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ARTICLE

Revisiting the Concept of Voice: Expression of Grievances across the English and Welsh National Health Service

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Abstract

This article reexamines the notion of voice in law and society scholarship, which has focused on journeys to complaints and claims. Using the English and Welsh National Health Service as a case study, it argues that looking at the articulation of grievances through a large number of channels across a large service sector offers new opportunities to examine a range of different political logics underpinning voicing mechanisms. Two key arguments emerge. First, it becomes clear that expressions of dissatisfaction can be collected for a variety of purposes other than dispute resolution or conflict management. Formal grievance procedures, rendered legitimate by concepts of rights and due process, not only interact with but compete with other ways of serving the collective good. The second key finding is that when looked at in isolation, the concept of voice can usefully be studied as a discrete concept rather than just a vital component of claiming.

Keywords: Social media; Voicing; evolution of disputes

Introduction

Unraveling the evolution, dynamics, and transformation of grievances and disputes is a major concern of law and society scholarship. Important work produced from the 1980s onward has encouraged us to look beyond courts to explore the antecedents of both justiciable and nonjusticiable disputes (Fitzgerald and Dickens 1980–81; Felstiner, Abel, and Sarat 1980–81). This research has acknowledged that potential claims voiced to lawyers by citizens are just the tip of an iceberg of justiciable grievances (Best and Andreasen 1977; Millar and Sarat 1980–81) and law and society scholars have turned to examine complaints procedures and alternative and informal dispute resolution systems as a result. Concepts such as "perceived injurious experiences," "naming, blaming, claiming," and "lumping it" are now well-understood terms of art that reflect an essentially backward approach to the study of grievances. Not only does scholarship in the field continue to focus on legal institutions, but it also focuses on examining discrete dispute resolution procedures (see for instance Olesen and Hammerslev 2023a). This article considers how our understanding of grievances is enriched if we broaden our lens of inquiry to examine multiple systems for the expression of grievances that exist in one service sector and foreground the act of voicing rather than resolution or settlement. Two key arguments emerge as a result. First, plotting out a broader panorama of opportunities to voice grievances reveals that systems that focus on rights and due process often jostle for legitimacy with systems underpinned by a different logic and that seek to address systemic problems. Second, that foregrounding voicing allows researchers to see it as a discrete act rather than something that is just a stage in a linear process involving responses, investigations, abandonment, and resolution.

"Voice" and the act of "voicing" are being widely discussed across disciplines. Indeed, some scholars claim that the "vocal turn" now rivals the linguistic and visual turns of the latter part of the twentieth century (Feldman and Zeitlin 2019; Kreiman 2019). Within this burgeoning field social scientists have long been most interested in the social and political dynamics of voice (see for instance Hirschman 1972). Viewed from this perspective, understandings of voice go beyond the phonic utterance to consider the function of voice as a metaphor and metonym for selfhood, sovereignty, identity, individuality, and agency. Broadly conceived, voice is seen as a signifier of presence and an act of self-conscious subjects who are able to articulate their views, needs, and desires. More particularly, feminists, queer theorists, and postcolonial scholars have also drawn our attention to the importance of recognizing silence and epistemological oppression as dominant hegemonic discourse can undermine the possibility of voice or its impact (see for instance Colgan and McKearney 2012; Crenshaw 2013).

Voice has also been seen as critical to law and society scholarship on disputes, not least because the articulation of a grievance is the only way to activate legal rights, engage with the legal system, or force a response from an opponent. Felstiner, Abel, and Sarat's (1980–81) work, and the broader Civil Litigation Research Project from which it drew, famously explored the threshold between voice and silence as well as the impact of audiences on what is voiced (Mather and Yngvesson 1980). Research into unmet legal need has developed this theme further by exploring the prevalence of injurious experiences and the reasons why they are not voiced to lawyers or the legal system (Lloyd-Bostock and Mulcahy 1994; Genn 1999; Pleasence, Balmer, and Sandefur 2013; Pleasence and Balmer 2018). Scholars have also considered how we encourage voicing on the subjects' own terms rather than translating it into something understood by state institutions (Ewick and Silbey 2009; Darder 2018). However, the focus of all these studies continues to be on use or nonuse of legal systems rather than an analysis of other avenues for voicing grievances that sit alongside the legal system.

The research project reported here draws on a large-scale review of voicing mechanisms in the English and Welsh National Health Service (NHS). It examines data on satisfaction, dissatisfaction, grumbles, grievances, complaints, and legal claims during one year, 2018.[1] The article draws on a variety of sources, including complaints systems, satisfaction surveys, and blogs designed to gather information about patient experiences or the litigation system. In order to differentiate it from the nomenclature of the legal system, I treat voicing as distinct from the concept of claiming, with all its associations with evidence gathering, advocacy, and requests for certain types of redress. Instead, voice is treated as the articulation of dissatisfaction to a formal state-sanctioned system designed to collect such utterances. This provides an opportunity to examine the multitude of opportunities to voice concerns across a large public sector service. In doing so it adopts a bottom-up or forward-looking focus in which the emphasis is on the panorama of options available to service users when they become aggrieved rather than an exploration of why they did not make a legal claim.

These issues are explored by reference to the UK NHS, which provides a rich case study to look at these issues. This publicly funded health care system provides clinical services to the majority of the UK population and collects a remarkable wealth of data. A typical day in the life of the NHS includes over 835,000 people visiting their community-based doctor's practice (General Practitioner) or community-based nurse; forty-nine thousand outpatient consultations in hospitals; ninety-four thousand people admitted to hospital as an emergency admission, and thirty-six thousand people in hospital for planned treatment.[2] With over 1.3 million staff, the NHS is one of the largest employers in the world, and the biggest in Europe. Government funding for NHS patients accounts for 78 percent of total UK health care spending (Office for National Statistics 2018).[3] Most importantly, the NHS also has a large number of avenues for the collection of voiced grievances beyond litigation. In line with the general rise of the risk society in the West (Beck 1992), the NHS claims to have a proactive approach to encouraging feedback about performance,[4] which can be used to inform policy as well as facilitating the monitoring and improvement of care.[5] It is worthy of note that risk- and quality-management systems that focus on the identification of near misses and systemic failures are a much more prominent feature of public sector organizations than was the case when scholars were conceptualizing grievances and disputes in the 1980s. Moreover, while the NHS is a unique case study, many of the arguments relating to the emergence of quality- and risk-management systems as possible alternative to formal complaints and claims are equally relevant to medical systems outside of the United Kingdom. It is not the

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[1] This year was chosen because up-to-date data on all the systems discussed below was available.

[2] https://www.jobs.nhs.uk/about_nhs.html.

[3] Government-financed health care expenditure was £166.7 billion in 2018 (Office for National Statistics 2018). In 2015 only 10.5 percent of the UK population had taken out private voluntary health insurance (Thorlby 2020).

[4] For instance since 2009, under the The Local Authority Social Services and National Health Service Complaints (England) Regulations, NHS providers must ensure that action is taken if necessary in the light of the outcome of a complaint. They are also required to prepare an annual report on complaints, which must be available to any person on request and include where action has been/is to be taken to improve services as a result of complaints.

[5] See further NHS Digital. https://digital.nhs.uk/.

intention of this article to comment on how well current avenues for the expression of grievances fulfill their role, but rather to draw attention to the shifting logics underpinning them.

The sections that follow start with a discussion of law and society research that has attempted to plot out the territory of voicing, avoidance, grievances, and dispute resolution. This is followed by a short description of the methods and data sets relied on in this article. The next three sections present the data collated for this study. The first maps out the various systems for voicing dissatisfaction across the NHS and the number of concerns received by each avenue in a given year. The second section examines the different logics underpinning each of these systems and the ways in which innovation has been fueled by a failing faith in the legal system in recent decades. The third section discusses the ways in which alternatives to dispute resolution systems have made apparent the importance of looking at voice as a discrete concept that is independent of notions of claims, disputes, or resolution.

Approaches to grumbles, grievances, and disputes in the existing law and society literature

Sociolegal scholars have a long-standing interest in the origin and transformation of disputes that can be traced back to the work of legal anthropologists (see for example Llewellyn and Hoebel 1941; Hoebel 1954; Gluckman 1955; Gulliver 1963; Nader 1969; Nader and Todd 1978; Roberts 1979). Two particular approaches are of relevance in the present context. The first focuses on the journeys that people make to voice and the factors that deter many people from voicing their grievances. In recent decades the naming, blaming, claiming model conceived of by Felstiner, Abel, and Sarat (1980–81) has been particularly influential (Albiston, Edelman, and Milligan 2014; Olesen and Hammerslev 2021, 2023a, 2023b). This model offers a seductively simple framework for understanding complex journeys toward the voicing of a grievance while also characterizing grievances as complicated, subjective, unstable, reactive, and incomplete. The model, which Kritzer (1991) has since labeled the developmental theory of litigation, includes several basic elements. “Naming” refers to the emergence of a “perceived injurious experience” (PIE) or subjective belief that something has gone wrong. It is possible to name without getting to the next stage of “blaming.” A person may, for instance, believe that the injurious experience is their fate or a divine punishment. When fault is attributed to a person or institution, naming transforms into blaming. “Claiming” occurs when the person injured articulates their concern to the person or institution they hold responsible *and requests a remedy*. In their discussion of the agents of transformation, Felstiner, Abel, and Sarat (1980–81) argue that the propensity of someone to name and blame is dependent on a wide variety of factors such as personality, beliefs, objectives, prevailing political ideologies, reference groups, and gatekeepers (see also Mather and Yngvesson 1980; Engel 1984; Greenhouse, Yngvesson, and Engel 1994). Progression from blaming to claiming may be rendered unlikely because of fear of retribution, lack of resources, reservations about the likelihood of compensation or redress, and the availability of help and legal representation (Kritzer 1991). This frequently leads to people failing to pursue their complaint or claim, an action that has become known as “lumping it” (see for instance Nader and Todd 1978; Engel 2010).

The influence of this model has been considerable. In their recent celebration of the publication of "Naming, Blaming, Claiming," Olesen and Hammerslev refer to it as one of the most cited and influential sociolegal articles ever produced (2021, 295; see also Olesen and Hammerslev 2023a, 2023b). The conceptual framework it provides has been used to structure a variety of research projects in numerous contexts using a range of empirical methods. These include an analysis of public debate about oil-induced social change in Niger (Schritt 2020), antigay campaigns (Wiethoff 2003), sexual harassment in the Australian workplace (Charlesworth, McDonald, and Cerise 2011), how civil justice is perceived in popular culture (Sarat 2000), and a study of lawyers with disabilities (Harpur 2014).

The naming, blaming, claiming model is not without its critics (Kritzer 1991). Some have suggested that disputes do not necessarily evolve in the order outlined, arguing that people are often forced to claim before they have sufficient information to attribute blame. This has led Lloyd-Bostock (1991) to argue that the linear nature of the model confuses sequences of reasoning and logic with actual temporal and causal sequences in the formation of beliefs, decision making, and action. In a similar vein, Olesen and Hammerslev (2023a) have argued that people constantly (re)name, (re)blame, and (re)claim in ways that do not fit neatly with the notion of a chronology. Others have argued that the notion of "lumping it" suggests a moral imperative to claim and serves to marginalize positive decisions to avoid voicing or disputing because it would disrupt family life or cause psychological turmoil (Mulcahy and Tritter 1998). It is also the case that by focusing on how grievances do or do not become legal disputes, the model devalues forms of voicing that do not result in a claim. This latter point has given rise to a significant number of studies that have reacted against this court-centric approach and sought to discover levels of unvoiced and unmet legal need (see for instance Genn 1999; Pleasence, Balmer, and Sandefur 2013; Flynn and Hodgson, 2017; Pleasance and Balmer, 2018).

Reflecting on the motivation behind the construction of a linear pathway with a specific point at the end, Austin Sarat has admitted that the model reflected the political concerns of the 1970s:

> Regarding PIEs and unPIEs, we were also really interested in the normative dimension; it obviously contains the view that this unPIE *ought* to be perceived. So there was a kind of normative spin to the work that wasn't fully articulated, and again both Rick and Bill named it with reference to this kind of access to justice where people needed to get justice that they were not able to get. They needed to be able to articulate grievances that they were not able to articulate. (Ole and Hammerslev 2021, 301)

To which Rick Abel added:

> In a sense, we were dealing with the Marxist concept of false consciousness . . . . They *had* to be made aware of their needs, and then the revolution would come and everything would be good. (Ole and Hammerslev 2021, 301–02, emphasis added)

Others have paid more attention to a broader range of outlets for voice, and this has helped to shift the focus away from unilinear explanations of dispute resolution trajectories. Most notably, Albiston, Edelman, and Milligan (2014) have called for replacing the pathway metaphor with that of a tree. Their approach takes into account a myriad of avenues for the voicing and resolution of grievances besides the courts,[6] with the branches of their metaphorical tree representing each distinct system, each of which might have different goals and remedies. Albiston, Edelman, and Milligan (2014) extend their metaphor further when they talk of a forest in which each tree represents a different sort of dispute such as contracts or discrimination and reason that different forests might represent public and private forms of ordering. What most obviously distinguishes their work from the naming, blaming, claiming model is their focus on broader structures for the resolution of disputes as opposed to individual journeys. In their words:

> The dispute tree metaphor moves the inquiry away from focusing on the individual's trajectory up the pyramid toward theorizing the role of structural processes that shape dispute resolution more generally. In other words, the tree metaphor not only invites questions about whether and how individuals climb a given tree but also examines the conditions under which a particular tree and its many branches will flourish or die. It also sweeps more broadly to consider the overall health of the forest as well as individuals' paths through that forest. (Albiston, Edelman, and Milligan 2014, 109)

The sections that follow seek to rise to the challenges posed by Albiston, Edelman, and Milligan (2014) by looking at opportunities for the voicing of grievances about the NHS, the different logics that underpin each of them, and the ways in which each system attempts to legitimize its distinctive approach. It also moves beyond they model they propose by moving beyond the focus on dispute resolution to voice. In doing so, it suggests that those using the systems may not want to progress to a dispute and see voicing as an adequate end in itself, or even a success.

Methods

The data relied on in this article take a number of forms. The first is large data sets from three sources from across the NHS held by the NHS Digital, the statutory body for health and social care data for England.[7] This includes data on complaints and patient satisfaction surveys. The second is data from the websites of various bodies with responsibility for overseeing the quality of care provided by the NHS including the Parliamentary and Health Service Commissioner and a number of self-regulatory professional bodies such as the General Medical Council (GMC) and the Nursing and Midwifery Council. The third source of secondary data is NHS Resolution, an "arm's length body" of the Department of Health and Social Care removed from direct

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[6] They refer to this as "DROL" or dispute resolution outside the litigation process.

[7] These data can be accessed through their website. See https://digital.nhs.uk/about-nhs-digital.

Ministerial control, which among other things manages all the legal claims against the NHS.[8]

Additional data, not available to the public, was donated to a team of researchers the author works with at the National Institute for Health Research–funded Quality, Safety and Outcomes Policy Research Unit, which has funded this research.[9] This includes data from one Patient Advice and Liaison Service (PALS) unit. PALS were set up in 2002 to deal with informal concerns and there is currently a PALS service in every NHS trust.[10] This makes them critical sources of information about the voicing of grievances that may or may not end up in formal systems. Unfortunately, there is no national data on who uses PALS, with the result that every unit collects and reports data in different ways. This makes the extensive data set collected by one unit, and made available to the project, extremely valuable. Though from only one out of 219 trusts, the data helps to make clear the contingent nature of much initial voicing in the NHS.[11]

One final data set collected all the posts on an NHS social media site called NHS Review, which invited both negative and positive evaluations about the quality of care in 2018.[12] The website has a page for each of its trusts, hospitals, and clinics, all of which include a "ratings and review" tab, where people can post comments, provide a numerical star rating, and view all the posts left by others within the last two years.[13] Subject to policies on posting (people cannot mention the names of staff or other patients or make political comments), there are few constraints on what people write and users are neither required to attribute fault nor request a remedy.[14] Opinions can also be posted anonymously, making it easier for those who might otherwise "lump it" or tone down their criticisms for fear of retribution to express themselves. In the interest of exploring the ways in which social media posts voluntarily offered up by service users differ from the feedback received through surveys, complaints, and claims, we downloaded a sample of 979 posts about forty-three hospitals and 180 community health care providers in one health care region between April 2018 and March 2019. This was the same health care region for which we had the PALS data referred to above. Posts varied from eleven to five hundred words with most being in the region of two hundred words. A content analysis was undertaken using an inductive coding framework developed for the project.

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[8] See https://resolution.nhs.uk/.

[9] The Quality Safety and Outcomes Policy Research Unit is a collaboration between the Universities of Kent and Oxford, the London School of Hygiene and Tropical Medicine (LSHTM), the Picker Institute, and Hull-York Medical School. It is funded by the NIHR from January 1, 2019, for five years. See https://www.qso.ac.uk/.

[10] An NHS trust could be one hospital or a collection of health care providers.

[11] See https://bmjopen.bmj.com/content/11/11/e053239. Our thanks go to Keegan Sheperd and the PALS service involved for allowing us to use this data.

[12] See https://www.nhs.uk/services/independent-provider/provide/X3446/leave-a-review. Another site considered is Care Opinion, but this was rejected for this study as all posts are mediated and curated by the owners of the site. See https://www.careopinion.org.uk/.

[13] https://www.nhs.uk/services/independent-provider/provide/X3446/ratings-and-reviews.

[14] Comments are screened before they are published to ensure they are not abusive and do not contain personal details. Moderators remove contributions that are unlawful, harassing, abusive, threatening, obscene, sexually suggestive, racist, homophobic, or sexist, or that incite or promote hatred of any group or individual.

A Carcophony of voices? mapping and quantification of opportunities to voice across the nhs

NHS service users have a multitude of opportunities to voice dissatisfaction about care that they have received or failed to receive. The main avenues are medical negligence claims; a formal complaints procedure; an external and independent complaint appeals system operated by the Parliamentary and Health Service Commissioner (PHSO); the initiation of fitness-to-practice procedures run by professional regulators; informal complaints at service level to Patient Advice and Liaison Service units; adverse event reporting systems; dissatisfaction surveys; and NHS-sponsored social media outlets.[15] Albiston, Edelman, and Milligan's (2014) tree metaphor works well in this context, not least because the notion of different branches representing alternative systems, criteria for use, procedures, and remedies works well in a sector like the NHS in which numerous routes for the expression of grievances exist (see Figure 1).

Examining the operation of each of these systems enhances our understanding of the broader context in which voicing occurs. At one level, the holistic approach adopted allows us to quantify the number of potential disputes rather than just those that become visible in dispute resolution systems. But it also allows identification of the ways in which disgruntled patients might go beyond the use of one system and consideration of levels of satisfaction that exist alongside dissatisfaction with NHS care.

Medical Negligence Claims

NHS Resolution has reported that 14,263 potential claims were notified to them by patients or lawyers in 2018. Of these, 4,482 (31 percent) moved to the end of the naming, blaming, claiming trajectory and became formal legal proceedings (NHS Resolution 2018–19). Among the minority who decide, or are able, to take legal action, rates of attrition are high. Some claims are abandoned by patients when an explanation is offered by a health care provider or compelling evidence refuting a claim is presented to them. In other instances, claims are settled very quickly by the defendant when the evidence against the NHS is clear, or the case is of a type that is notoriously difficult to defend, such as cases regarding failed sterilizations or retained surgical instruments. In 2018, just 120 cases against the NHS, out of over fourteen thousand notified to NHS Resolution, ended up at trial (see Figure 2 below).

Other sources of data reveal something of what happens before NHS Resolution are even notified of a potential claim. The UK Association of Personal Injury Lawyers has reported that lawyers turn away up to 85 percent of the potential medical negligence claims that come through their door after undertaking an initial screening

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[15] Other systems such as the The Medicines and Healthcare Products Regulatory Agency were considered for inclusion in this list but on further examination feedback from patients appears to play little or no role in the way they operate. For instance, their annual review of Good Clinical Practice referrals for 2020 shows that only two out of seventy-nine referrals were made by members of the public. See https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1048975/Annual_review_of_MHRA_good_clinical_practice_referrals_2020.pdf. The office of the coroner was also considered. Anyone who is unhappy about the cause of a death can inform a coroner about it, but in most cases a death will be reported to a coroner by a doctor or the police.

Figure 1. Using Albiston et al.'s (2014) Tree Metaphor to Map Systems for Voicing Perceived Injurious Experiences in the NHS.

(Association of Personal Injury Lawyers n.d.).[16] Elsewhere, the UK-based Society of Clinical Injury lawyers have reported that their membership, which is made up of experienced lawyers, currently filter out one hundred thousand clinical negligence cases per year on a pro bono basis. On the basis of their experience, they have concluded that only 3 percent of all cases that reach them are actionable.[17]

Other scholars have been able to provide an indication of the number of unperceived injurious experiences that underpin these statistics. Charting the journey from unperceived injurious experience to perceived injurious experience is usually so complex that it is rarely attempted by sociolegal scholars. Unperceived injurious experiences are by their very nature often invisible, making them simultaneously part of a critical transformation for us to study while also being the most difficult and costly to research. Cost is less of an issue in high-risk sectors such as health care or aviation where the potential human and financial costs of adverse events can be considerable. This has made it worthwhile to search out these data and led to considerable efforts being devoted to identifying the incidence and types of mistakes made in health care settings. Data for 2018 is not available, but the US-based Harvard Medical Practice Study conducted in the 1990s set the standard by which adverse events in medicine are identified[18] and its methodology has been copied in similar studies around the world (Brennan et al. 1991; Wilson et al. 1995, 1999;

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[16] See https://www.apil.org.uk/files/campaigns/medical-negligence-brochure.pdf. This document is not dated but the footnotes contain a reference to a freedom of information request lodged in 2015, suggesting that the document was produced after that.

[17] Access to Justice section: https://www.scil.org.uk/campaign. Last visited January 2021.

[18] An adverse event was defined as an injury resulting from medical treatment, as opposed to the underlying disease process, that prolonged a patient's hospitalization, caused disability at the time of discharge, or both.

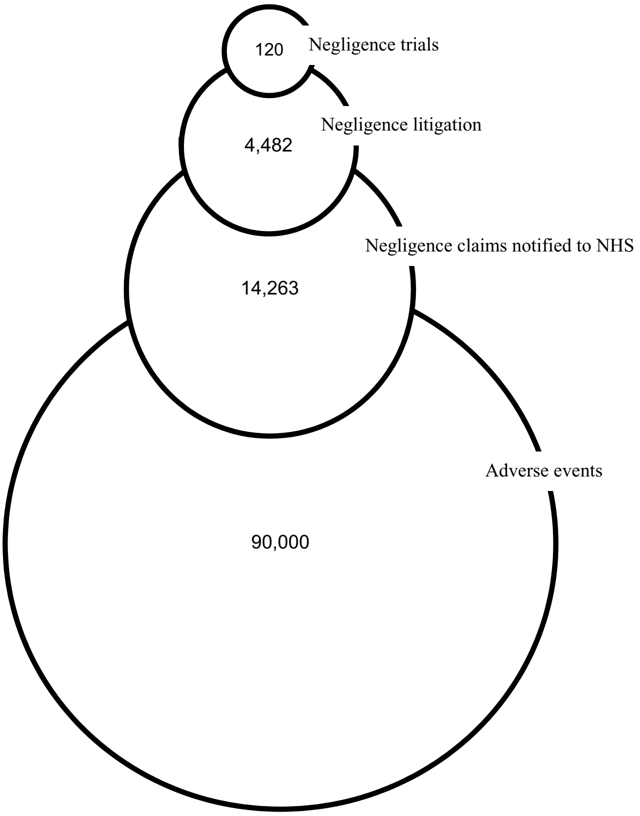

Figure 2. The Number of Medical Negligence Claims and Potential Claims in the NHS 2018.

Schiøler et al. 2001; Vincent, Neale, and Woloshynowych 2001; Davis et al. 2002; Baker et al. 2004; Mendes et al. 2009) including the United Kingdom (Vincent, Neale, and Woloshynowych 2001). The Harvard study of over thirty-two thousand medical files discovered a ratio of adverse event to malpractice claim of 8:1. A similar disparity between the number of injurious experiences and the small number of people who pursue a medical negligence claim has been demonstrated in the United Kingdom. Using estimates from the United States and United Kingdom, Towse and Danzon (1999) estimated that there were ninety thousand adverse events per annum in the United Kingdom, of which 13,500 involved the death of patients; resulting in just seven thousand claims (8 percent) and two thousand payments (2 percent).[19] Gray et al.'s (2017) more recent longitudinal study focused on the frequency and severity of *perceived* adverse events in Great Britain over a twelve-year period using a total

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[19] Vincent, Neale, and Woloshynowych's (2001) pilot study of 1,014 medical and nursing records in two acute hospitals in the Greater London area found that 110 patients (11 percent) experienced an adverse event. About half of these events were judged preventable if ordinary standards of care had been employed and a third led to moderate or greater disability or death. See also Sari et al. (2007).

sample of just under twenty-eight thousand patients. The proportion of respondents reporting that they had suffered some illness, injury, or impairment that in their opinion was caused by their medical treatment or care was 2.5 percent in 2013, compared with 4.8 percent in 2001. The proportion of respondents who pursued a legal claim for financial compensation stood at 11 percent in both 2013 and 2001. These data reveal the size of the iceberg of adverse events and PIEs sitting below the surface of the legal system and provide important baseline data about the number of cases that might give rise to claims capable of being evidenced.

Professional Regulators, the Ombuds, and the NHS Complaints Procedure

Systems for the management of clinical negligence claims sit alongside other formal dispute resolution procedures in the NHS (see Figure 1), all of which are free to use and do not necessarily require the input of a lawyer.[20] The most restrictive of these procedures are those overseen by professional regulators (licensure boards) and are primarily concerned with whether a clinician has done something that renders them unfit to practice. The total number of complaints made to professional regulators responsible for determining whether a health care professional is fit to practice was 20,963 in 2018. The vast majority of these were directed to the General Medical Council (8,573) and the Nursing and Midwifery Council (5,373). Of these, just 1,614 (8 percent) were heard by a professional misconduct committee with the powers to strike a professional off a register, though warnings and advice can be issued to practitioners without the case having to go through to a full tribunal (see Figure 2).

The Parliamentary and Health Service Commissioner, or Ombudsman (PHSO), has a much broader role than the professional regulators. It is a public body that sits outside of the NHS but is able to review formal complaints that have not been resolved in the NHS complaints procedure discussed below.[21] In 2018, 5,658 complaints to the PHSO resulted in a review of how well the NHS had handled the complaint at service level (see Figure 2) (Parliamentary and Health Service Ombudsman 2018–19). The NHS formal complaints procedure has an even broader remit since patients and their carers have the right to make a complaint about *any* aspect of NHS care, treatment, or service.[22] Given its broad ambit, it is not surprising that the system is used much more frequently than other avenues. In 2018 it received and responded to 110,700 complaints (see Figure 3).

Despite the fact that the NHS formal complaints system and the PHSO are much easier to access than the litigation system, there is some evidence that health care users remain reluctant to voice grievances through complaint systems. In a large qualitative study in the United States, which evaluated the use of a predischarge complaint surveillance program, 1,233 patient interviews identified 695 instances of dissatisfaction, of which only twelve formed the basis of a formal complaints (Garbutt et al. 2003).

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[20] For the statutes underpinning these three schemes see for instance the Hospital Complaints Procedure Act 1985, Parliamentary and Health Service Commissioners Act 1987, and the Medical Act 1983.

[21] https://www.ombudsman.org.uk/.

[22] In addition to being required by the Hospital Complaints Procedure Act 1985, this right is also contained in the NHS Constitution. See https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england.

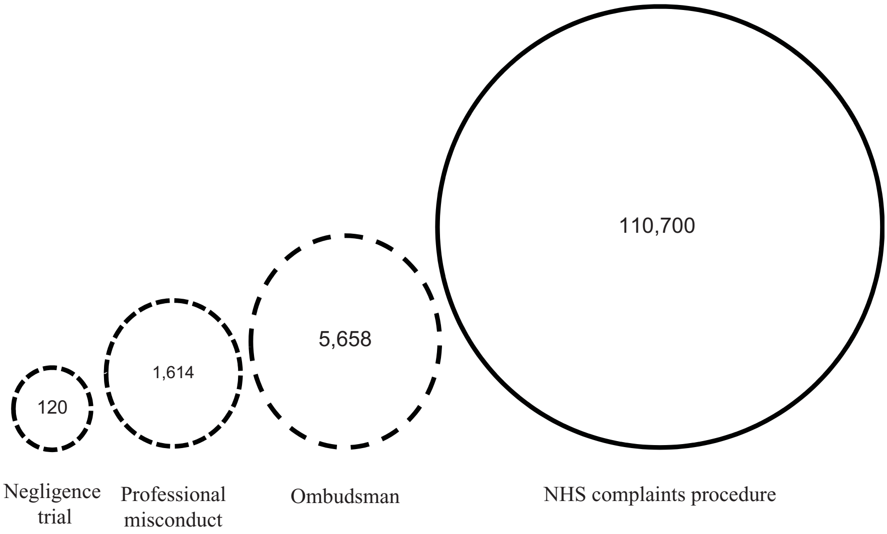

Figure 3. To Show the Number of Grievances Voiced in Formal Channels Other than Litigation.

In a UK context, a door-to-door survey of 1,637 householders found that while 860 expressed dissatisfaction with some aspect of the NHS care they had received, only 326 had voiced their concerns at service level or written to their health care provider. Only 134 viewed their action as making a formal complaint and just three of those interviewed made a legal claim (Mulcahy and Tritter 1998). There are many reasons why a common reaction to naming and blaming is silence. Service users may be nervous about the repercussions of complaining to a practitioner they have a long-term and dependent relationship with; they may fear stepping "out of role" by challenging professional workers; or their concerns may be suppressed, hidden, or ignored by busy or defensive staff (Mulcahy 2003).

Significantly, looking at parallel systems for the voicing of grievances reveals the potential for patients and their carers to be "bounced" between systems or the branches of Albiston, Edelman, and Milligan's (2014) tree (see Archer et al. 2014). By way of example, in 2018 the PHSO received 112,262 "enquiries" from the public about making a complaint. Of the 29,841 that came within their jurisdiction, 24,183 were rejected, often because the complainant had not gone through the NHS complaints procedure first. The GMC has also expressed concerns about the number of potential complainants who approach them about issues they do not have the capacity to consider. Of the 20,963 complaints made to professional regulators in 2018, just 1,614 (8 percent) got through to a hearing before a professional misconduct committee with the powers to strike a professional off the fitness-to-practice register. The GMC has also expressed concerns about the constant need to redirect complainants to another more appropriate complaint handler. There is no way of knowing whether those diverted to another system make it there, but it seems likely that being turned away by one complaints handler has considerable potential to exacerbate the original sense of grievance and alter thresholds of tolerance in ways that will be significant for the system in which the grievance eventually lands. These factors suggest that looking at complaints procedures across a sector provides fertile ground to understand the many and complex journeys that people make to voice their concerns.

Satisfaction and Dissatisfaction Surveys

It is a common tendency for law and society scholars interested in disputes to focus on negative evaluations of services and in doing so to orient research away from the equally important task of studying social resilience rather than legal actors (Felstiner, Abel, and Sarat 1980–81; Ole and Hammerslev 2021). The availability of large NHS data sets and the organization's interest in positive as well as negative evaluations of care provide an important opportunity to place grievances in a broader social context. Proactive approaches to seeking out concerns are highly significant to law and society scholars because of their potential to remove some of the structural, cultural, and knowledge-based barriers to voicing grievances that exist in reactive systems for the management of complaints, legal claims, or fitness-to-practice procedures. This suggestion is reinforced in a study by de Vos, Hamming, and Marang-van de Mheen (2018), which found that patients who are reluctant to file a formal complaint are more inclined to report their concerns in a patient survey.

The proactive approach to gathering positive and negative evaluations of care manifests itself in a number of different ways in the NHS, but patient satisfaction surveys are of particular value in this context.[23] When looking at the extensive range of NHS surveys, each with their own particular approach, it is important to acknowledge that expressions of satisfaction and dissatisfaction are complex and volatile evaluations of service provision that raise a host of methodological issues. Surveys often suffer from a lack of agreement about what constitutes a satisfactory service, and others have argued that satisfaction and dissatisfaction should be seen as different phenomena rather than opposites (Judge et al. 1992; Coyle and Williams 1999; Lee et al. 2010). One example of the complexity surrounding such studies is that in spite of claims about rising levels of dissatisfaction, the British public consistently show considerable loyalty to the NHS as a public institution (Calnan 2000), with dissatisfaction being linked to low levels of funding by the government rather than

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[23] For example, the Care Quality Commission is responsible for setting and monitoring standards, registering care homes, and inspecting an extensive range of health and social care providers. This includes hospitals, community doctors, dental practices, hospices, ambulances, and prisons. Their patient-facing work involves inspectors talking to patients and carers during site visits as well as reviewing complaints and feedback forms on their national website. See https://www.england.nhs.uk/publication/patient-experience-improvement-framework/. Other NHS initiatives that aim to collect data on positive and negative experiences of health care provision include patient access to systems for recording adverse incidents (see https://www.england.nhs.uk/patient-safety/learn-from-patient-safety-events-service) and Patient-Led Assessments of the Care Environment, which involve local Patient Assessors going into hospitals as part of teams to judge how the environment supports the provision of clinical care (see https://digital.nhs.uk/data-and-information/areas-of-interest/estates-and-facilities/patient-led-assessments-of-the-care-environment-place). Patient satisfaction is also evaluated in the British Social Attitudes Survey, the Ipsos MORI "Public Perceptions of the NHS and Social Care" survey, and the Friends and Family Test reported in this section. It is evident from all these studies that patient satisfaction fluctuates over time and that rates vary considerably when one looks at evaluations of particular services.

poor care (NatCen 2015). Nowhere is this broader context more evident than during national elections when any political party advocating a reduction in NHS funding or privatization of the service does so at their peril. Klein (1980) identified the importance of loyalty as an alternative to voice and exit in a commercial setting some decades ago, but it is clear that loyalty is also an important concept in understanding the dynamics of dissatisfaction, complaining, and claiming in a UK health care context.[24]

Despite these reservations, satisfaction surveys provide us with a starting point to grapple with this largely uncharted law and society territory. Of the various patient satisfaction surveys conducted by the NHS, the Friends and Family Test attracts the largest number of anonymous evaluations of satisfaction levels, with nearly 10 million reviews now provided on an annual basis by recent users of the NHS.[25] Indeed, it has been claimed that the "test" aims to be the "biggest source of patient opinion in the world" (Robert, Cornwell, and Black 2018). Data from 2018 shows that, when 9,636,197 users were asked how likely they were to recommend the NHS service they had used to friends or family if they needed similar care or treatment, 311,979 or just 3 percent of survey participants were unlikely or extremely unlikely to do so.[26] A further 8,913,910 or 93 percent indicated that they were either extremely likely or likely to recommend the service to others.

The Friends and Family Test has been criticized for being a vague measure of satisfaction and one that tends to find much higher levels of satisfaction than other national surveys.[27] Of the other measures available, the NHS National Patient Survey Programme gathers more nuanced data in the form of five surveys that focus on particularly important services.[28] Chart 1 shows data from the five surveys combined, providing responses from 163,598 respondents.[29] Though these data do not produce results that are as dramatic as the Friends and Family Test, they still demonstrate very high levels of satisfaction with a number of key NHS services. When the two tools are compared, it can be seen that a similar proportion (3.7 percent) of 5,982

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[24] It would have been interesting to see how levels of dissatisfaction and complaints changed during the pandemic when there was a groundswell of support for NHS workers. However, in order to place less burden on NHS services the government suspended the collection of this data during the period.

[25] Monthly Friends and Family Tests April 2013–March 2019. https://www.england.nhs.uk/fft/friends-and-family-test-data/fft-data-historic/.

[26] The NHS is largely a monopoly, but patients may have the opportunity to choose to go to a selection of service providers, especially in large conurbations.

[27] Data from the Friends and Family Test are vulnerable to bias from demographic factors and from the mode of administration (Sizmur, Graham, and Walsh 2015). For other concerns/calls for caution see Manacorda et al. (2017) and Iacobucci (2013).

[28] These are: the Children and Young Person's Patient Experience Survey, the Adult Inpatient Survey, the Urgent ad Emergency Care Survey, the Maternity Survey, and the Community Mental Health Survey. All five surveys are sent to people who have used the NHS within a specified time frame and contain the same question asking respondents to rate their overall experience on an 11-point Likert scale from very poor to very good.

[29] The adult inpatient and mental health surveys are for 2018–19; the A&E, urgent care, and parent/children's ones are from 2017–18 as they are not run every year. The A&E, urgent care, and children's surveys only provided total number of respondents and a percentage breakdown per band between 0–10. I calculated the numbers for each band, but had to round a few as they didn't come out to whole numbers.

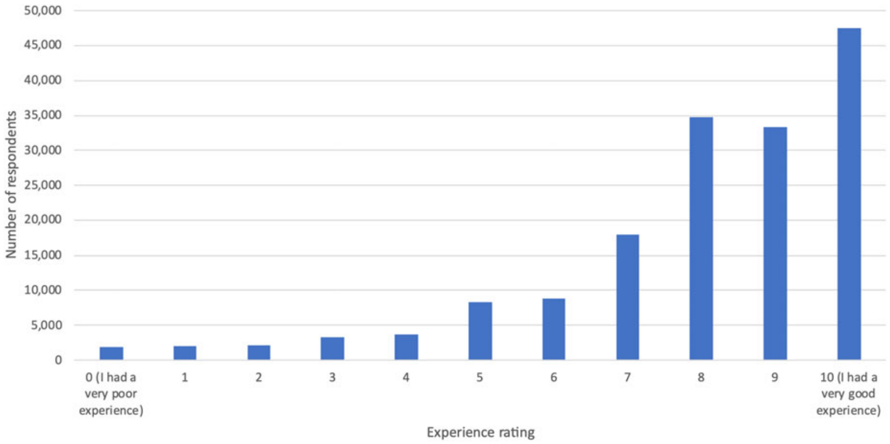

Chart 1. NHS National Patient Survey Program Data for One Year on Satisfaction Levels with Services, n = 163,598.

participants registered dissatisfaction in the lowest three categories of the Likert scale with 115,472 (70.6 percent) registering satisfaction in the top three categories.

Beyond pathways and trees: Jurisprudential and nonjurisprudential logics

When discussing the emergence of the naming, blaming, claiming model, Austin Sarat recently acknowledged that "[t]here is a whole world that didn't exist in [the 1980s] for articulating grievances" (Olesen and Hammerslev 2021, 298). This section considers the ways in which contemporary debates about risk and governance (Beck 1992; Giddens 1999) have driven the emergence of new avenues for the expression of grievances about care. The tree metaphor discussed above encourages us to see a variety of dispute resolution systems operating together in pluralistic harmony, but close analysis of what has happened in the NHS reveals that fundamentally different rhetoric or ideologies underpin proactive and reactive approaches to the voicing of grievances. A key question posed in this section is the extent to which systems that allow service users to voice concerns in the NHS sit in harmony or compete with each other. As we shall see, this has implications for the ongoing legitimacy of systems based on concepts of due process or procedural justice.

Systems for managing medical negligence claims, complaints, and fitness-to-practice concerns respond to voiced grievances in ways that ascribe to a rights-based model underpinned by the principles of due process. Each system focuses on the production of evidence, offers an impartial investigation, takes into account the perspectives of all involved, and offers a diet of remedies (see Table 1).[30] Each system is in turn enmeshed in chains of legal accountability that involve mechanisms for appeal or review. Appeals from the NHS complaints system can be made to the PHSO

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[30] Remedies are described by Albiston, Edelman, and Milligan (2014) as fruit that sit at the end of each branch of their tree.

Table 1. Systems for Resolving Disputes about the NHS

System	Complaints About	Who Can Access	Outcomes Available
Civil Justice System	Negligence or product liability	Anyone with locus standi—usually patient or their estate	Unlimited financial compensation in the form of damages
Parliamentary and Health Service Ombudsman[*]	Complaints about NHS and NHS funded not resolved locally	Patients, carers, family, & reps	Apologies, commitment to improvement, referral to Parliamentary, payments of up to £10k[†]
NHS Complaints System	Complaints about the NHS (local resolution)	Patients, carers, family, & reps	Flexible but commonly include an apology, an explanation, or remedial action
Judicial Review Action[‡]	Legal challenge to the way the NHS has made a decision or has done or not done something lawfully	Anyone with "sufficient interest"	The High Court can ask the NHS body involved to remake the decision

[*] Scotland and Wales have a separate Public Services Ombudsman.

[†] See Parliamentary and Health Service Ombudsman (n.d.).

[‡] Only five judicial review actions against NHS bodies went to trial in in 2018 and included challenges to how a procurement process was run and the lawfulness of policy promoting an unlicensed treatment. For a discussion of all the cases, see https://www.england.nhs.uk/wp-content/uploads/2019/01/09-pb-31-01-2019-litigation-update.pdf.

and their decisions can in turn be subject to judicial review. Appeals from a first-instance medical negligence decision can be made to the High Court or Court of Appeal. Each of these systems also bears the hallmarks of a reactive dispute resolution system in the sense that users retain formal control over decisions to pursue, settle, or abandon their case, though in practice their choices are severely restricted by access to resources.

The common features of these systems allow us to conceptualize them as different branches of the same tree. There is a danger that this vision of pluralistic harmony underplays the extent to which the different systems battle for light and water. This point becomes clear when we attempt to map patient satisfaction surveys and adverse event reporting systems onto the same tree.

Reactive dispute resolution systems are increasingly having to compete for cases and legitimacy with other NHS systems underpinned by a very different logic that focuses on systemic change rather than investigating and responding to the concerns of individuals. In contrast to accounts of legal pluralism that have tended to focus on a state law/non–state law dichotomy, all the NHS systems discussed in this article have their origins in state law and reveal how pluralism can also be present *within* state-sanctioned services. They provide examples of the ways in which state-sanctioned systems that gather voiced grievances can be heterogeneous, messy, inconsistent, and hard to distinguish from non–state law (Reyntjens 2016; Benda-Beckmann and Turner 2018; Sani 2020).

If adverse events and satisfaction surveys are not concerned with dispute resolution or redress of citizen grievances, what is their purpose? How is the expression of grievances viewed in these schemes? Clinical governance has its roots in quality assurance, quality improvement, and risk and incident management discourse.[31] These ways of thinking have been transplanted from the private sector, but are now firmly established as desirable, if not essential, ways of thinking within the NHS (Scally and Donaldson 1998; Hutter 2005; Vincent 2006). The concept of patient voice features prominently in clinical governance rhetoric and an increasing number of initiatives since the late 1990s have stressed the importance of patient evaluations of care. By way of example, since 2009 the NHS Constitution has pledged that:[32]

> NHS services must reflect, and should be coordinated around and tailored to, the needs and preferences of patients, their families and their carers . . . . The NHS will *actively* encourage feedback from the public, patients and staff, welcome it and use it to improve its services.[33] (author's emphasis)

In a similar vein, the NHS Patient and Public Participation Policy, published in 2017 (NHS Public Participation Team 2017), identifies complaints as a resource the NHS can use to attune services to the needs of patients or "experts by experience." There is now widespread acknowledgment that patient feedback has a significant role to play in the identification of "adverse events," poor performance, and systemic errors (Reader, Gillespie, and Roberts 2014).[34] It would seem that rather than putting up jurisdictional barriers to voice, as research has found is common in the reactive systems discussed above, clinical governance initiatives provide a wide array of outlets that encourage voice. Table 2 provides major examples of such systems.

These systems share a common interest with grievance systems in hearing about "trouble" but consider it significant for very different reasons. Writing in the early 1980s, Felstiner, Abel, and Sarat (1980–81) argued that it was a rare organization that actively sought out examples of poor performance or mistakes, yet this is exactly what the systems of clinical governance discussed in this section have been doing since the 1990s. In contrast to reactive dispute resolution systems, they actively encourage the voicing of negative evaluations of care. As a result, these systems generate much larger data sets of grumbles, concerns, and grievances that promote a clearer picture of patterns of behavior and the need for structural change. They are oriented toward collective rather than individual needs, sharing an interest in improving the quality of care for all patients rather than those who make complaints or claims.[35] As such, they could be said to lean more toward notions of systemic, social, or distributive justice than the legal or remedial model that characterizes reactive dispute resolution systems.

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[31] For a description of how the NHS views clinical governance, see https://www.gov.uk/government/publications/newborn-hearing-screening-programme-nhsp-operational-guidance/4-clinical-governance.

[32] See for instance House of Commons Health Committee 2007; NHS Public Participation Team 2017; section 242 of the NHS Act 2006; Health and Social Care Act 2007.

[33] NHS, "The NHS Constitution: the NHS Belongs to Us All." Principles that guide the NHS 1.4. 2015.

[34] NHS Public Participation Team (2017). For additional NHS documents, see https://www.england.nhs.uk/get-involved/resources/docs/.

[35] See for instance Department of Health (2000); Department of Health (2004); Fenn and Egan (2012).

Table 2. Examples of NHS Clinical Governance Systems

System	Concerned With	Who Can Access	Outcomes Available
Patient Safety Reporting	Risk management—reporting patient safety incidents	Public and staff	Supporting national learning through National Patient Safety Alerts
Clinical Audit	Risk management—peer review of cases	Professionals	Review of procedures and practice nationally or at local level
National Patient Surveys	Quality management—how likely someone is to recommend a service	Anyone who uses a service—but anonymous	No individual response but results and information about change is made available to the public
NHS Ratings and Review	Quality management	Anyone	Airing of views and possible response

Note: For further information on patient safety reporting, see https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/#public.

The governance model also shifts the focus of how voiced grievances are responded to. It does not involve offering personalized responses as anticipated by the concept of claiming discussed above. By way of example, members of the public can record patient safety incidents using an "e-form," but this does not result in an investigation of individual incidents, and members of the public who report incidents do not receive a reply.[36] The system does not require details of the identity of the reporter, patients, health care staff, or other individuals involved in problems to prompt action as a dispute resolution system would. In this way, patients and their supporters are viewed less as citizens with rights to a response and more as valuable providers of organizational data.

It is important to note that the clinical governance systems being discussed did not just emerge in parallel to the reactive or rights-based models in Table 1; they also sought to replace them. Governance initiatives in the NHS can be traced back to the 1980s and have frequently emerged as a reaction to the failings of litigation, complaints, and self-regulation to manage risks to patients or engender change through standard setting (Newdick 2014). Notable among the inquiries that have led to this shift in thinking are the Bristol Inquiry (Kennedy 2001), Alder Hay Inquiry (Keeling, Powell, and Redfern 2001), Shipman Inquiry (Smith 2004), and the Mid Stafford NHS Hospital Inquiry (Francis 2010, 2013).[37] Indeed, Liam Donaldson (2002), the Chief Medical Officer who did so much to introduce clinical governance into the NHS, has argued that it was these public scandals that prompted a fundamental turning point in thinking about how poor standards should be managed. As the Harvard Medical Practice research team also asserted:

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[36] https://www.england.nhs.uk/patient-safety/report-patient-safety-incident/#public.

[37] See also Department of Health (2000); Pauffley (2004); Matthews (2004); Pleming (2005); Clwyd (2013).

> If the permanence of a disability, not the fact of negligence, is the reason for compensation, the determination of negligence may be an expensive sideshow. It may pollute the compensation process by creating an adversarial atmosphere and may interfere with quality-improvement efforts. (Brennan et al. 1996, 1967)

The shift toward resourcing proactive approaches to managing risk reflects a consensus that reactive systems, which focus on punitive sanctions and adversarial confrontation, are often counterproductive in the management of collective risk and harm. Research shows that system design and failure is a more common cause of adverse events in the medical arena than the type of discrete human error by individual professionals that might form the basis of a complaint or claim (Reason 1990; Rosenthal, Mulcahy, and Lloyd-Bostock 1999). Rather than contributing to the exposure of harm, it has been argued that reactive systems encourage everyone involved in an adverse incident to remain silent for fear of reprisal or punishment (see Reason 1990; Department of Health 2000; Kohn, Corrigan, and Donaldson 2000). This raises important questions about the extent to which clinical governance can be seen as an addition to reactive rights-based approaches or a substitute for them. Either way, these initiatives cast doubt on the significance of the role that such systems play in calling the modern state to account.

In between the reactive legal and proactive governance model there also exist a bricolage of approaches to the voicing of grievances in the NHS that sit uncomfortably between the two. By way of example, in addition to resolving complaints made by individuals, the PHSO also shares findings from its casework to help Parliament scrutinize health care provision and help drive improvements in public services and complaint handling.[38] There is also evidence of model switching within NHS Resolution, the organization responsible for defending medical negligence claims. This organization has created a Faculty of Learning or repository of educational learning products and resources developed by NHS Resolution to support the health service to learn from errors made evident in the course of litigation.[39] Public and private inquiries, established when the care provided by particular individuals or organizations leads to public concern and loss of confidence, also serve a number of functions that cross the ideal types of reactive conflict management and governance. These include establishing the facts, learning from events, catharsis, reassurance, accountability, blame and retribution, and other political functions such as diffusing tensions (Carlyle 2019; Walshe and Higgins 2002; Walshe 2003).[40] Significantly, they often involve the sort of collective claiming that Albiston, Edelman, and Milligan (2014) have argued has been much neglected by law and society scholarship.

Another important example of seepage between traditional reactive systems and the language of risk and quality management discourse can be seen from an

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[38] This includes PHSO asking NHS trusts to share the investigation reports made about them with the Care Quality Commission, who can follow up on the PHSO recommendations in their inspections (Parliamentary and Health Service Ombudsman 2019).

[39] See https://www.gov.uk/government/publications/nhs-resolution-annual-report-and-accounts-2018-to-2019

[40] For a review of a selection in inquiries set up since 1969, see Walshe (2003).

Table 3. Systems for Self-Regulation of Professional Groups

System	Complaints About	Who Can Access	Outcomes Available
General Medical Council	Doctors	Patients and health care providers	Removal from register and/or restrictions on practice
Nursing and Midwifery Council	Nurses and midwives	Anyone	Removal from register and/or restrictions on practice
General Pharmaceutical Council*	Pharmacists, technicians, & pharmacies	Anyone	Removal/suspension from register and/or restrictions on practice
Health and Care Professions Council	Various including arts therapists & chiropodists	Anyone	Mediation, caution, conditional practice, and removal/suspension from register
General Dental Council	Dentists and dental treatment providers	Patient, their representative, or a dental professional	Removal from register or restrictions on practice
General Chiropractic Council	Chiropractors and chiropractic service providers	Anyone	Removal/suspension from register, restrictions on practice, or formal warning
General Osteopathic Council	Osteopaths	Anyone	Removal/suspension from register, restrictions on practice, or formal warning
General Optical Council	Opticians and some other businesses	Anyone	Removal/suspension from register, restrictions on practice, fines
Care Quality Commission	Registration, standard setting and monitoring, inspection	Public and staff	

Note: In addition to the regulatory bodies included in this table there is also a Professional Standards Authority, which oversees the activity of the other regulators by reviewing every fitness-to-practice decision made. They have the power to refer a decision for review by a court in the interest of protecting the public. Between 2018 and 2019 they considered twenty-two decisions and referred sixteen to the courts, nine of which were decisions made by the Nursing and Midwifery Council.

*There is a separate council for Northern Ireland with largely the same powers.

examination in shifts in the approach adopted by the self-regulatory professional bodies shown in Table 3. In their work on the GMC, Lloyd-Bostock and Hutter (2008) have charted the various ways in which the discourse of risk-based regulation has begun to emerge in the way the council presents itself to the public.

By way of example, the GMC invites and manages complaints about its members but the sanctions they impose, such as striking off the professional register or fining a practitioner, are not directed at resolution but punishment and are justified by reference to the need to maintain and improve standards for everyone rather than remedy a wrong done to an individual.

The various examples in this section demonstrate the ways in which concepts of clinical governance have come to challenge the focus on rights and individual remedies in the NHS, and even to dominate prevailing discourses and claims to legitimacy among policy makers and senior managers. In doing so, these governance structures draw attention away from the central institutions of the state such as the courts, which easily begin to look monolithic, formal, and lacking in dynamism (Bevir 2012). In this new landscape, voicing of grievances becomes a matter that is of interest to a plurality of stakeholders rather than those with a grievance and the person they hold responsible.

Sticking it to the man? voice as a distinct activity

This final section considers whether there is also value in reorientating law and society scholarship to consider voice as a distinct from the notion of "claiming." Felstiner, Abel, and Sarat (1980–81) say remarkably little about voice in their work, and when it is mentioned, it is conceived of as synonymous with claiming, which is seen as involving a request for a response and remedy. While this conceptualization of voice may work well when describing grievances that become justiciable disputes, it is less useful when used in the context of nonjusticiable disputes or governance systems. By way of example, the anonymous and large-scale nature of the surveys discussed in previous sections mean that individual concerns are not responded to nor tailored remedies provided. Moreover, it seems unlikely that those voicing concerns would expect this. This allows us to imagine the act of voicing as a discrete activity; divorced from claiming, investigation, and resolution of a particular grievance; as more than just one component of an instrumental process that invokes a request for something.

The data drawn on for this article suggests that voice can encompass many different forms of expression, that it is often an incomplete expression of a grievance, and that the mere act of voicing may fulfill a function that goes unnoticed in accounts of dispute resolution and governance procedures. This is most evident from an analysis of the data gathered from a Patient Advice and Liaison Service,[41] which suggests that voicing can occur without attributing fault or requesting a remedy. The PALS portfolio is extremely broad, and can involve PALS staff providing responses to health-related questions, assisting in the resolution of concerns or problems, listening to suggestions with a view to service improvement, and advising service users about the NHS complaints procedure.

The PALS database used for this study recorded 2,494 interactions with service users in 2018–19. Chart 2 shows the reason staff gave for PALS being approached.[42] These data reflect a more nuanced approach to understanding the voicing of "trouble" than is evident from data sets produced by dispute resolution and governance systems. The subtle distinction between the categories of "inquiry," "comment," "concern," and "complaint" indicates a range of ways in which voice can manifest itself that incline toward the negative and positive. In a small way these categories designed by those at the front line make clear the nebulous quality of voice. More particularly, it suggests the hesitant quality of some voicing (inquiry) and

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[41] PALS offer confidential advice, support, and information on health-related matters to patients, their families, and their carers, and a PALS officer can be found in every NHS hospital. See https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/.

[42] Within the complaints category, sixty-one involved complaints to Members of Parliament and the remaining cases involved formal complaints to the NHS complaints procedure. It is possible that some of the cases were potential claims or involved adverse events. Fifteen of the 212 complaints and forty of the 2,101 concerns were certainly flagged by the PALS team as serious.

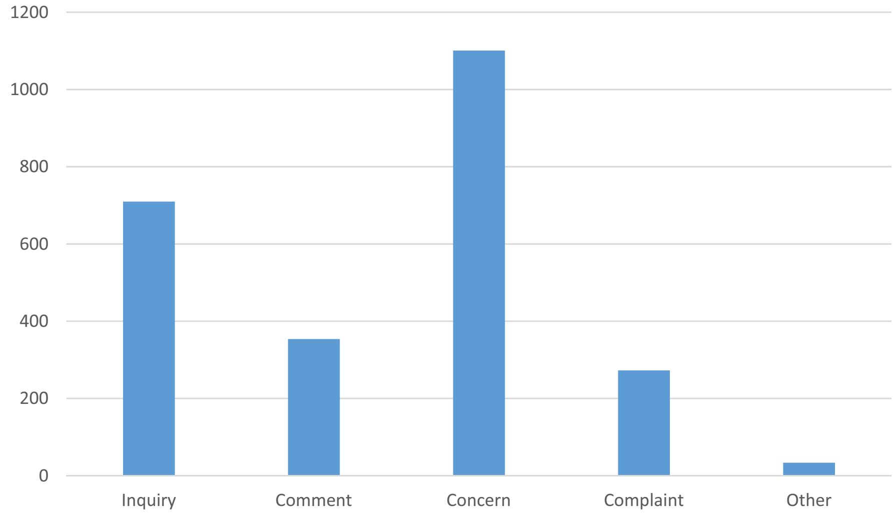

Chart 2. PALS Data for One NHS Trust 2018–19, n = 2,494.

its disassociation (comment, concern) with calls for a response. Other research has also suggested that the act of voicing is inappropriately treated as synonymous with attribution of fault or a request for a remedy. This is evident in the dissatisfaction surveys discussed above in which service users participate without any expectation that their particular concerns will be investigated, responded to, or remedied. Moreover, Lloyd-Bostock's (1984) early work on personal injury compensation schemes found that the relationship between the attribution of fault and the desire for recompense is a complex one in which the attribution of fault is a justification rather than a motivation for seeking damages. In a later study of NHS complaints procedures, Lloyd-Bostock and Mulcahy (1994) found in their analysis of around four hundred complaints files and in-depth follow-up interviews that 40 percent of formal complaints involved *no* request for a specific remedy.

Further light can be shed on the phenomenon of voice by looking at a social media site called NHS Ratings and Review alluded to in Table 2 above. Recognizing its capacity to provide new opportunities to name and shame outside of formal grievance procedures, Sarat has argued that social media constitutes the second major example of a phenomenon that did not exist when Felstiner, Abel, and Sarat (1980–81) were constructing their naming, blaming, claiming model (Olesen and Hammerslev 2021, 298). Indeed, it could be argued that revisiting the concept of voice in a social media context allows us to distinguish it from the notion of claiming more clearly than ever before. Digital technologies are having a particular impact in the health care sector where countless websites, blogs, vlogs, and apps provide the public with more information about health care and ways to offer their evaluations of it (Neville 2017). Patients can now utilize the Internet to interact 24/7 with service providers, closed groups, or broad public audiences. In addition, there is evidence from the private sector that social media outlets increase the number of complaints received significantly (Sun, Gao, and Rui 2021). Perhaps most importantly, social media differs from the other channels for the voicing of grievances considered above by facilitating the expression of dissatisfaction to unknown publics in an accessible forum. In contrast to claims and complaints seen only by those involved in a case or its resolution, Rodino-Colcino (2018) has argued that phenomena such as the #MeToo movement have allowed grievances to gather momentum through public empathy expressed as support. In this way, social media sites can collectivize the incomplete information that individuals are not prepared to voice and add legitimacy to the voice of others. In ways that speak directly to the complex early stages of the naming, blaming, claiming model, social media can be transformative in raising consciousness of unperceived injurious experiences for giving legitimacy to the act of voicing.

The "NHS Ratings and Reviews" website encourages informal feedback from service users. Unencumbered by the restraints of jurisdictional boundaries outlined in Tables 1 to 3, it makes possible the anonymous expression of a grievance in ways entirely determined by the person posting. The site can be used to post positive as well as negative comments. In common with the satisfaction surveys discussed above most of the 979 items posted in 2018 and analyzed for this article concerned positive (65 percent) evaluations of care, a figure that is within 5 percent of satisfaction rates for national surveys reported in Chart 1 above. Further analysis showed that people commonly used the website to express their intense gratitude for the care they received with particular attention being drawn to courtesy, politeness, good humor, and respect for dignity. This calls into question the expectation that social media sites will mainly serve as repositories for complaints and criticism (Sun, Gao and Rui, 2021).

Significantly, those using the NHS Review site are directed to the NHS formal complaints procedure as an alternative avenue to express concerns, but despite this prompt many continue to post their negative evaluations of care on NHS Review. The fact that so many people chose to do so suggests that expressing concerns on this forum has a number of attractions over more formal channels. Given concerns about stepping out of role or fear of retribution discussed above, these might include the ability to voice with a view to venting rather than provoking a response, investigation, or attempt at dispute resolution. Only a small number of posts did any of the work anticipated by the naming, blaming, claiming model. Only 51 (5 percent) of the posts in the sample of 979 indicated that the person posting wanted the NHS to do anything in response. Our analysis shows that getting a response from the service criticized was common; 84 percent of all posts received responses from the health care provider concerned. However, a more detailed examination showed that these were highly standardized. Replies such as "Thank you for your valuable feedback" or "We take all expressions of concern seriously and will take your comments on board" were common. Tailored comments were much more likely to be made when the comments posted by a service user were negative, suggesting that posts carry some reputational risk for the NHS.[43]

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[43] Analysis revealed that 30 percent of responses to negative posts were original, compared to only 6 percent of responses to positive posts.

While much has been made of the ability of social media to open up extensive public debate, as was seen during the Black Lives Matter and Me Too movements, NHS Ratings and Reviews is better characterized as a mundane backwater of social media. There is very little evidence of anyone posting a message in response to another message or to momentum about a particular issue building across posts over time. This suggests that it is not only high-profile sites, or those in which people interact, that have a value for those who want to voice. Indeed, the lack of engaged responses may make these sites attractive as places in which venting can take place without repercussions. These findings lend weight to the argument that voicing and requests for remedy should not be treated as synonymous. The act of voicing may serve an important function to the individuals involved as a signifier of presence, sovereignty, and agency unencumbered by the stress of awaiting a response, or the expectation that it will be challenged or undermined. Further research could usefully explore the extent to which "stand-alone" or backwater voicing of this kind is seen by those who engage in it as an attempt to cause irritation, facilitate catharsis, heckle, record resistance, or even a defy a perceived source of oppression.

Conclusion

This article has attempted to add to the important debate about voicing of grievances that has engaged law and society scholars for decades. Drawing on two seminal attempts to create meta-level theories of journeys to disputes, and using the NHS as a case study, it has attempted to shift the focus of law and society scholarship from individual systems for grievance resolution to a broader panorama in which a number of procedures for collecting voiced grievances jostle alongside each other for legitimacy. By adopting a broader lens and looking at multiple avenues for the voicing of grievances across a sector we can begin to see how dispute resolution systems are not the only, or even the most important, way of gathering information about justiciable problems or dissatisfaction. This broader perspective also allows us to put the lawyers' focus on harms, wrongs, and calling to account in the broader context of positive or systemic evaluations of service provision. The adoption of this approach has allowed us to see the ways in which the logic and legitimacy of lex-centric systems that focus on the resolution of individual disputes are being challenged by governance systems that claim to have a great impact in providing redress for a collective audience by instigating systemic change.

The purpose of this article has not been to determine how well clinical governance works or the extent to which it does a better job of searching out poor practice than the civil justice system and medical negligence claims. Indeed, governance structures continue to experience their own problems. The recent introduction of a statutory "duty of candour" for NHS staff in relation to medical mishaps introduced in 2014 and the launch of the "Freedom to Speak Up" program in 2015 suggest that there continue to be difficulties in collecting evidence of adverse events within the NHS and involving patients in treatment decisions. The Outram Review (2021) also illustrates the ongoing pull of inertia of NHS staff and defensive cultures that undermine the impact and value of voicing by patients and staff.[44] However, the article does attempt to prompt debate about the ways in which a narrow focus on formal, state-sanctioned dispute resolution systems are in danger of ignoring a broader political revolution in which legal discourse based on notions of accountability, rights, and remedies is at risk of being marginalized by policy makers, funders, and practitioners. Political discourse about governance is a well-established phenomenon that has brought a raft of new opportunities and channels through which patients and their carers can voice grumbles, grievances, and concerns as well as satisfaction. We continue to know very little about the extent to which these alternative avenues for voice sit in parallel to formal systems for conflict management or act as substitutes for them. Do they serve similar or radically different purposes for those who use them? Is voicing through these new channels a second-best option or a liberation from the expectations of formal grievance systems? Does it attract those who would otherwise abandon the option of voice or provide another conduit for those who feel able to articulate their concerns? It is hoped that these questions and the many others posed by the data presented here will open up new channels of inquiry by law and society scholars.

At its heart, this article has also argued that the concept of voice needs to be taken more seriously as a discrete concept that is independent of claims for recompense. Looking at the plethora of opportunities to voice across a whole sector raises critical issues about the ways in which voice has been narrowly conceived of in much law and society research in which blame and remedy has been placed at the fore. The more we excavate, the more it becomes clear that the concepts of voice that are now offered up by the NHS in the guise of clinical governance initiatives may not marry existing understanding of what motivates people to articulate their concerns in formal settings. Treating voice as a significant sociolegal phenomenon in its own right offers up the exciting promise of new ways of imagining citizen engagement with public services.

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[44] For more information on these initiatives, see https://nationalguardian.org.uk/about-us/ and https://www.gov.uk/government/publications/nhs-screening-programmes-duty-of-candour/duty-of-candour.

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