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Title	Why do medical professional regulators dismiss most complaints from members of the public? Regulatory illiteracy, epistemic injustice, and symbolic power
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Publication date	2018-07-10
Original Citation	O'Donovan, O. and Madden, D. (2018) 'Why Do Medical Professional Regulators Dismiss Most Complaints From Members of the Public? Regulatory Illiteracy, Epistemic Injustice, and Symbolic Power', Journal of Bioethical Inquiry, (10 pp.). doi:10.1007/s11673-018-9869-2
Type of publication	Article (peer-reviewed)
Link to publisher's version	https://link.springer.com/article/10.1007/s11673-018-9869-2 - 10.1007/s11673-018-9869-2
Rights	© Journal of Bioethical Inquiry Pty Ltd. 2018. This is a post-peer-review, pre-copyedit version of an article published in Journal of Bioethical Inquiry. The final authenticated version is available online at: http://dx.doi.org/10.1007/s11673-018-9869-2
Download date	2026-11-01 11:31:59
Item downloaded from	https://hdl.handle.net/10468/6999

UCC
University College Cork, Ireland
Coláiste na hOllscoile Corcaigh

[issue] **15(3)**

[category] **Original Research**

[title] **Why do medical professional regulators dismiss most complaints from members of the public? Regulatory illiteracy, epistemic injustice, and symbolic power.**

[subtitle]

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Abstract Drawing on an analysis of complaint files that we conducted for the Irish Medical Council (Madden and O'Donovan 2015), this paper offers three possible explanations for the gap between the ubiquity of official commitments to taking patients' complaints seriously and medical professional regulators' dismissal—as not warranting an inquiry—of the vast majority of complaints submitted by members of the public. One explanation points to the "regulatory illiteracy" of many complainants, where the remit and threshold of seriousness of regulators is poorly understood by the general public. Another points to possible processes of "institutional epistemic injustice" (Fricker 2007; Anderson 2012) that unjustly undermine the credibility of certain complainants, such as those with low levels of formal education. A third explanation highlights the marginalization of the general public from "symbolic power" (Bourdieu 1984) to define what matters in medical professional regulation. The paper is offered in a spirit of ideas in progress and raising questions rather than definitive insights into the regulatory process.

Keywords Patients' complaints; Medical professional regulation; Regulatory illiteracy; Institutional epistemic injustice; Symbolic power

Introduction

By now commitments to taking patients' complaints seriously are ubiquitous, including from medical professional regulators. One such commitment can be found in the foreword to an Irish Medical Council (2015) report on a study in which we were involved, *Listening to Complaints. Learning for Good Professional Practice*. In the foreword, the Medical Council's president and vice president state, "Making a complaint about a doctor is not an easy step for a patient or their family to take. It is important that their voices are listened to and that their concerns are taken seriously" (Medical Council 2015, 3). However, the same report notes that for the period 2011–2012, of the complaints made by members of the public, only 7 per cent were deemed to warrant an inquiry. Although the actual number of cases was small, in contrast, 82 per cent of complaints made by the Health Services Executive and other employers were referred to an inquiry. Following these inquiries only 1 per cent of complaints made by members of the public resulted in a high impact sanction, compared to 11 per cent for complaints made by the Heath Services Executive and other employers. A similar pattern has been reported by other medical professional regulators; for example, the British General Medical Council (2014) reported that between 2010 and 2013, although 64 per cent of complaints it received were submitted by members of the public, only 11 per cent of complaints that resulted in sanctions and warnings originated from that source. Drawing on an analysis of complaint files that we conducted for the Medical Council (Madden and O'Donovan 2015), this paper tentatively offers three explanations for this gap between commitments to taking patients' complaints seriously and the outcomes of the Medical Council's complaints processes. Underpinning our analysis is this question: are complaints from patients and their families dealt with unjustly in comparison to complaints from healthcare and other professionals?

We begin with a two-part background discussion. A brief overview is provided of explanations for the ubiquity of commitments to listening to patients and taking their concerns seriously, many of which emphasize the emergence of a new epistemic identity of the patient as a knowledgeable and rational subject and a resultant "new politics of medical regulation" (Salter, 2001). The Medical Council's complaints process and the outcomes of its investigations in recent years are then described. This is followed by a brief note on the study on which this paper is based. Three possible explanations for the low rate of referral to an inquiry of complaints submitted by members of the public are then considered. The first points to the "regulatory illiteracy" of many complainants, an explanation based on the remit and threshold of seriousness of regulators being poorly understood by the general public. This explanation is implicit in the Medical Council's descriptions of its procedures for handling

complaints against doctors, which note that many complaints are trivial or without substance. Resembling the emphasis on "scientific illiteracy" in "public understanding of science" explanations of public controversies about science (Jasanoff 2005), this explanation attributes the low rate of referral to inquiry of complaints from members of the public to deficits in public understanding of the grounds on which the Medical Council deems complaints to warrant action. If there is an injustice here, it is the unequal distribution of regulatory knowledge.

The second explanation points to possible processes of "institutional epistemic injustice" (Fricker 2007; Anderson 2012) that result in the voices of some complainants not being heard because of who they are and how they communicate. Alerting us to habits of credibility attribution, epistemic injustice refers to various systematic ways in which the credibility of some people's testimonies is unfairly deflated and their capacity as knowers unjustly denied. This explanation builds on the work of researchers (Carel and Kidd 2014; Blease, Carel, and Geraghty 2017; Buchman, Ho, and Goldberg 2017) who argue that patients are particularly vulnerable to epistemic injustice, where the attribution of characteristics such as cognitive unreliability and emotional instability can diminish the credibility of their testimonies.

The third explanation focuses attention on the unequal distribution of "symbolic power" (Bourdieu 1989) to define matters of concern and what constitutes evidence in medical professional regulation. Shaped by a history of medical professional self-regulation, crucial to the regulatory regime in which the Medical Council functions is the official sanctioning of a privileged, albeit not exclusive, role for the medical profession in defining "categories of perception" (Bourdieu 1989, 20) surrounding professionalism. This is evident in the Medical Council (no date) guide to patients about how to make a complaint, where professional misconduct is explained as "conduct that experienced, competent and reputable *doctors* consider disgraceful or dishonourable" (emphasis added). This may be explained, to some extent, by the judicial attitude to the definition of professional misconduct which refers to conduct which is "infamous or disgraceful in a professional respect" or "conduct connected with his profession in which the medical practitioner concerned has seriously fallen short, by omission or commission, of the standards of conduct expected among medical practitioners" (*O'Laoire v The Medical Council* Unrep. High Court 27 Jan 1995). Both of these definitions of professional misconduct rely heavily on the views of other medical professionals to indicate to the Medical Council and the courts what the standards to be expected of the medical practitioner in question are in any given context and thus whether this practitioner fell below those standards.

The Emergence of the Expert Patient and the new Politics of Medical Regulation

The ubiquity of commitments to listening to patients and taking their concerns seriously has been explained repeatedly with reference to the emergence of a new epistemic identity of the patient as a knowledgeable and rational consumer (Lupton, 1997; Callon, 1999; Rabeharisoa, Moreira, and Akrich 2014). This new and knowledgeable patient who is more involved in her own medical care, more likely to conduct independent research on her condition, and question and complain about doctors' decisions and professional conduct has been identified as a crucial player in what Brian Salter (2001) calls the "new politics of medical regulation." In many countries transitioning from self-regulation, the power relations of medical regulation have shifted due to greater state involvement in clinical governance, but a push for greater public involvement from increasingly sophisticated patients and their organizations has also been noted. For Salter (2001, 882), this requires "working towards a collaborative model of regulation capable of translating the rhetoric of 'partnerships with patients' into practical power relationships." Beaupert et al.'s (2014) review of the literature on the regulation of healthcare complaints considers a number of such new models of regulation, including networked governance, flexible or responsive regulation, and a growing interest in finding alternatives to traditional legal forms. One of the conclusions of their review of 118 papers is that raising awareness about complaints processes and how to access them is important, resembling the remedial action suggested by the regulatory illiteracy explanation that we consider. But also, similar to the concerns raised by the two other explanations we elaborate, Beaupert et al. (2014, 513) conclude by highlighting the "scope for examining the processes of health complaints commissions and comparable bodies in their own right, to understand how to make these processes fairer and better able to meet complainants, health professionals and society's complex needs."

Some commentators, however, caution against tendencies to overstate transformations in the epistemic status of patients' knowledge. Accepting that much remains unclear about patients' "experiential knowledge" and the credibility and authority it should be accorded relative to professional knowledge, Stuart Blume (2017) nonetheless acknowledges that it has emerged as a form of cultural capital used to legitimate demands for greater inclusion of patients in healthcare decision-making. However, this is not the case for all patient knowledge. He argues that notwithstanding the pervasive rhetoric of listening to patients, their "experience is treated as authoritative, as worthy of being characterized as 'knowledge' only to the extent that it appears compatible with medical knowledge and assumptions" (Blume 2017, 99).

When patients' and their organizations' knowledge is at variance with medical knowledge, its status as cultural capital tends to be significantly diminished and is likely to meet considerable scepticism. Highlighting the intersections of economic and symbolic power, Blume emphasizes how powerful interests shape the status given to patients' experiences, including differences in socio-economic status: "Groups and communities which lack status, which lack articulate spokespeople, will find that their experiences are unheard, barred from access to the status of knowledge" (Blume 2017, 101). Blume argues that the authority given to patients' knowledge is determined by a number of filtering processes, including compatibility with professional opinion, but also the market orientation of contemporary healthcare.

The Medical Council Complaints Process and Outcomes

Similar to the trend in many other countries (Beaupert et al. 2014), the number of complaints about doctors made to the Irish Medical Council has risen in recent years. Between 2008 and 2012 it increased by 46 per cent, from 335 to 488 complaints per year (Medical Council 2015), although it is interesting that the figures for 2016 show a decline to 411 in that year (Medical Council Annual Report 2017). That said, complaints continue to be made about a very small number of doctors. In 2016, 21,795 doctors were registered with the Medical Council; even if each of the 411 complaints submitted that year related to 411 individual doctors, that constitutes less than 2 per cent of all those registered.

Governed by the 2007 Medical Practitioners Act, there is a three-stage process for dealing with complaints. In the first instance, all complaints are investigated by the Preliminary Proceedings Committee (PPC), a committee with a majority of medical professional members. Following its review of the complaint and the doctor's response, the PPC can refer the complaint to the Fitness to Practise Committee (FPC) for an inquiry, decide it does not warrant further action, refer to it to another body, or recommend mediation. *Listening to Patients* (Medical Council 2015, 9) notes that the PPC may decide that no further action is required in relation to a complaint on grounds that "there is no prima facia (at first appearance) evidence of poor professional performance or professional misconduct." Elsewhere, a more detailed description of the PPC procedures (Medical Council 2012, 4) lists a number of reasons why the committee can decide that a complaint does not warrant further investigation. These include instances where the complaint is deemed to be "trivial or vexatious or without substance or made in bad faith" and where there is not "sufficient cause to warrant further action." The legal reason for making such assessments is due to the judicial

interpretation of the meaning of professional misconduct and poor professional performance as requiring a threshold of seriousness before a complaint could by upheld against a practitioner (*Corbally v The Medical Council* [2015] IESC 9).

Secondly, those complaints referred to the FPC become the subject of an inquiry conducted under the provisions of the Act. Unlike the PPC, the FTP committee has a non-medical professional majority and inquiries are usually held in public. Thirdly, the report of the FPC is considered by the Medical Council, twelve of whose twenty-five members are medical professionals. Sanctions that can be imposed by the Medical Council range from reprimanding the doctor to cancelling their registration. There have been calls for the overhaul of this complaints process due to the time it takes to process complaints. In 2017, the CEO of the Medical Council argued that the council should have more flexibility outside of the current "straitjacket" which requires that all complaints are considered by the PPC. He is reported as saying, "We would like the ability to be able to resolve complaints as quickly as possible in a manner that is satisfactory for the complainant and also protecting the public interest" but where "serious" cases would still go to full inquiry (O'Regan 2017).

The Medical Council emphasizes in its guidance on how to make a complaint that it understands that this can be a difficult process for complainants; for example, it states, "We understand that making a complaint can be stressful, so we will try to deal with your complaint as quickly as we can." Elsewhere, and as quoted above, it is acknowledged that "Making a complaint about a doctor is not an easy step for a patient or their family to take" (Medical Council 2015, 3).

In the period between 2008 and 2012, the PPC investigated a total of 1,961 complaints, 221 (11 per cent) of which were referred to the FPC, with 148 (7 per cent) resulting in Medical Council sanctions. During 2011, the Medical Council began recording the source of complaints. Even though the number of complaints for which we have this information is small, clear patterns can be discerned. Table 1 below provides details of the referral of complaints from various sources to an inquiry by the FPC between mid-2011 and 2012. The vast majority of complaints (86 percent) were made by members of the public, but only 7 per cent of these were referred by the PPC to an inquiry. As noted earlier, in contrast 82 per cent of complaints submitted by the Health Services Executive and other employers resulted in an inquiry. Of the five categories of sources, complaints submitted by members of the public were least likely to lead to an FPC inquiry. Similar trends are evident in data on the complaints that result in high impact sanctions by the Medical Council. Fewer than 1 per cent of the complaints submitted by members of the public, only three of the 330, resulted in a

high impact sanction, compared to 11 per cent of complaints made by the Health Services Executive. Although the Medical Council[1] seems to suggest that this gap between the outcomes of complaints submitted by members of the public and by professional peers might be explained by the greater insight that employers have into doctors' practice, we suggest that consideration needs to be given to three additional possible explanations.

Table 1 Referral of complaints from various sources to an inquiry by the fitness to practise committee (2011–2012)

Source	Number of complaints received	% of all complaints received	Number of complaints referred to an inquiry	% of complaints by source referred to an inquiry
Members of the public	330	86%	23	7%
Doctors & other healthcare professionals	25	7%	6	24%
Health Services Executive & other employers	11	3%	9	82%
The Medical Council*	10	3%	4	40%
Others**	6	2%	2	33%
Total	382	100%	44	12%

*Anonymous complaints or complaints arising from other Medical Council Functions

**Includes other regulators, patients' organizations, and solicitors

Source: Medical Council (2015)

The Qualitative Review of Complaints

In keeping with official commitments to listening to patients and recognizing their epistemic identity as repositories of information critical to patient safety, in 2014 the Irish Medical Council commissioned us to conduct a qualitative review of complaints it received between

[1] See https://www.medicalcouncil.ie/Professionalism/Handling-Concerns/)

2008 and 2012. Prior to this the Medical Council had undertaken quantitative analyses of complaints data and presented these in its annual reports. With a view to enhancing the Medical Council's learning from complaints and using these lessons to foster good medical professional practice, this was the first time a systematic qualitative analysis was conducted to complement the annual statistics produced by the council on the complaints it receives. In 2015 the Medical Council published a summary report on this combined qualitative and quantitative systematic analysis of complaints, *Listening to Complaints. Learning for Good Professional Practice*. Our report on the qualitative review of a sample of one hundred complaints (Madden and O'Donovan 2015) and the methodology employed is available on the Medical Council website; the analysis offered in this paper draws on data presented in that report. We recognize the limitations of the qualitative review we undertook and that much work remains to be done, theoretically and empirically, to explain the complex processes involved in the handling of complaints about doctors. Ethnographic observations of the functioning of the PPC and FPC over a long period of time could, for example, afford much more in-depth insight into why so few complaints from members of the public are referred to an inquiry. Our analysis in this paper, therefore, is tentative and is offered in a spirit of ideas in progress and raising questions rather than definitive insights.

The Regulatory Illiteracy Explanation

Our review of complaints found evidence that some complainants misunderstand the role of the Medical Council and the grounds on which complaints are upheld. We identified what could be regarded as a continuum of "regulatory literacy," a concept we use to refer to knowledge of and fluency in the language of legislation and guidelines for the regulation of the medical profession and an understanding of the current regulatory regime. At one end of the continuum were complaints that demonstrated considerable familiarity with medical regulation legislation and guidelines, such as those that cited specific aspects of the Medical Practitioners Act 2007. For example, one complaint began with "I wish to make the following formal complaints of 'Professional Misconduct' and/or 'Poor Professional Performance' as described in 'GUIDE TO PROFESSIONAL CONDUCT AND ETHICS FOR REGISTERED MEDICAL PRACTIONERS, 7TH EDITION 2009'." Some complainants specified the form of sanction they expected the doctor to receive, such as "it would be my expectation that the Council would impose the most severe sanctions permissible under the Medical Act 2007 on [Doctor]."

Although not citing the guidelines or legislation, other complainants framed their concerns in a way that is consistent with the Medical Council's remit in protecting the public and promoting patient safety. Many complainants expressed their concerns in terms of prevention of future harm to others. One complainant stated that she wanted to "stop [Doctor] from doing this to any other patient" while others used similar language in seeking to "protect any women who may be misfortunate enough to attend [Doctor]" or "I would hate to think that this could happen to anyone else in the future."

At the other end of the regulatory literacy continuum were complaints related to matters outside the Medical Council's remit. For example, some complainants requested the Council to change their medical diagnosis and treatment. One wanted the Medical Council to investigate what he regarded as his wrongful diagnosis with a psychiatric disorder, whereas another requested termination of his treatment with psychiatric medicines. Another still submitted a complaint in order to secure a psychiatric diagnosis and treatment.

Some sought answers to their specific concerns or questions about what happened in their treatment; for example, one complainant asked the Council to "look into this matter for me and find out why these errors were made." Others who had sought answers from the doctor in question complained that their questions or concerns were either unanswered or not answered in a manner that the complainants could understand. One complainant reported he was "shoved from pillar to post," and another that the doctor had answered with "misleading comments." Others simply wanted an explanation in terminology they could understand. One particular complainant who had been given information relating to the cause of her mother's death using highly technical medical terminology simply wanted to know "Did Mom die from stroke?"

For those who wrote to the Medical Council seeking a specific outcome, common amongst these was punishment which the complainants felt would provide justice for them personally. For some of these complainants, accountability was interpreted as to "name and shame" the doctor. One wrote, "If I have to put his name in the papers I will." Another complainant described the outcome sought as follows: "I also want a head on a plate even if they are retired." Another who complained about feeling frustrated and angry as a result of her experience said, "I feel like I need some justice."

At odds with representations of patients as expert knowledgeable subjects, the regulatory illiteracy explanation highlights deficits in public understanding of the regulatory regime. The remedial action suggested by this explanation for the low rate of referral of complaints from members of the public is improved public education about the medical regulator's role and

complaints process so as to ensure a more equitable distribution of regulatory knowledge. This is consistent with calls for awareness raising about complaints processes that have been made by other researchers who have investigated the regulation of healthcare complaints (Beaupert et al. 2014) and with efforts by the Medical Council, such as the inclusion of a "video tour" of the complaints process on its website.

Our review of complaints, however, provides evidence that this explanation is unlikely to be convincing to the many complainants who, having learnt about the decision not to refer their complaint to an inquiry, wrote to the Medical Council to express concerns about the complaints process. Amongst these were complainants who raised questions about the fairness of the process, including one who queried the privileging of the doctor's testimony over hers and asserted "there is no way that this can be considered an adequate, nor fair, judicial process." Furthermore, many of the examples presented above as instances of regulatory illiteracy could also be regarded as indicative of underlying injustices in respect of interpretive resources and cultural capital that better dissemination of regulatory knowledge is unlikely to redress. These underlying injustices are explored in our second explanation, which draws on the concept of epistemic injustice.

The Epistemic Injustice Explanation

In Harper Lee's classic book *To Kill a Mocking Bird* (1960), due to racist prejudice the jury in the trial of Tom Robinson accord greater credibility to white than to black witnesses. Philosopher Miranda Fricker argues that in situations such as this, where a person's credibility is discounted due to prejudice, a distinct and important form of injustice is occurring, and she labels it epistemic injustice. Synthesizing theories of knowledge and injustice, her influential book *Epistemic Injustice: Power and the Ethics of Knowing* (2007) distinguishes two forms of epistemic injustice, testimonial and hermeneutical. Identity prejudice, such as that based on racism, sexism, and perhaps more subtly on class accent, is at the root of testimonial injustice that results in certain groups of people having a credibility deficit and others a credibility excess. The second form, hermeneutical injustice, occurs when the testimonies of certain groups are deemed unintelligible because of these persons' lack of interpretive resources or cultural capital. The remedy for these injustices advocated by Fricker centre on a call for critical reflection on the part of individuals on their cognitive biases and habits of credibility attribution.

While welcoming Fricker's conceptualization of epistemic injustice, many have been critical of her account of its causes and remedies and have offered revisions. Elizabeth Anderson

(2012, 169), for one, argues "we need to get past the [individual] prejudice model of testimonial injustice" and identifies structural causes of some social groupings having credibility deficits. Pointing to the intersections of epistemic and socioeconomic injustices, she points out that there can be differentials (based on class and other social inequalities) in access to "markers of credibility," such as formal education and the communicative styles that tend to accompany it (e.g. the use of standardized grammar). Secondly, she highlights epistemic ethnocentrism, and thirdly, "shared reality bias," both of which result in hearers privileging the testimonies of those who share a similar set of schemata and sensibilities. Departing from Fricker's account, Anderson (2012, 171) points to the limitations of individual level remedies for epistemic injustice, saying "individual epistemic virtue plays a comparable role to the practice of individual charity in the context of massive structural poverty." While acknowledging the profound challenges of epistemic justice, she argues epistemic injustice is structural, and structural injustices call for structural remedies. This move beyond the individual helps us appreciate that institutions, such as medical regulators, can act in ways that promote epistemic justice or injustice. Following on from Mary Douglas's (1986) classic account of *How Institutions Think*, such bodies also have habits of thought and of attributing credibility that can privilege some styles of communicating and evidencing testimonies and disadvantage others.

Reflecting on epistemic injustice in the context of healthcare, Havi Carel and Ian James Kidd (2014) argue that patients are particularly vulnerable to testimonial and hermeneutical injustice, whereas medical professionals enjoy epistemic privilege in both justified and unjustified ways. Testimonial injustice occurs when the very identity of being ill or a patient increases the likelihood that a person is regarded as "cognitively unreliable, emotionally compromised, existentially unstable or otherwise epistemically unreliable in a way that renders their testimonies and interpretations suspect" (Carel and Kidd 2014, 531). The prospect of this occurring is even greater for patients with stigmatizing and invalidating diagnoses, such as a psychiatric condition. Situations where the credibility of patients' testimonies are downgraded because they do not have the concepts to communicate their experiences and lack access to medical terminology are instances of hermeneutical injustice. Carel and Kid claim contemporary healthcare practices systematically "privilege impersonal third-person reports and empirical data over personal anecdote and pathographic testimonies in a way that structurally disables certain testimonial and hermeneutical activities" (Carel and Kid 2014, 535). Acknowledging that many health professionals might like to make greater

efforts to take patient testimonies more seriously, they note that time, financial, and other pressures can militate against this.

We are not in a position to identify instances of epistemic injustice in our review of complaints submitted to the Medical Council. However, we identified two differentials that could possibly make some complainants vulnerable to testimonial and hermeneutical injustice. In addition to variations in regulatory literacy discussed above, our review of complaints identified two other variations that are strongly related to socioeconomic injustices—basic literacy skills and medical knowledge or literacy. The time pressures within which the PPC operates, which as noted above have been raised as a concern by the Medical Council's CEO, could also militate against such complaints being heard. While most of the sample of one hundred complaints we reviewed were submitted in typed form either by letter or email, twelve were handwritten. Many of these handwritten complaints, all of which were submitted by patients on their own behalf or by family members, included crossed out words and spelling and grammatical errors indicative of the complainants' low levels of formal education. The content and narrative style of these complaints contrasted sharply with those submitted by solicitors on behalf of patients, all of which were typed and written in a formal, succinct legalistic style. Consistent with the figures presented in Table 1 above, of the four complaints in the sample submitted by solicitors, three were referred to the FPC. Although the reason for holding inquiries into these complaints is undoubtedly related to how the facts alleged by the solicitors on behalf of these complainants met with the Medical Council's threshold of seriousness, the possible difficulties experienced by complainants who articulate their complaints themselves, especially those who cannot afford the services of a solicitor, should not be ignored.

Secondly, and of particular significance in the medical regulation context, was a continuum of levels of medical literacy. Some complainants explicitly acknowledged their lack of medical knowledge and that they are not conversant in medical terminology; this was the case in the example given above of the complainant who sought information from the Medical Council about the cause of her mother's death in language she could understand. In contrast, other complaints, including one submitted by a complainant who was both a doctor and a patient, displayed considerable medical knowledge and capacity to communicate using medical concepts. In another case that illustrates how some had considerable interpretive resources pertinent to the medical regulation field, the complainant wrote, "Mom had all the signs of limb Ischaemia. A simple pulse examination with Doppler Scan should have been ordered." In the doctors' responses to complaints made against them, a number included

denials that highlighted the medical illiteracy of the complainants. One doctor, for example, denied having misprescribed medication, noting,

> With regard to the cream that [Patient] says caused side effects for him. I would like to state that this cream was [medication] cream which is a very safe and effective cream. I am not aware that this could cause any upset to his stomach. I feel that this complaint does not make sense from the medical point of view.

Our review considered the "credibility tactics" (Epstein 1995) used by complainants and doctors and the various forms of evidence they mobilized in support of their testimonies. A standardized feature of the doctors' responses was a list of their medical credentials and work experience. This may be perceived by complainants as a means by which doctors try to establish themselves as beyond reproach due to their education and status, however doctors are commonly advised by professional indemnity bodies to set out such information in an attempt to indicate professional and clinical competence to the regulator. Many doctors also refer to the authority of their medical notes to remind themselves of the events in question and defend themselves against the allegations made by the complainant. Whilst intended by the doctor to provide exculpatory evidence by means of a contemporaneous record of facts by which to refute the complainant's allegations, some complainants argued that there may be a tendency to ascribe too much weight to such notes by comparison to the unrecorded and unwritten recollection of events by the complainant, thus rendering them less likely to be believed.

A striking feature of many of the complaints from members of the public that we reviewed was their emotional content where complainants relayed their emotional response to the alleged events as evidence of the depth and seriousness of harm caused, which in turn led them to conclude that the doctor's behaviour ought to be considered as professional misconduct. For example, one complainant wrote,

> This letter has taken me eight months to write as so many times I have started and stopped because it upsets me so much. The trauma could have and should have been avoided if the doctors listened, but unfortunately they just brushed me off and ignored my concerns.

Complainants commonly use the words "distress" and "trauma" in relaying these emotions in the same manner as a victim impact statement in a criminal prosecution, but in this context it seems to be offered as a measure of credibility regarding the seriousness of the behaviour. A particularly striking example of emotional content is provided in one of our narrative analyses in the report. The case highlights a marked gap in perception and experience

between the wife of a dying patient and the out-of-hours doctor who answered the call to provide assistance to the patient at home. There are numerous descriptions in the complainant's account of the events that she alleges occurred during the house visit which are replete with grief and distress, with accounts of ongoing trauma and anger towards the doctor. For example, "words cannot ease the pain that was her responsibility as she was the doctor on call," and, "I can't grieve for my husband, I can't let go. The anger towards that woman is eating me up." The possible contribution of such emotional styles of communication to the unfair treatment of some complaints is worth considering, given the privileging of impersonal third-person reports and data in many medical settings and the assumption that emotions are incompatible with cognitive reliability (Carel and Kidd 2014). Testimonial injustice can be regarded as occurring if the credibility of the complainant is discounted because they are identified as being emotional, but also hermeneutical injustice can be seen to occur if their emotional evidence is deemed unintelligible. Furthermore, the emotional content of complaints may also point to epistemic incommensurability, where complainants and the Medical Council have incompatible interpretations of what constitutes evidence of poor professional performance or misconduct, a point we return to below.

The Symbolic Power Explanation

Having been informed of the Medical Council's decision not to refer their complaint to a Fitness to Practice Inquiry, a group of family members wrote to the council, stating,

> … may we respectfully suggest that if the committee found [doctor's] conduct to be acceptable and within the guidelines … then perhaps it is time the guidelines were reviewed, improved and vigorously implemented in order to protect the vulnerable people in our society."

What is being called into question here is the institutional definition of professional misconduct and matters of concern in the Medical Council's guidelines, which is the focus of our third explanation.

In Pierre Bourdieu's (1989, 20) sociological theory of power, he distinguishes symbolic from other forms of power, using the concept to refer to the power to construct "the legitimate vision of the social world" or common sense "categories of perception, the schemata of classification, that is, essentially, the words, the names which construct social reality as much as they express it." The concept has been used extensively to address questions of power, politics, and inequality and, specifically, practices of naming and defining situations. In analyses of the symbolic power of the medical profession, much emphasis has been placed on

the power to define, name, categorize, and diagnose illnesses but also on the practices of resistance of some patients' organizations (Crossley 2004). Using these ideas, the symbolic power explanation for the dismissal of the vast majority of complaints submitted by members of the public as not warranting an inquiry highlights the marginalization of members of the public from meaning-making in medical professional regulation and the defining of professionalism. The quotation above from the dissatisfied complainants can be seen as an instance of symbolic struggle and a call for a transformation in the Medical Council's categories of perception of professionalism. The institutional difficulty appears to be that many complaints from members of the public did not relate to matters of concern or present sufficient evidence within the terms of the Preliminary Proceedings Committee, but the public is marginalized from the definition of those terms. Likewise, many complaints did not meet the criteria for serious fitness-to-practise concerns, but complainants have little opportunity to contribute to the definition of those criteria.

The suggested injustice here is that there is no adequate process for dealing with complaints—many of which we found very disturbing to read—relating to issues that complainants define as matters of concern, frequently concerning poor communication and lack of respect and empathy. Time and time again, poor communication with patients and their families has been found to be at the core of what goes wrong in medicine (Parliamentary and Health Service Ombudsman 2011). It appears that the medical profession has prioritized matters of technical competence and not adequately recognized communication, respect, and empathy as decisive aspects of professional conduct or as crucial matters of fitness to practice. Indeed, how poor communication can be enmeshed with multiple other causes of concern is illustrated in the extract below from our review in which a complaint about a delayed diagnosis raised concerns about the doctor not listening, not taking the patient's concerns seriously, rushing the consultation, and failing to conduct a full examination:

> I understand that [medical condition] is very difficult to diagnose, but I feel [Doctor] did not listen to me or take any of my complaints seriously. Had she taken the time to fully examine me and listen to what I was telling her or sent me for a simple blood test or scan, a lot of this could have been avoided. I understand it could not have been prevented but I would have less of the complications I have now ….

There is by now a substantial literature on the importance of questioning common sense understandings of professionalism within the context of medicine. For example, writing from the U.S. context, Wynia et al. (2014, 712) argue that "health professionals must come

together to continually define, debate, declare, distribute, and enforce the shared competency standards and ethical values that govern their work". However, the symbolic power explanation that we offer for the dismissal of many complaints by medical regulators suggests that patients and other members of the public must be included in such ongoing debates about the definition of professionalism but also the definition of other categories of perception such as "trivial" and "serious" complaints. Undoubtedly this would present significant challenges, such as clarifying the credibility and authority that should be accorded to patients' experiential knowledge relative to doctors' professional knowledge (Blume 2017). However, greater inclusion of the public in such fundamental meaning-making appears to be crucial to working towards genuinely collaborative models of regulation in which there is a greater possibility of developing shared expectations and understandings about what can and should trigger regulatory action. Such remedies recognize that attention to symbolic power is an essential part of a new politics of medical regulation.

Conclusion

In addition to the conventional explanation that emphasizes deficits in public knowledge, in this article we have considered other possible explanations for why so few complaints submitted by members of the public are referred to an inquiry by medical professional regulators. One of these suggests that due to their identity and how they communicate, processes of epistemic injustice may contribute to the credibility of some complainants being unfairly discounted. Another explanation suggests that the dismissal of most complaints from members of the public may point to incommensurable understandings of what constitutes professionalism and evidence of professional misconduct and to regulatory regimes that unfairly confer the medical profession with considerable symbolic power to define these matters. These explanations are offered in a spirit of raising questions and offering alternative ways of thinking about the outcomes of the Medical Council's complaints process. Many theoretical and empirical questions remain, not least about the remedial actions suggested by each of the explanations. Some such remedial actions may be relatively straightforward, such as better public dissemination of regulatory knowledge. Others, however, may require profound change in medical regulators' institutional thinking, such as going beyond thinking about emotional evidence as an oxymoron. Most challenging of all, however, are remedial actions aimed at ensuring socially disadvantaged complainants and those with limited cultural and symbolic power are heard and have their complaints taken seriously.

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