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From Patient Voice to Institutional Accountability: A Rights-Based Framework for Dignity-Centred Governance in Public Healthcare

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Abstract

Public healthcare institutions routinely invite patients to report their experiences, raise concerns and participate in decisions. Yet the presence of feedback channels does not establish that an institution has listened, recognised the rights at stake or accepted responsibility for an adequate response. Recent research has examined patient and public involvement, the organisational conditions that support patient voice, complaint-based learning and the use of patient-experience data. These developments make the question of institutional accountability more—not less—pressing. This article develops a rights-based conceptual framework for understanding how patient voice can become an institutional claim to explanation, review and appropriate remedy. Drawing on a critical integrative synthesis of scholarship in health services research, public administration and human rights, it proposes the Patient Voice-to-Accountability Framework (PVAF). The framework distinguishes five connected institutional functions: accessible voice, rights-based interpretation, reasoned response, review and remedy, and governance-level learning and answerability. Inclusion, procedural fairness and protection against retaliation operate across the framework. The article's contribution is not the invention of patient participation or complaint-learning concepts; it is the specification of the normative and administrative links that should connect a patient's account to an institution's duty to explain, correct and learn. The PVAF is a conceptual proposition, not an empirically validated model. Its value and limits require testing across different legal systems, healthcare settings and patient groups.

Keywords: patient voice; institutional accountability; patient rights; human dignity; public healthcare governance; institutional responsiveness; complaint handling.

Introduction

Public healthcare institutions exercise authority over decisions that can affect bodily integrity, privacy, autonomy, access to treatment and the distribution of scarce resources. Their legitimacy therefore depends on more than clinical competence or administrative efficiency. It also depends on whether people can understand decisions, participate in matters affecting them, question institutional conduct and obtain a meaningful response when something has gone wrong. These obligations are especially visible in public healthcare, where decisions are made

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under public mandates and must be defensible not only to individual service users but also to oversight bodies and the wider community. The familiar language of patient-centred care captures an important part of this responsibility, but it does not by itself specify what institutions owe patients when their experiences reveal a possible failure of rights, process or service delivery.

International policy has repeatedly called for health systems to become more integrated and people-centred. The World Health Organization's framework on integrated people-centred health services links empowerment and engagement with governance, accountability and coordination (World Health Organization [WHO], 2016). The OECD similarly argues for health systems that are organised around people rather than institutions alone (OECD, 2021). These policy commitments have helped establish patient participation as a recognised feature of contemporary health governance, building on longstanding work on quality improvement and patient-centred systems (Institute of Medicine, 2001; Kruk et al., 2018). However, the existence of a participation policy or feedback mechanism says little about the institutional consequences of what patients communicate. A system may collect extensive experience data while leaving unanswered the questions of who must respond, what standards guide the response and how a patient can challenge an unsatisfactory outcome.

Patient voice encompasses more than satisfaction ratings. It includes the experiences, preferences, questions, complaints, observations and proposals through which patients and families communicate how care is delivered and how it affects them. It may arise in a clinical encounter, through a formal complaint, in a patient council or in wider public participation. Carman et al. (2013) show that engagement ranges from consultation to partnership and occurs at different levels of the health system. More recent mapping work confirms the variety of terms, settings and outcomes used to describe patient and public involvement, while also identifying persistent gaps in the evidence on its impact (Bergholtz et al., 2024). Earlier conceptual accounts of patient-centredness likewise emphasise the relational and communicative foundations of care (Mead & Bower, 2000; Scholl et al., 2014; Santana et al., 2018). Fredriksson et al. (2025) further connect health services research with social-science accounts of public participation, showing why involvement must be considered at individual, organisational and societal levels.

These developments are important, but participation and accountability are not interchangeable. An opportunity to speak is not the same as an obligation to listen; listening is not the same as giving reasons; and giving reasons is not the same as providing review or remedy. The distinction matters because participation can become tokenistic when institutions solicit views without demonstrating how those views affect decisions (Ocloo & Matthews, 2016; Tritter, 2009). It also matters because patient-reported experience data may be collected and analysed without becoming visible in the decisions made by providers, regulators or other authorities. Vanneste et al. (2026), for example, identify continuing barriers to the systematic use of patient-experience data in healthcare decision-making, including questions about methods, standards, capacity and transparency.

Complaint systems make the gap particularly clear. A complaint may concern an individual encounter, but it can also reveal failures in communication, coordination, access, dignity or organisational culture. Reader et al. (2014) developed a taxonomy for analysing patient

complaints, while their later realist review examined how complaint information can support learning and improvement (Reader et al., 2020). More recent work has continued to reframe complaints as sources of governance intelligence rather than administrative burdens. Pripkó and Pusztafalvi (2026) argue that complaints should be connected to quality governance, while Teymourifar (2026) maps complaint management as an organisational system involving leadership, classification, learning, analytics and legal-ethical considerations. A 2026 scoping review of low- and middle-income countries also identifies weaknesses in organisational response mechanisms and policy arrangements (Arage et al., 2026).

At the same time, new research cautions against assuming that patients can always speak freely or that staff will automatically welcome their concerns. Cordeaux et al. (2025) identify organisational behaviours and contextual conditions that facilitate patient and caregiver voicing in hospital settings. Déom et al. (2026) show that patient- and family-activated escalation mechanisms can be difficult to use when people fear damaging relationships with staff, lack awareness or encounter communication barriers. Akulov et al. (2026) develop a conceptual model connecting patient voice with organisational adaptation and personalised care. These studies advance understanding of how voice is enabled and translated into care processes. They also make it necessary to define more precisely what is distinctive about an account of voice grounded in rights and public accountability.

Human dignity supplies a normative basis for that account. In healthcare, dignity is not exhausted by courteous interpersonal behaviour. It is connected to autonomy, privacy, equality, bodily integrity, access to information and the ability to participate in decisions. The right to the highest attainable standard of health, as interpreted by the UN Committee on Economic, Social and Cultural Rights (2000), includes dimensions of availability, accessibility, acceptability and quality. The Convention on the Rights of Persons with Disabilities adds obligations concerning accessibility, autonomy, participation and equality for persons with disabilities (United Nations, 2006). These instruments do not mean that every unsatisfactory experience is necessarily a legal violation. They do mean that institutions should be capable of identifying relevant rights and standards when responding to patient accounts.

The public-administration literature offers a complementary perspective. Accountability involves a relationship in which an actor is required to explain and justify conduct to a forum that can question, assess and, where appropriate, impose consequences or require correction (Bovens, 2007). In healthcare, the actor may be a practitioner, service manager, hospital, provider organisation, regulator or public authority. The forum may be the patient, an independent complaints body, a professional regulator, an ombuds institution, a court or a public oversight body. The applicable standards may arise from law, professional regulation, policy or publicly stated commitments. Health-system accountability is complex because responsibilities are often distributed across multiple actors and levels (Brinkerhoff, 2004; Emanuel & Emanuel, 1996).

The central problem addressed here is therefore not a lack of recognition that patient voice matters. It is the incomplete institutional connection between what patients communicate and what organisations are required to do with that information. Patient participation frameworks often explain who may be involved and at what level; complaint-management frameworks

explain how concerns can be recorded, classified and used for learning; rights-based approaches identify the standards that should govern healthcare; and accountability theory explains answerability. What remains useful is a framework that specifies how these strands should connect in the institutional handling of a patient's account, without treating complaint closure or data aggregation as sufficient evidence of accountability.

This article proposes the Patient Voice-to-Accountability Framework (PVAF) to address that conceptual problem. Its contribution is deliberately bounded. It does not claim that patient voice, rights recognition, responsiveness, remedy or organisational learning are individually new ideas. Nor does it claim to be the first model to connect patient experience with organisational action. Rather, it specifies a rights-based sequence of institutional functions and makes the connection between reasoned response, review, remedy and public answerability explicit. The article asks: how can patient voice be understood as a trigger for institutional accountability; what functions must connect patient accounts to rights-based decisions and remedies; and what organisational and legal conditions are needed to ensure that the process is inclusive and fair?

Method

This article uses a critical integrative review and conceptual synthesis. The approach was selected because the research problem crosses several bodies of scholarship that use different concepts and methods: health services research, patient participation, complaint handling, public administration, human rights and healthcare governance. The purpose is to develop an analytically coherent framework rather than estimate the effect of a clinical intervention or report primary empirical findings. Integrative approaches are useful when a question requires comparison across theoretical, empirical and policy literature, provided that the scope and limitations of the synthesis are made explicit.

Source identification involved targeted searches of PubMed and PubMed Central records, publisher journal pages, and the reference lists of relevant publications. The literature search and update were completed in preparation for the planned submission in August 2026. Search expressions combined terms including "patient voice", "patient and caregiver voicing", "patient and public involvement", "patient experience data", "patient complaints", "complaint handling", "institutional accountability", "healthcare governance", "human rights in patient care", "dignity", "institutional responsiveness" and "organisational learning". Priority was given to peer-reviewed articles, established theoretical works, international human-rights instruments, and policy documents with a direct bearing on public healthcare governance. Recent publications were considered alongside foundational literature to establish the contemporary relevance of the analysis while retaining its conceptual and theoretical grounding.

Sources were considered relevant where they addressed at least one of the following: the meaning and forms of patient voice; the organisational conditions that enable or constrain speaking up; patient and public participation in healthcare decisions; complaint handling and the use of complaints for learning; accountability relationships in public services; or legal and ethical standards concerning dignity, equality, autonomy and the right to health. Literature was compared

according to its analytical focus, the institutional level addressed, the type of evidence offered and the relationship it established between patient input and organisational action. Particular attention was paid to recent conceptual frameworks to avoid overstating novelty.

The synthesis proceeded in three stages. First, sources were grouped around normative foundations, voice and participation, institutional response, accountability and remedy, and organisational learning. Second, similarities and gaps were examined across these groups. This comparison considered whether a source addressed the opportunity to speak, the institution's duty to respond, the standards used to assess the response, the availability of review or remedy, and the way lessons were reported or embedded in governance. Third, these relationships were assembled into the PVAF as a proposed institutional pathway. Inclusion, procedural fairness and protection against retaliation were treated as cross-cutting requirements rather than as a final stage.

The review is targeted and interpretive, not systematic or scoping. It does not claim exhaustive retrieval, does not report database hit counts or screening totals, and does not use a PRISMA flow diagram. No protocol was registered and no formal risk-of-bias appraisal was applied across the heterogeneous sources. No primary participants were recruited, no patient records were accessed and no original clinical or administrative dataset was analysed. The framework is therefore a conceptual proposition derived from published material and analytical reasoning; it has not been empirically validated. These limits are material to the interpretation of the article's contribution.

Patient voice is evidence, participation and a possible claim to answerability

Patient voice performs several functions that should be distinguished. It provides experiential evidence about how care is encountered; it enables participation in decisions that affect the patient; and, in certain circumstances, it raises a claim that an institution should explain or reconsider its conduct. These functions overlap, but they are not equivalent. A satisfaction score may indicate a general evaluation of a service while concealing the event, interaction or decision that produced it. A complaint may contain a detailed account of a specific failure, but it may also express a concern about repeated patterns or an unmet duty. A patient council may contribute to service design without having authority to challenge an individual decision.

Patient accounts also provide situated knowledge. Patients know how symptoms, treatment plans, communication practices and transitions affect their daily lives. This knowledge does not displace clinical expertise, but it may reveal practical consequences that are not visible in routine administrative indicators. Fricker's (2007) account of epistemic injustice is relevant where a patient's credibility is unfairly discounted or where available interpretive resources are insufficient to make an experience intelligible. In healthcare, the institutional response should therefore consider not only what is reported but also whether the person has had a fair opportunity to describe it in their own terms.

Recent work strengthens this understanding. Cordeaux et al. (2025) show that voicing depends on organisational commitment, supportive work processes, communication practices



and staff orientation. Déom et al. (2026) identify barriers to patient- and family-activated escalation, including fear, low awareness and concerns about challenging professionals. These findings suggest that institutions cannot place the entire burden of speaking up on patients. They must create safe routes for expression, explain how those routes work and avoid penalising people who raise concerns. Voice is not meaningful if using it exposes a patient to intimidation, neglect or deterioration in the quality of care.

The governance implication is that patient voice should be treated as information capable of triggering an institutional duty to consider, not as proof that a particular allegation is correct. Patient-centred communication research also demonstrates that the quality of clinician-patient communication is consequential for how information is understood and acted upon (Epstein et al., 2005; Street et al., 2009). The institution must investigate fairly, distinguish factual findings from interpretations, and avoid assuming either that every complaint is accurate or that a complaint is merely subjective dissatisfaction. Patient-based evidence has also been recognised as relevant to the development of clinical guidance and service improvement (Staniszewska et al., 2014). This balanced approach respects patients while protecting procedural fairness for staff and other parties.

Rights recognition provides the normative test

A rights-based approach changes the question asked of an institution. Instead of asking only whether the patient was satisfied, it asks which rights, duties or standards may be engaged by the reported experience. Relevant concerns may involve dignity, autonomy, privacy, informed consent, equality, accessibility, non-discrimination, communication or the right to health. The right to health is not a guarantee of perfect health or an entitlement to every preferred treatment. It requires that health services be available, accessible, acceptable and of appropriate quality (UN Committee on Economic, Social and Cultural Rights, 2000).

Rights recognition must be careful rather than automatic. A negative experience does not by itself establish a breach of law. Clinical decisions may involve uncertainty, competing risks, limited resources and legitimate professional judgement. The institutional task is to identify the standards that apply, establish relevant facts, consider whether the decision was justified and explain the outcome. Cohen and Ezer (2013) argue for understanding human rights in patient care as a framework that protects patients while also recognising the rights and responsibilities of healthcare workers. Sekalala et al. (2020) similarly connect the right to health with transparency, participation and accountability mechanisms.

The capabilities perspective adds an important social dimension. Sen (1999) distinguishes the possession of formal resources from the substantive freedom to use them. A nominal right to complain may be ineffective where a patient cannot understand the procedure, communicate in an accessible format, obtain interpretation or advocacy, or raise a concern without fear. Levesque et al. (2013) likewise show that access depends on both the characteristics of services and the abilities of populations to perceive, seek, reach, pay for and engage with care. Rights recognition

must therefore examine the practical conditions under which a patient can exercise a right, not simply whether a policy mentions it.

Disability rights are particularly relevant. The Convention on the Rights of Persons with Disabilities requires respect for dignity, autonomy, accessibility and participation (United Nations, 2006). These obligations support practical measures such as accessible formats, interpretation, supported communication, advocacy and reasonable adjustments. Inclusion should not be treated as a separate box to tick after the response has been designed. It is a condition of whether the institution has heard an adequate range of experiences in the first place.

Institutional responsiveness requires reasons, not merely acknowledgement

Institutional responsiveness is the process through which an organisation receives a concern, establishes what is being alleged, gathers relevant information, communicates with the person and determines what action is justified. Acknowledgement is necessary, but it is not sufficient. A generic letter confirming receipt may satisfy a procedural requirement while leaving the substance of the concern untouched. Likewise, a rapid case closure may be administratively efficient but substantively inadequate. Responsiveness should be assessed through the quality of the process and the relevance of the explanation, not simply the time taken to close a file.

Research on complaints has repeatedly shown that patients value being heard, receiving an intelligible response and seeing that concerns are taken seriously. Reader et al. (2020) identify mechanisms through which complaint handling can support patient-centred learning, including accessible information, advocacy, tailored responses, consistent data systems and leadership engagement. Martin et al. (2021) show how formal response systems can fail when standardised procedures are poorly equipped to deal with complex, cross-cutting or difficult-to-categorise concerns. These findings caution against reducing responsiveness to a standard script or a checklist of administrative steps.

Recent literature makes the governance problem explicit. Pripkó and Pusztafalvi (2026) distinguish case processing from governance-integrated complaint handling, in which concerns are classified, aggregated, reviewed and linked to improvement. Teymourifar (2026) similarly treats complaint management as a multidomain organisational system. Arage et al. (2026) identify continuing gaps in organisational response mechanisms and policy arrangements across low- and middle-income settings. These publications support the importance of organisational learning, but the PVAF adds a separate requirement: system-level use of a complaint must not displace the institution's duty to provide an adequate response to the individual who raised it.

Reason-giving is central to this duty. An institution should explain what it understood the concern to be, what information it considered, which standards it applied, what it found and why it selected a particular response. The explanation should be accessible and proportionate to the issue. It may acknowledge uncertainty or disagreement. Where an institution cannot meet a request, it should explain the relevant clinical, legal or resource constraints and identify any available alternative or route of review. A reasoned response enables the patient to understand

the decision and makes it possible for an independent forum to assess whether the institution acted properly.

Accountability is incomplete without review and appropriate remedy

Bovens (2007) provides a useful account of accountability as a relationship between an actor and a forum. The actor is required to explain and justify conduct; the forum may question and judge the explanation; and consequences may follow. This model helps distinguish accountability from transparency alone. Publishing complaint statistics may make information visible, but it does not necessarily create a relationship in which an institution must answer questions or correct its conduct. Emanuel and Emanuel (1996) also show that accountability in healthcare involves multiple actors and standards, including professional, institutional and public responsibilities.

In public healthcare, the relevant forum depends on the issue. A patient may seek an explanation from a clinical team, a formal response from a provider, review by an independent complaints body, regulatory scrutiny, an ombuds process or judicial remedy. These routes are not interchangeable. Some concerns require immediate clinical escalation; others concern professional conduct, service access, discrimination, privacy or systemic failures. A coherent framework should make the available routes understandable and should not imply that every complaint must proceed through the same channel.

Remedy is similarly context-dependent. It may involve an explanation, apology, correction of a record, reconsideration of a decision, restoration of access, compensation where legally available, a change in practice or a formal review. Not every concern warrants every form of remedy, and the appropriate response depends on evidence, law and context. Nevertheless, a system that offers no credible route to correction risks reducing accountability to performance. Brinkerhoff (2004) emphasises the importance of conceptual clarity in health-system accountability; the PVAF uses that insight to distinguish individual redress from wider organisational improvement.

The distinction matters because institutions may learn from a complaint while failing the person who raised it. Aggregated data can inform training or policy change, but it cannot substitute for an explanation or remedy owed to an individual. Conversely, a satisfactory individual response does not necessarily address a recurring system failure. The PVAF therefore treats individual answerability and collective learning as related but separate obligations. Both should be documented, and both should be open to scrutiny.

Governance-level learning must not absorb individual claims

Complaint-derived information can reveal patterns that routine indicators miss. Reader et al. (2014) show the value of structured coding for analysing complaints, while Reader et al. (2020) discuss how complaint information may be translated into organisational learning. A recent editorial argues that complaints provide a continuing account of patient and family experiences and that the challenge has shifted from whether organisations should learn from

complaints to how they can analyse and use them reliably (Reader, 2026). Pripkó and Pusztafalvi (2026) and Teymourifar (2026) similarly position complaint data within quality governance and organisational learning.

However, aggregation creates risks. Standard categories can flatten the meaning of a patient's account, obscure the context of an event or privilege concerns that are easier to code. A low number of complaints may indicate good performance, but it may also indicate that people do not know how to complain or do not trust the process. High closure rates may indicate efficient handling, but they may also reflect a narrow definition of closure. Institutions should therefore interpret complaint data alongside other evidence, including patient-reported experience, safety information, staff accounts and independent oversight.

Governance review should examine patterns, recurrence, disparities in access and response, and the actions taken as a result. It should also record whether the institution has informed complainants about system-level changes where appropriate. Public reporting can strengthen answerability, but it must protect confidentiality and avoid disclosing identifiable patient or staff information. The goal is not to turn every patient account into a performance metric. It is to make sure that repeated signals are not lost within isolated case files.

The Patient Voice-to-Accountability Framework

The synthesis supports the PVAF as a proposed institutional pathway linking patient expression with rights-based and accountable action. The framework comprises five connected functions. They are analytically distinct but may overlap or recur. A new fact may require rights reassessment; an unsatisfactory explanation may lead to review; and a pattern identified through governance monitoring may require renewed engagement with patients. The framework is therefore better understood as a cycle of answerability than as a rigid linear procedure.

First, accessible voice concerns the conditions under which patients can express experiences and concerns. It includes direct conversations, feedback mechanisms, complaints, advocacy, patient councils and community participation. Second, rights-based interpretation requires the institution to identify the rights, duties and standards that may be engaged. Third, reasoned response requires acknowledgement, fair fact-finding, communication and an explanation of the decision. Fourth, review and remedy ensure that decisions can be questioned and that proportionate correction is available. Fifth, governance learning and answerability require institutions to analyse recurring issues, take corrective action and demonstrate to appropriate oversight forums what has changed.

The framework differs from recent models in emphasis and purpose. Cordeaux et al. (2025) focus on the organisational and interpersonal conditions that facilitate voicing in hospital settings. Akulov et al. (2026) propose an organisational model for using patient voice to personalise care and assign operational responsibility. Pripkó and Pusztafalvi (2026) and Teymourifar (2026) focus on complaint handling as a governance and learning function. Fredriksson et al. (2025) integrate patient and public involvement with wider questions about impact in health services. The PVAF does not replace these contributions. Its narrower claim is to make explicit the

normative and procedural links between patient voice, rights-based reason-giving, independent review, remedy and public answerability.

Table 1. The Patient Voice-to-Accountability Framework (PVAF)

Core institutional function	Question the institution must answer	Evidence of accountable practice
Accessible voice	Can patients communicate experiences and concerns safely and in a form they can use?	Accessible channels; interpretation and advocacy; supported communication; protection against retaliation.
Rights-based interpretation	Which rights, duties, professional standards or public obligations may be engaged?	Consideration of dignity, autonomy, equality, privacy, accessibility, consent and applicable law.
Reasoned response	Has the institution investigated fairly and explained its decision?	Acknowledgement; proportionate fact-finding; accessible reasons; updates; clear escalation routes.
Review and remedy	Can the decision be challenged, and can appropriate correction follow?	Independent review where appropriate; apology or correction; reconsideration; redress under applicable rules.
Governance learning and answerability	What has the institution learned, changed and reported to the appropriate forum?	Trend analysis; leadership oversight; corrective action; monitoring; privacy-protected public reporting.

Source: Author's conceptual synthesis.

Inclusion, procedural fairness and protection against retaliation apply across all five functions. They are not optional additions. A process is not accessible if people with disabilities cannot use it, if language barriers prevent meaningful participation or if patients fear that speaking up will jeopardise their care. Nor is a process fair if allegations are treated as proven before investigation or if staff are denied a reasonable opportunity to respond. The framework therefore requires institutions to balance the patient's right to be heard with fair procedures for all parties.

The PVAF also suggests that accountability should not be measured by one indicator. Relevant evidence may include the accessibility of voice channels; the diversity of people who use them; the quality and timeliness of responses; the clarity of reasons; the availability of review; the appropriateness of remedies; recurrence of similar concerns; and evidence that organisational decisions have changed. These indicators should be interpreted together and should not create

incentives to discourage complaints or prioritise cases that are easy to close. Donabedian's (1988) distinction between structure, process and outcome remains useful here: institutions need appropriate structures and processes, but they must also examine whether those arrangements make a meaningful difference to patients. Evidence on respect and dignity in inpatient care also reinforces the need to assess patients' experiences as part of quality governance (Dutra et al., 2022).

The framework can be applied at different levels. At the clinical level, it can guide communication, consent, shared decisions and responses to concerns. At the organisational level, it can inform complaint systems, patient participation arrangements, governance committees and quality-improvement processes. At the system level, it can help regulators, ministries, commissioners and public oversight bodies examine whether providers have accessible response mechanisms and can demonstrate learning. The levels are connected, but responsibility should remain identifiable at each stage.

Implications for law, public administration and healthcare practice

For law and policy, the PVAF suggests that patient rights should be linked to operational duties. Legal recognition of dignity, autonomy and access is important, but it is weakened if people cannot raise concerns, receive reasons or seek review. Policy frameworks should clarify the responsibilities of providers and oversight bodies, establish accessible complaint pathways and define when concerns must be escalated. Human-rights accountability requires more than statements of principle; it requires institutions to show how rights standards inform decisions and remedies (Cohen & Ezer, 2013; Sekalala et al., 2020; WHO, 2023).

For public administration, the framework shifts attention from procedural completion to answerability. A complaint should not be considered fully handled merely because it has been logged, assigned and closed. The institution should be able to explain what it did, why it did it and what followed. Bovens' (2007) actor-forum relationship provides a way to assess whether an accountability process gives the forum a genuine opportunity to question and judge institutional conduct. This also cautions against confusing transparency with accountability: data disclosure is useful, but it is not a substitute for an answerable decision-making relationship.

For healthcare managers, the PVAF encourages a separation of functions that are often conflated. The individual response should address the complainant's account and any appropriate remedy. Governance review should identify recurring issues and assign responsibility for improvement. Leadership should monitor whether corrective actions are implemented and whether similar concerns recur. A just culture is essential: institutions should distinguish human error, system weaknesses, reckless conduct and deliberate wrongdoing rather than respond defensively to all criticism. The Global Patient Safety Action Plan emphasises system learning and the prevention of avoidable harm (WHO, 2021).

For professional practice, the framework does not mean that every patient preference must be adopted or that clinical judgement should be displaced. It requires that patients are involved to the extent possible, that decisions are communicated respectfully and that concerns are taken

seriously. Shared decision-making and patient-centred communication can improve the quality of clinical relationships, but they depend on organisational conditions such as time, accessible information, continuity and staff support (Elwyn et al., 2012; Street et al., 2009). A sustainable system must recognise the dignity and rights of patients alongside the working conditions and professional responsibilities of staff.

Limitations and propositions for empirical assessment

The PVAF has not been empirically validated. It is a conceptual framework developed through a targeted integrative synthesis, and its proposed functions and relationships require testing. The review is not exhaustive and does not provide a formal assessment of the methodological quality of every included source. The framework is focused on public healthcare, although many systems include private, charitable and mixed providers. The allocation of duties across these arrangements may require further specification.

Future research could examine the framework through comparative case studies of complaint pathways in different jurisdictions; interviews with patients, advocates, clinicians, managers and regulators; analysis of anonymised complaint records and institutional responses; and surveys of perceived fairness, responsiveness and trust. Studies should examine whether patients can access voice mechanisms without fear, whether rights-based reason-giving improves perceived legitimacy, whether review and remedy are available in practice, and whether governance-level learning reduces recurrence. Research should also test whether the framework works for groups whose experiences are less likely to appear in formal complaint data.

Several propositions can guide this work. First, accessible and safe voice mechanisms should be associated with a broader and more representative range of patient accounts. Second, responses that explain the standards applied and the reasons for decisions should be associated with stronger perceptions of procedural fairness than generic acknowledgements. Third, the availability of review and proportionate remedy should strengthen institutional answerability, although the effects may vary across legal settings. Fourth, governance processes that aggregate complaints while preserving individual response duties should be better able to connect patient experience with organisational change. These propositions are hypotheses for empirical testing, not findings established by this article.

Conclusion

Patient voice has become an established feature of contemporary healthcare policy and practice. Yet the invitation to speak is only the beginning of an institution's responsibility. Patients may communicate experiences that raise questions about dignity, equality, access, communication, safety or the exercise of professional and administrative authority. Public healthcare institutions must be able to consider those accounts fairly, identify the rights and standards that may be engaged, explain their decisions and provide routes to review and appropriate remedy.

This article has proposed the Patient Voice-to-Accountability Framework as a way of specifying the institutional functions that connect patient expression with answerable action. The framework comprises accessible voice, rights-based interpretation, reasoned response, review and remedy, and governance learning and answerability. Inclusion, procedural fairness and protection against retaliation apply throughout. The contribution is not to claim novelty for each component, nor to present another general model of patient engagement. It is to make explicit the rights-based and administrative obligations that should connect what patients say to what institutions must explain, correct and learn.

The PVAF should be treated as a conceptual proposition rather than an empirically validated model. Its usefulness will depend on whether it can be applied across different health systems, legal environments and organisational settings without creating excessive administrative burden or discouraging legitimate clinical judgement. Future research should test the framework with patients, professionals, managers and oversight bodies, paying particular attention to accessibility, fairness, remedy and evidence of institutional change. Dignity-centred governance requires more than collecting patient experience. It requires institutions to remain answerable for how they interpret, respond to and act upon it.

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