Real Talk
Engaging people in end of life talk

"Strategies employed by healthcare professionals to handle complaints in palliative care contexts"

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When a person is unhappy, they may complain. That is, they may express discontent about a situation and blame someone for it. Most published research about complaints in healthcare has focused on formal, written complaints to the service. We investigated the more fleeting activity of complaining in the course of healthcare consultations. When this happens, professionals have a chance to address concerns before circumstances deteriorate.

As a social action, complaining can be a risky thing to do for patients and their representatives. Outright expressions of grievance regularly attract negative evaluations and consequences in institutions. Sarah Ahmed, in her book, 'Complaint!' (2021) describes how those complaining within institutions can be treated as 'rocking the boat'. So, raising a concern may be delicate for a patient and their representatives. Meanwhile, those receiving a complaint also face a dilemma: complaining invites recognition of, or even agreement with, the complainer's position and perspective. If a professional endorses a patient's complaint about their care, they can be seen as siding with the patient against the service, violating norms of professional neutrality and impartiality, and potentially providing material that could be leveraged in the future to seek compensation. However, if a professional adopts a neutral stance towards a complaint, they may be perceived as lacking empathy. We refer to this as the 'distance-involvement dilemma'.

Our article describes how patients receiving palliative care complain about matters for which the healthcare professional they are talking with can be treated as responsible, either personally or as part of a care team. This research is based on an analysis of audio-visual recordings of consultations that are featured in the RealTalk modules. They involve palliative care patients, their companions including family and friends (when present), occupational therapists, and physiotherapists. The consultations took place at a large UK hospice.

We found that patients and their companions imply, rather than explicitly state, complaints and matters of responsibility. This is not altogether surprising: it is one way that patients avoid attracting negative inferences about themselves. Alluding to a problem allows it to be treated as a less damaging object than a frank complaint.

Here is an example we share in our paper. This extract is drawn from the closing part of an inpatient consultation between an 83-year-old woman with lung cancer, Carol (pseudonym) , and two occupational therapists (OTs). Carol has been receiving treatment in a hospice for several days. Prior to this extract, she has mentioned her desire to go home. At one point, she voiced her hope to be discharged today, to which the OTs responded that discharge has not been mentioned yet. They also conveyed concerns about Carol's ability to cope at home because of her reduced mobility, possibly indicating that going home would be premature. Coming towards the end of their consultation, one OT begins to arrange the next meeting:

OT: We'll come and see you later, but if you feel that - actually now I've had me dinner, I just want to rest - that's absolutely fine, we can come and see you tomorrow.
Carol: Yeah. That is fine… I don't like the way you're saying I'll see you tomorrow.

Someone receiving a complaint can produce equivocal 'mid-range' responses to avoid the undesirable alternatives of supporting a complainer's position or disagreeing with them. When a complaint is not explicit, but implied, the recipient can respond to some other aspect of what has been said. In service interactions, another option is to treat the complaint as a problem to be solved rather than as a grievance. Displaying recognition of the complainer's perspective and treating it as reasonable has been shown to be crucial in moving towards complaint resolution.

In this example, the OT first responds with a statement:

OT: Because you want to go home.

The OT shows she understands Carol's discontent to be about staying at the hospice for another night. Her response recognises Carol's conveyed perspective as reasonable, so is hearably empathic. It also foregrounds the positive outcome that Carol wants to achieve (going home) and maintains in the background the complainable matter (being kept at the hospice) and who is responsible for it.

Carol replies by repeating, and agreeing with, the OT's comment, and then expanding:

Carol: Because I want to go home. But, if me husband and daughter are here, they'll say "No. You're not coming home, you're in the best place, they know what they're doing." And this is all I'm getting all the while from them.
OT: Just want to get to the bottom of it really,
Carol: Mm
OT: Just find out what- what's making you feel drained
Carol: Yeah.
OT: Okay then. So we'll do that-
Carol: Mm
OT: that's the plan later.
Carol: Well, thank you ever so much for your care and -

OT: That's okay.
Carol: you've been working, I'm really grateful. I really am.

The complainable matter is one for which the clinical team, which the OT represents, can be seen as responsible. Interestingly, Carol has now offset the possibility of being heard as blaming the clinical team for keeping her at the hospice by blaming her family instead. She uses well-documented practices for complaining, including reported speech and extreme case formulations ('this is *all* I'm getting *all the while* from them'. Even so, the OT continues to treat Carol's complaint as pointing to the clinical team's responsibility by providing a best interest account for extending her stay, although she stops short of articulating who exactly is responsible for Carol's discharge. The conspicuous absence of a pronoun in subject position works to gloss over who wants to 'get to the bottom of it'. It avoids detailing the circumstances of the complainable matter, which could amount to making explicit something that Carol has only implied. In this way, escalation of a nascent complaint (i.e., making it overt) is arguably pre-empted.

Furthermore, the OT alludes to the possibility of a quick resolution of the complainable matter, suggesting that Carol will not be held for longer than necessary. The OT thus maintains the practical, solution-oriented focus already implied by her earlier formulation of Carol's perspective. This contrasts with other possible responses, such as an apology for extending Carol's discharge, which could amount to an admission of responsibility for a wrongdoing. Subsequently, the OT moves towards closing the conversation with 'Okay then' and goes on to treat the problem as a practical matter for which a 'plan' has been agreed on.

To summarise, the OT balances recognising Carol's dissatisfaction with avoiding commenting on the complainable matter and attendant attribution of responsibility. Carol's actions had set the stage for this by avoiding blaming the clinical team and blaming her family instead. A complaint about the hospice staff delaying Carol's discharge is collaboratively maintained as a somewhat implicit matter and, concurrently, as a controllable problem rather than a major cause of dissatisfaction.

We observe how, in a palliative care setting, professionals can deploy a combination of resources to navigate the distance-involvement dilemma, producing mid-range responses which treat the patient's perspective as legitimate without endorsing it as a complaint, and attending to other aspects of action, addressing them as 'problems to be solved'. Thus, what we see emerge is not a full-blown complaint, but rather a shared attempt to solve a problem. Understanding how this is achieved offers practical options for professionals to pre-empt overt articulation of complaints.

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