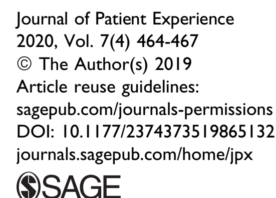
Journal of Patient Experience
2020, Vol. 7(4) 464-467
© The Author(s) 2019
Article reuse guidelines:
sagepub.com/journals-permissions
DOI: 10.1177/2374373519865132
journals.sagepub.com/home/jpx



Patient Complaints: Patients' and Physicians' Interaction in Handling Complex Requests of Care

Sanna Ryynänen[1]

Abstract

Objective: The study report focuses on the interaction of patients' complaint cases and their related physicians' responses in handling patients' complex requests based on the dynamics of power and ideology. **Method:** Data consist of 3 selected patients' complaints and 7 physicians' responses in a specialized medical care organization in December 2016. Data of the qualitative case study were used in narrative analysis. **Results:** The study revealed storylines of narratives ending in physicians' collective ideology of encounters with dissatisfied patients. **Conclusion:** The interaction between patients' complaints and physicians' responses showed emergent patterns of conflicts, which were both constraining and enabling.

Keywords

interaction, decision-making, power, ideology, complex responsive process, patient complaint, patient complaint handling, specialized medical care, Finland

Introduction

Previous studies have shown that more research is needed to investigate the quality of interaction with patients when health-care organizations handle written complaints and not focusing solely on the formal structures of the complaint process in reducing complainants' dissatisfaction (1–5). Regarding complaints, patients mainly report negative experiences of care and often present requests to solve these complex situations (3,6–8). The "patient complaint" is the patient's right to launch a complaint concerning care provided by health-care professionals in an organization (Section 10, Act on the Status and Rights of Patients 1992).

This study focuses on the dynamics of power and ideology in the decision-making process of patient complaints, described as human relationships of enabling-constraining activity with the aspects of including and excluding, cooperative and competitive, imaginative and defensive activity, and explorative and polarized conflict (9). In human interaction, an interest is in particular contexts, times, and power relations (9). The focus of this study is on the written form of interaction of decision-making in which patients make requests and physicians respond.

Method

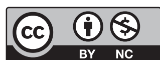
Case Study Research

In this qualitative case study (10), the inclusion criterion for the cases was a complex matter concerning patients' requests for care. The selected patient complaints and their related responses provided the cases used in the study. Each case's request was different and from different medical specialties, which were psychiatry, surgery, and internal medicine.

The aim of this case study is not to generalize or saturate the results, and therefore, the results are not generalizable to a wider extent. The study focuses on the interaction between patient complaints, their handling, and its specific elements, based on social constructionism. Knowledge, reality, and its structures and phenomena are understood to be constructed by social and linguistic interaction (9). In this study, the analytic generalization aims at the

[1] Faculty of Social Sciences, University of Lapland, Rovaniemi, Finland

Corresponding Author:
Sanna Ryynänen, Faculty of Social Sciences, University of Lapland, PO Box 122, 96101 Rovaniemi, Finland.
Email: sanna.ryynanen@ulapland.fi



Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (https://creativecommons.org/licenses/by-nc/4.0/) which permits non-commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (https://us.sagepub.com/en-us/nam/open-access-at-sage).

theoretical proposition, and in that meaning, it can be applied to other situations by consideration (10). The studied organization operates in several medical specialties in a wide geographical region but is described in a general manner to maintain anonymity. Cases describe the characteristics of the phenomenon of patients' care requests and health-care professionals' responses to them.

Data and Analysis

Data were collected from the Finnish specialized medical care organization's database. Samples were selected from the total data in December 2016 (N = 21). The research permission for data was received from the specialized medical care organization's executive board on April 5, 2017.

Narrative analysis (11–13) aims to produce a new narrative from the bases of narratives of data (13). This type of analysis is a synthesis in which elements or central themes are constructed for an entity (11). The new narrative is complete (from the beginning to the end), plot-filled, and chronologically ordered (13). The data in this study consisted of 3 complaint cases and 7 physicians' written responses (n = 10); all of the cases and responses were analyzed as core narratives. The length of the core narratives varied from 1 to 2 pages.

In the analysis, the core narratives were read several times until the storyline became familiar and different nuances could be identified (14). Storylines and nuances can be words, sentences, or several sentences (an entity of the same description). When nuances were included in a specific storyline, they had the same storyline meaning. The core narratives of patient complaints and their responses were combined separately into one of their own larger basic narratives that describe the storylines of core narratives and by them, the main storyline. In the end, the basic narratives were construed with the literature.

Results

Table 1 shows abbreviations of core narratives of patient complaints and a related example of a physician's response. The patients' and physicians' larger basic narratives are shown in the final part of Table 1.

The core narratives describe patients' requests for a discontinuing treatment, an alternative treatment, and an unacceptable treatment. For these reasons, the patients had made contact several times with the care unit's physicians. The physicians had tried to explain their decisions in person to the patients during care and again in written responses, and the administrative physicians continued to maintain their decisions on the final responses to the complaints. In Figure 1, the storylines of core and basic narratives show constraining-enabling encounters in the interaction of patients' complaints and respondents.

In Figure 1, the patients' 4 storylines showed several nuances. Lack of consent included dissatisfaction with care, a desire to change the treatment, and the refusal of treatment. Patients' care alternatives during long-lasting situations were described by the longevity of sickness; during their sickness, the patients had experienced different types of treatment or learned more about them. During care, patients' mistrust had emerged through feelings of failed promises or expectations. The repetition of requests was common in all 3 cases, which was shown as asking several times for an answer and presenting a suggestion for the physician's treatment.

The physicians' 4 storylines also included several nuances. Informing included medical and care practice information. Physicians staying in their position was shown as repetition of knowledge and lack of encounters with a patient. An enlarging total of responses indicates an expansion of respondents and an increase in hierarchical levels. Physicians leaned toward their authority with the support of their medical expertise and professional status.

Discussion

Results showed concurrently constraining and enabling activity of interaction with the organizational dynamics of power and ideology on decision-making (9). Patients' care experiences and repetitive requests for treatment, for example (5,15), enabled an imaginative activity of encounters regarding complainants' decision-making. Physicians explained their decisions on complaints as a collective ideology that used information as their mutual including and cooperative activity but appeared to patients as excluding, competitive, defensive, and polarized activity.

Understanding the dynamics of power and ideology gives perspective to the emergence of tension between legitimate and dissatisfied aspects of interaction. Repetitive requests for treatment can be improved on the basis of patients' and physicians' experience of interactive processes, first by diminishing the difference of power in their care relationships, then by recognizing the presence of different emotional aspects in their power relations (such as fear, anxiety, loyalty, and acceptance), the intertwined care path and its conflicts, the meaning of inclusion–exclusion situations, the interplay of different ideologies, norms, values, and intentions, and interpreting them functionally in specific, contingent situations (9). As they have different expectations, demands, and intentions, the relationships of patients and physicians frequently involve conflictual activities, but there is an opportunity to exercise evaluative choice and compromise with the aim of enabling explorative conflict instead of polarized conflict with its constraining effects (9).

The positive human relationships of enabling activity, with the aspects of including, cooperative and imaginative activity, and explorative conflict (9), could add to health-care professionals' understanding of the dynamics of power and ideology on decision-making. Enabling activity could, from the beginning of care, change the relationship between dissatisfied patients and professionals in expected and

Table 1. Core Narratives and Basic Narratives of Patient Complaint Cases and Their Responses.

Core Narratives	Narratives of Patient Complaint Cases	Narratives of Responses
Core narrative I: The request for discontinuing the treatment	The patient was forced to arrive for psychiatric care against his will by the sending physician. He did not meet a physician during 4 days of psychiatric surveillance. When he met a doctor, he got a decision of treatment against his will. He wanted to discharge from the hospital and also to change his physician in outpatient care because the physician sent him to the hospital.	The physician explained that he had met the patient 4 times during his care. The physician explained several times that the patient was disoriented and not responding correctly despite many efforts. (Changing the physician was not addressed.)
Core narrative II: The request for alternative treatment	The patient has a long-term sickness, but during hospital care, she did not get the treatment that she wanted. She had called the health-care unit several times without success. When she finally got the treatment with the equipment, it failed, as the physicians had warned her before the procedure. The patient stated that the reason for failure was a different problem than her sickness; rather, she had a physical problem with her hand which did not allow her to follow the equipment's instruction correctly. Now, she wants an operation on her hand to have the previous treatment again. The patient also hopes that she can be treated holistically.	During the patient's care, she got the treatment which she requested many times but it failed because of the problem with her hand. Now, she cannot get the treatment again because another physician refused to operate on her hand for a medical reason.
Core narrative III: The request for the unacceptable treatment	The patient wants a treatment that is not accepted by the general rules of acceptable care practice. She does not trust the physician, even though the physician had explained that the treatment is not performed at the hospital. She had heard that the treatment could be provided abroad.	The physician explained several times in detail why the treatment the patient wants cannot be provided by the specialized medical care organization. He expressed that the patient is fixed on the treatment.
Basic narratives	A patient received care for her or his sickness but is not satisfied with the ongoing care. The patient wants another treatment, which she or he thinks might be better. The patient repeats the request several times during care. The patient wants to be treated holistically and not to focus on one thing at a time. The sickness has lasted so long that the patient has experience and information about care and other alternatives. The patient's trust begins to weaken. The patient hopes that further care continues with a physician who understands her or his situation.	The physicians who cared for the patient presented more accurate details about the patient's care. The care was found to be appropriate and medically approved. Based on other physicians' responses, the administrative physician provided the last response. Her or his response follows the contents of responses and does not add any new information on the matter.

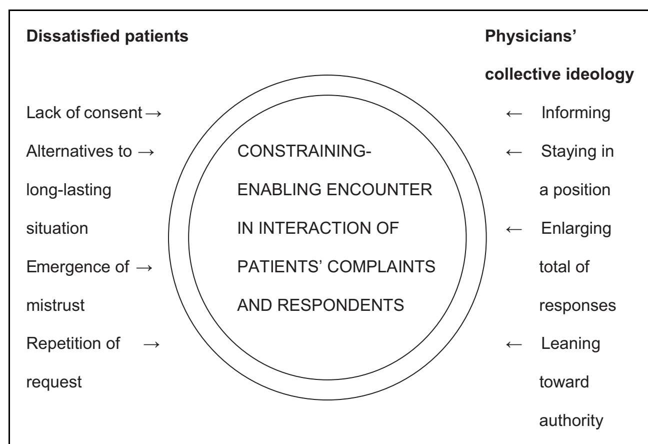


Figure 1. The constraining-enabling encounter in the interaction of patients' complaints and respondents.

unexpected interactions. This positive activity enables professionals to be cooperative with patients and their real, difficult situations and to help patients to understand the medical reasons, such as the risks and consequences caused by treatment or lack of it. Since they are based on specific complex situations, the results of this study can especially benefit physicians' handling of patient complaints and the responses they make and, more widely, serve as self-evaluative guiding tools of reflective interaction for health-care professionals, as well as for patient experience professionals during encounters of care processes.

Limitations

The study was carried out on a data sample of small size, by which it was possible to receive the preliminary results of individual cases and to investigate the applicability of the

dynamics of power and ideology perspective for additional action research by the author with her research group. The major data will include written patient complaints and care meetings—so-called cooperation meetings—which are arranged on the request of a patient or health-care personnel of the studied organization to clarify and solve an existing disagreement or dissatisfaction with care. A patient can also ask other persons (such as a friend) to the meeting, and furthermore, the researchers of the further study have the opportunity to participate and explore the conversations in greater depth and how they are handled compared to written patient complaints.

Conclusion

The interaction between patient complaints and physician responses showed emergent patterns of conflict that were both constraining and enabling based on the organizational dynamics of power and ideology on decision-making. Care experiences and complex, repetitive treatment requests by patients ended in physicians' collective ideology in their decisions on complaints. Physicians provided information as their mutually including and cooperative activity but were viewed by patients as excluding, competitive, defensive, and polarized. Recognizing the dynamics of power and ideology on treatment decisions gives perspective to the emergence of tension between legitimate and dissatisfied aspects of interaction.

Author's Note

Sanna Ryynänen is also affiliated with Helsinki University Hospital, Helsinki, Finland.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The study was supported by state funding for university-level health research at Helsinki University Hospital.

ORCID iD

Sanna Ryynänen https://orcid.org/0000-0001-8392-7183

References

1. Cowan J, Anthony S. Problems with complaint handling: expectations and outcomes. Clin Govern Int J. 2008;13:164-8.
2. Wessel M, Helgesson G, Lynöe N. Experiencing bad treatment: qualitative study of patient complaints concerning their treatment by public health-care practitioners in the County of Stockholm. Clin Ethics. 2009;4:195-201.
3. Skålèn C, Nordgren L, Annerbäck EM. Patient complaints about health care in a Swedish county: characteristics and satisfaction after handling. Nurs Open. 2016;3:203-11.
4. Mirzoev T, Kane S. Key strategies to improve systems for managing patient complaints within health facilities—what can we learn from the existing literature? Glob Health Action. 2018;11:1458938.
5. McCreaddie M, Benwell B, Gritti A. Traumatic journeys: understanding the rhetoric of patient complaints. BMC Health Serv Res. 2018;18:551.
6. Veneau L, Chariot P. How do hospitals handle patient complaints? an overview from the Paris area. J Forensic Leg Med. 2013;20:242-7.
7. Reader T, Gillespie A, Roberts J. Patient complaints in healthcare systems: a systematic review and coding taxonomy. BMJ Qual Saf. 2014;23:678-89.
8. Schaad B, Bourquin C, Bornet F, Currat T, Saraga M, Panese F, et al. Dissatisfaction of hospital patients, their relatives, and friends: analysis of accounts collected in a complaints center. Patient Educ Couns. 2015;98:771-6.
9. Stacey R, Mowles C. Strategic Management and Organizational Dynamics: The Challenge of Complexity to Ways of Thinking About Organisations. 7th ed. London, England: Pearson Education; 2016.
10. Yin RK. Case Study Research: Design and Methods. 5th ed. Thousand Oaks, CA: Sage; 2014.
11. Polkinghorne D. Narrative configuration in qualitative analysis. In: Hatch JA, Wisniewski R, eds. Life Story and Narrative. London, England: Falmer; 1995:5-23.
12. Hänninen V, Koski-Jännes A. Narratives of recovery from addictive behaviours. Addiction 1999;94:1837-48.
13. Heikkinen H. Whatever is narrative research? In: Huttunen R, Heikkinen H, Syrjälä L, eds. Narrative Research: Voices of Teachers and Philosophers. Jyväskylä, Finland: SoPhi; 2002: 13-28.
14. Frank A. The Wounded Storyteller: Body, Illness, and Ethics. Chicago, IL: University of Chicago Press; 1995.
15. Southwick F, Cranley N, Hallisy J. A patient-initiated voluntary online survey of adverse medical events: the perspective of 696 injured patients and families. BJM Qual Saf. 2015;24:620-9.

Author Biography

Sanna Ryynänen is senior lecturer in Administrative Sciences at the Faculty of Social Sciences of the University of Lapland and Researcher and Patient Ombudsman at Helsinki University Hospital.