Thus the findings from this thesis differ from comparable studies in providing a detailed, systematic account of opposing ways of responding/ reacting to the inherent contradictions in the complaint handler's role with reference to organization orientation versus complainant orientation, drawing on three social science disciplines. Displays of *organization orientation* were consistent with the socio-legal and public administration frameworks generated in Chapter One of the thesis and also a social psychological framework exploring individuals' responses to injustice. *Complainant oriented* complaints manager responses were explained best through public administration and sociological frameworks explored in Chapter One of the thesis.[12]

The analysis of the responses/ reactions of individual complaints managers to the inherent contradictions in their role is taken one step further with the generation of a typology of different types of complaints managers, which is discussed in the next section.

A typology of complaints managers' responses and reactions to the inherent contradictions in their role with reference to organization orientation versus complainant orientation

An important discovery of the thesis was that the complaints managers in this study demonstrated different patterns of adjustment in terms of how *individual managers*

[12] Complainant orientation/ client orientation does not give the impression of being discussed *directly* in public administration literature or socio-legal literature in the same way as organization orientation (for example in terms such as *organizational loyalty* and *anti complainant ethic*). Indeed, the best way of achieving an insight into client orientation is in all probability *indirectly*, when client orientation is framed *within a typology of organizational actors adjustment to their role*, for example, in the 'Reformer'/ 'Ambivalent'/ 'Non Capitulation' type of organizational actor outlined in Chapter One of the thesis.

came to grips with the contradictions in their role. These different patterns of adjustment seem to signify *different types of complaints managers* and thus a complaints manager typology. In turn, it could be argued that different patterns of adjustment would affect the tensions experienced by different complaints managers.

In terms of other relevant studies, the only other *comparable typology* generated in another study is Klein's (1973) typology of complaints clerks.[13] However this differs substantially from the typology generated in this thesis, as Klein's typology is *legalistic* in terms of conceptualizing complaints clerks as legalists and conciliators while the typology in this thesis draws from *public administration and administrative ethics* literature. Additionally, the typology relating to this study is a more in-depth analysis than that given by Klein and incorporated detailed quotations in arguing the case for different types of complaints managers. Furthermore, the complaints handler typology generated by this study is distinctive in conceptualizing complaints handlers' responses/ reactions in terms of organization orientation versus complainant orientation.

Summary

When compared to other relevant studies, this study is unique in providing a detailed, focused, systematic account of the inherent contradictions in the role of NHS complaints handlers. It is likely to be the first study to provide such an analysis for complaints handlers in general. Second, this study is pivotal in providing a detailed, systematic analysis of opposing ways of responding/ reacting to the complaint handler's role with reference to organization orientation versus complainant orientation. Finally, as far as the author is aware, this is the first analysis to present an in depth typology of complaints handlers drawing from a public administration and administrative ethics perspective with reference to the outlook of complaints handlers in terms of organization orientation versus complainant orientation.

[13] See Chapter One of the thesis.

Research Contribution: Implications of the Research for Policy Makers

The findings of this study have indicated a number of issues for policy makers. These are considered below.[14]

First, with regard to the issue of independence and impartiality, findings demonstrated an organizational bias against complainants. This was particularly apparent in complaints managers' behaviour in complaints investigations (Trusts) and complaints managers' reservations about Practice level complaints procedures (Health Authorities). It could be argued that making the system more independent would help alleviate the problems of bias in the system and thus help to reduce the contradictions inherent in the complaints manager's role. *In relation to Trusts*, there is scope for improving independence in the Trust complaints system. For example, with reference to the part of the procedure where the complaints managers have the responsibility for coordinating complaints investigations, Trusts could appoint independent investigators rather than relying on investigations by service managers (See Simons 1995: 92). In addition, policy makers should consider whether *Health Authorities* [15] rather than Trusts should 'employ' Trust complaints managers so, like their Health Authority counterparts, Trust complaints managers are one stage removed from the complained about organization. *In relation to Health Authority complaints*, the role of complaints managers could be reassessed with a view to giving Health Authority complaints managers overall responsibility for Practice-based procedures. This would remove the pressures of Health Authority complaints managers redirecting reluctant complainants to the Practice to complain, and

[14] A number of 'policy' findings were beyond the scope of the conceptual framework of the thesis. For example, findings indicated that isolation was a problem for some complaints managers. Because many complaints managers were not in any particular management structure, not surprisingly, they often worked in an isolated way. Thus organizations need to ensure that complaints managers can draw on support networks, a point which has been stressed by complaints experts. Findings also indicated that more could be done in terms of training for complaints managers. This is consistent with the findings of the Public Law Project (1999), which indicated that the initial investigation of the complaint was often poor and that there was a lack of training for complaint handlers.

[15] As a consequence of changes to the organization of the NHS, Health Authorities were abolished. Duties of Health Authorities for operating parts of the complaints procedure transferred to *Primary Care Trusts* in 1 October 2002. These Primary Care Trusts are different from the Hospital Trusts referred to in this thesis (See Department of Health 2003d).

generally increase the impartiality of the system. This could be combined with the appointment of independent investigators who would carry out the complaints investigations in Practices and report back to the Health Authority complaints manager.

Second, findings also drew attention to the question of authority and status in the complaints manager post. Longley (1992: 22) argues that effective handling of complaints requires an individual with the necessary resources, authority and commitment to instigate and follow up investigations. This study found that there was a limit to what complaints managers could accomplish in relation to obtaining information relating to complaints investigations, and also with regard to follow up action after complaints investigations, that is, using complaints to improve the quality of services.[16] In addition I argue that the low level of some complaints manager posts makes them an easier target for staff frustration. Would more authority for complaints managers reduce some of the pressures and constraints on complaints managers emanating from the organization? Perhaps if complaints managers had sufficient authority, they would experience less defensiveness, obstructions, and general negativity from the organization. Complaints managers also need more authority in Health Authorities in terms of directing General Practitioners to make necessary changes; they need to be able to monitor local resolution (Stage One of the complaints procedure) more closely in Practices. Overall, the evidence suggests that organizations should consider increasing the status of complaints managers posts so that complaints managers have the necessary authority to negotiate with NHS staff with regard to complaints handling and follow up action. This finding is consistent with the Sixth report of the House of Commons Select Committee on Health that recommends NHS trusts should be encouraged to appoint a 'quality and risk manager' with sufficient training, authority and personal skills to deal with complaints and bring relevant issues to board level where the appropriate action could be taken (para 80).

[16] See Chapter Four and Chapter Five of the thesis.

Third, findings indicated that more resources were needed for using complaints to improve quality in terms of complaints analysis and persuading directorates to take action in improving specific areas of service delivery.[17]

Fourth, this study illuminated the need for a change in NHS culture. An issue that was particularly influenced by organizational culture was the complaints investigation process. Obstructions to complaints investigations in Trusts by medical staff were an important issue in this study because such obstructions made the work of complaint managers significantly more difficult. As one complaints manager pointed out:

> We can't resolve complaints without the full support of the staff.

Complaints managers' accounts of problems relating to persuading staff to cooperate with investigations, whilst having no authority over them was a strong theme. Some doctors clearly have great difficulty in being answerable for their actions. These obstructions can be traced to the medical profession preserving their clinical autonomy, which is closely linked to the principle of professional self-regulation; one of the consequences of professional self-regulation is that doctors are likely to resist the criticisms of lay people (Allsop and Mulcahy 1999: 126-127).[18] Thus, the culture of medicine is an important factor here. The Bristol Inquiry (2001: 271) refers to the aspect of NHS culture, which tends to be 'defensive and secretive', with 'old-style attitudes of paternalism and self-protection.' Jean Robinson, a campaigner representing patients interests (See Rosenthal *et al* 1999: xii) argues that the culture of medicine must change and that health care professionals need to learn to cope emotionally with their own mistakes and the mistakes of their colleagues (Robinson 1999: 255). Similarly, The Bristol Inquiry recommends a new culture of 'openness and honesty' and stresses the need for the prompt acceptance of responsibility when things have gone wrong. It calls for practical action geared to being more open about error and mistakes and the removal of 'one of the greatest of all barriers to openness', namely, the fear of clinical negligence litigation. In addition, the report emphasizes the need for an appropriate apology, and ensuring any compensation due is paid speedily. The report also stresses that openness should be valued and rewarded so that

[17] More resources were also needed for complaints training and for managing the general workload.

[18] See also Chapter Two of the thesis.

healthcare professionals would be encouraged to put these values into practice. Additionally, administrative ethics scholar, Denhardt (1988: 140) recommends developing an 'organizational conscience', enhancing 'ethical discourse' (1988: 153) and protecting the individual, for example, those individuals who perceive that they have been treated unfairly as a result of their whistle blowing (1988: 149-150). It could be argued that complaints managers operating in a culture of openness and honesty are less likely to be required to adhere to organizational loyalty at the expense of duty to complainants. Lloyd-Bostock (1992: 219-220) has speculated that defensive attitudes to complaints were probably counterproductive because when complainants do state what they want, it is very rarely compensation; it is an explanation, an investigation, someone disciplined, an assurance the event will not recur, and a genuine apology. Indeed Lloyd-Bostock and Mulcahy's (1994) findings indicated the importance of acknowledging the complaint, taking it seriously, and accepting responsibility as appropriate; the results reflect the importance of a suitable social response to the complaint (1994: 140-141). Perhaps improvements to organizational culture by making the organization more consumer oriented and accountable would go some way to diminishing the contradictions in the complaints manager's role as increases in consumer orientation and accountability would decrease the current bias against complainants.

Finally, the NHS needs to be sensitive to recruiting individuals who can cope with the specific challenges encountered in the handling of healthcare complaints. As mentioned earlier in this chapter, it is precisely because the initial complaint handling stage is so important that this aspect of complaint handling raises major questions about the disposition of complaint handlers (See Partington 1999: 542). As mentioned earlier, Mulcahy (1999b: 79) notes that the lower levels of the grievance hierarchy are the places where it is most likely that abuse will occur. Given the pressures of working in the organization that has been complained about, this study has shown that many complaints managers take on primarily organization oriented stances. These actions are to some extent understandable as most employees are in search of a trouble-free existence within their organizations. However, it could be argued that this stance could result in the suppression of the critical enquiry necessary for an impartial investigation. It could also be argued that there is a link between an organization oriented pattern of accommodation and defensive complaint handling,

particularly the approach of the 'institutionalized person'. A case could be made that this kind of reaction in the initial complaints handling stage could cause complainants to go to court to obtain redress (See Nicol 1999: 243). The findings of this study are consistent with Jean Robinson's (1999: 249) observations that the complaint handlers, not just the medical profession help maintain the defensive culture of the NHS. She notes that administrators frequently:

> dismiss bereaved complainants, without investigation, as suffering the "typical guilt syndrome of bereavement."

As this study has shown, the more organization oriented complaints managers tended to label complainants as troublemakers, for example, 'persistent complainants', 'vexatious complainants', 'gratuitous complainants'. They often attribute complaints to ignorance and unrealistic expectations and some complainants are dismissed as having mental health problems. Robinson (1999: 249) notes 'dissatisfaction with care was likely to become a "personality disorder"'. In addition, The Bristol Inquiry Report (2001: 268) indicates the contradiction that healthcare professionals can be enormously dedicated and caring, yet as members of a large organization may not always act in the interests of patients as a whole:

> This is not because the professionals involved, be they managers, doctors, nurses or others, are bad people. It is merely that they have come to view the world in a particular way and, as a consequence, are unable to see the wider interests of patients as a whole ...

Thus, while this organization oriented pattern of accommodation may be successful in resolving role conflict, it could well have a negative impact on the complaints manager's role as complaint handler in terms of their duty to complainants. The complaints manager's ability to meet the requirements of person specifications (for example, tact, sensitivity, diplomacy) could be compromised.

As mentioned previously, the 'split personality' type of accommodation illustrates in the extreme, the conflict of the complaints manager caught between the complainant and the organization. In all probability the split personality managers' stance on a particular issue switch from complainant orientation to organization orientation,

depending on the situation; some situations may promote a complainant orientation, whereas others encourage the opposite. When they identify with the complainant, they are extremely sensitive to the distress of the complainant. A positive aspect of their accommodation is that they were all very empathetic with the plight of complainants, which has been shown to have a positive impact on patients (See Robinson 1999: 250). A negative outcome of this pattern of accommodation is that the emotional effect of identifying strongly with two opposing sides can be huge and could possibly lead to burnout. It could be argued that complaints managers with this kind of disposition are not suited to the job.

In the case of the 'reformer', their pattern of accommodation is of course consistent. Essentially, they try to change the organizational culture single-handedly. In the current climate of culture change in the NHS, theoretically these kinds of individuals are useful for their innovative practices. Indeed the Bristol Inquiry Report (2001:271) underlines culture change as stated above and has called for 'a culture of flexibility in which innovation can flourish in response to patients' needs'. However, for the individual complaints manager, the experience of attempting to transform the system, unaided, could have a negative impact emotionally.

'Accommodators' seem to overcome their predicament in less 'extreme' ways than other complaints managers although more than half the accommodators tended towards indifference (indifferent accommodators) with just under half swaying towards complainant orientation (complainant oriented accommodators). Essentially, then, in terms of striking a balance between the organizational agenda and duty to complainants, accommodators seemed to be the most successful complaints managers in doing this.

Reformers seem to epitomize the ideal of good employee in terms of personal morality. On the other hand, institutionalized persons may embody the ideal of loyal employee. Perhaps the accommodators were able to maintain a balance between these two extreme positions. Ultimately, it could be argued that reformers and complainant oriented accommodators should not need to compensate for organizational amorality. The NHS complaints procedures should correspond to a

system that is fair and impartial without having to rely on the personal morality of individual complaints managers.

Appendix One: Complaints Manager Interview Guide

A. Background

What is the official title of your post?
Level of post in the organization?
Background to post?
Type of organization, i.e. Health Authority or Trust, type of Trust
Length of time in the post

B. The Complaints Manager and the Complainant

Does your job remit include supporting patients in their complaint - or is it purely investigating the complaint/ fact-finding? If yes, how far can you go in supporting the patient with their complaint?

Is it easy to maintain neutrality?

Do you ever feel the complainants have unrealistic expectations? Do you ever feel complaints are unjustified? If yes, how do you deal with these types of complaints?

Do ever identify with the complainant? Roughly, how often?

Are you personally affected by any of the complaints - if you hear a particularly bad case?

Do you ever identify with the staff complained about - do you feel sorry for them? Roughly, how often?

C. The Complaints Manager and the Organization

Is it difficult having to investigate complained about staff?

Do you need special skills to obtain necessary information regarding complained about staff (for final response letter)?

Are there difficulties in obtaining this information? If yes, how do you get round these difficulties? /Any other ideas?

Are there occasions when you get conflicting stories from the complainant and the complained about staff? How do you feel about this? If yes, what generally happens in this situation?

Are there occasions when you don't feel you are getting the full picture of the situation from complained about staff/investigating staff? What do you do?

Do you have differences of opinion of how to handle complaints with other complaint handling staff (for example, convenors, medical directors, nursing directors, investigating staff)? Are there occasions when you have come to a conclusion about a complaint, but another/other members of staff do not accept it?

Are there any occasions when you feel the complainant should be given certain information, but because of rules and regulations you cannot divulge this information?

Do you get the same complaints coming up again and again about the same member of staff/unit/ward (and so on)?

Do you ever feel you would like to be more proactive about complaints than your job/the rules/regulations allows? Do you ever feel your hands are tied?

Does the organization have a mechanism by which lessons are learned by complaints i.e. the quality of the service is improved through complaints monitoring and analysis? Do you think this is enough?

D. Other questions

What do you think of the complaints system in terms of fairness/justice for the complainant?

Is your post more stressful than the typical managerial job? If yes, what are the key problems/stresses?

If a Mental Health Trust, do you think the mental health aspect of this Trust affects your post? If yes, how?

If a Mental Health Trust, do you think complaints managers working in Mental Health Trusts need additional training?

Appendix Two: Complaint Expert Interview Schedule

1. Do you consider a. stress b. job turnover to be significant issues in the complaints manager role?

2. As employees of the complained about Trust/ Health Authority, how realistic is the aim of being fair to both complainants and complained against staff?

3. Complaints managers are encouraged to be proactive in using complaints to bring about quality improvements. A complaints manager job description described the need to demonstrate 'assertiveness and tenacity' in this area. How realistic is this aim? Do you perceive this to be a potential source of frustration for complaints managers? Your comments.

4. Complaints managers may have problems dealing with conflicting stories from the complainant and complained about staff; they may have problems getting the full picture of a situation from investigating staff. Do you think this is a significant issue? Your comments.

5. Complaints managers may have differences of opinion with the Trust/ Health Authority on how to deal with a complaint; there may be differences of opinion with line managers (for example, nursing directors/ medical directors), convenors, investigating staff, the chief executive. Do you think this is a significant issue? Your comments.

6. How far should a complaints manager 'support' a complainant? Do you think there is uncertainty/confusion on how far to go in supporting complainants or are complaints managers generally clear about this? (For example, some complaints managers may emphasize the fact-finding / advice aspect of their role while others may stress the supporting aspect of their role). Your comments.

7. Do you think there are different personal approaches to handling complaints? Are their different 'types' of complaints managers? (For example, some complaints managers may 'over identify' with complainants while others may not empathize enough; complaints managers may differ in their interpretation of job descriptions with regard to how far they 'support' the complainant; some complaints managers may be more proactive than others; some complaints managers may believe the system is fair while others believe the system is essentially unfair). Your comments.

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