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

Sanna Ryynänen

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
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 healthcare 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
unexpected interactions. This positive activity enables professionals to be cooperative with patients and their real, difficult situations and to help physicians in outpatient care because the physician sent him to the hospital.

**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.

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ORCID iD

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

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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.