UNIVERSITY OF CALGARY

Understanding the Experiences of Nurses Managing Querulous Complainants: What Does Health Care Know?

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE

DEGREE OF DOCTOR OF PHILOSOPHY

GRADUATE PROGRAM IN NURSING

CALGARY, ALBERTA

APRIL, 2020

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Abstract

Society demands and rightfully deserves excellence in health care but unfortunately, this expectation is not always met. Having worked in the Department of Patient Relations for 13 years, I am privileged to have conversed with thousands of patients and families to resolve concerns related to unsatisfactory health care experiences. Unfortunately, I have also engaged with countless patients and families who remained unsatisfied with their care and are thus labeled difficult or querulous. I became increasingly perplexed by the presentation of such complainants and recognized that there was more to be understood about the experience of attempting to reach resolution. For this research study, I have utilized a qualitative design of hermeneutic inquiry as guided by the philosophical hermeneutics of Hans-Georg Gadamer (1900-2002) to address my research question: How might we understand experiences of nurses managing querulous complainants? I recruited five Registered Nurses (RN) employed by Alberta Health Services (AHS) as Patient Concerns Consultants (PCC). The data for my research were generated through planned, skillfully conducted, semi-structured interviews with participants. This approach allowed me to listen and be open to the participants' understandings of their experience with querulous complainants. My research relied on the concepts of the hermeneutic circle and fusion of horizons in order to understand the experiences and bring forth interpretations. Through the research process, new and altered understandings emerged through the interpretations of Apology, War, Monsters, Soldiers, Robots, Gods, and the Black Hole. The research suggests that there is an absence of relationship between querulous complainants and PCCs. Querulous complainants cause distress, suffering, and require a unique concerns management process. The ways in which politics and Groupthink in health care play an integral part in querulous complaint management is also tendered. This study is the first known

qualitative research inquiry intended to explore querulous complainants which creates a platform for new research related to managing health care complaints.

Acknowledgments

Choosing to engage in doctoral studies begins as an independent decision but cannot be achieved without the support of everyone in your life. I was not prepared for the many ways this endeavor would challenge me, test me to defy all odds, and how I would never have been able to reach my dream without the dedication of so many. First I must thank Dr. Nancy Moules, my doctoral supervisor, who was open to my address and supported me in pursuing this research topic. You have never doubted me or the importance of this work. I will be forever grateful for your unwavering commitment, support, and knowledge to bring this topic to life as well as your passionate persistence that navigated me through so many challenges along the way. Thank you to the members of my doctoral committee, Dr. Graham McCaffrey and Dr. Loraine Venturato. I genuinely appreciate their time and commitment. They have always gone above and beyond to support me, share their knowledge, and inspire me to be my very best. I thank my examiners, first Dr. Kathryn King-Shier who has supported me since I took a class from her in my master's program so many years ago and continued to guide me in my doctoral studies. Thank you to Dr. Theodore (Ted) George for being willing to share your hermeneutic wisdom as my external examiner. You are a legend, and I feel so privileged. I also express my sincerest gratitude to the Patient Relations Consultants who participated in this study. Without their participation and willingness to share experiences, this research would not have been possible. Their dedication to patients and families is truly remarkable and I hope that I have served them well. Thank you to all of the faculty and staff in the Faculty of Nursing at the University of Calgary. It is an honor to have been part of such a wonderful group of professionals and I hope that I can contribute back, through my research, to the future of nursing. Finally, I would like to acknowledge my amazing family, Emrys, Harper, Randy, and Dad; you have done so much to take care of me through the

years of late nights, missed weekends, and tears. I love you all so very much and thank you for this accomplishment.

Dedication

I dedicate this thesis to my father. You raised us alone for so many years and now without Dylan, my brother, you alone serve as my nuclear family. You have sacrificed so much because you believed in me, told me every day “you can do this” and you always understood. I will be forever grateful to you for your love, encouragement, and support. Your commitment to lifelong learning will be passed along to Emrys, Harper, and generations to come.

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Chapter One: Introduction

As a graduate student, I am questioned consistently about my area of study. In response, I identify that I am proposing to understand experiences of managing querulous complaints. I look forward to the reaction to this declaration. Most individuals will express their curiosity, question why I would have interest in complaints, and ask what *querulous* means. It is true that I am not interested in an area of research that examines a clinical subject matter or particular skill set that is common in nursing practice. At the same time, I did not purposefully select this topic; this topic summoned my attention.

In this chapter, I offer a synopsis of this thesis and further explain the basis of my topic. I introduce the background of complaints management in Alberta Health Services (AHS), explain the role of a Patient Concerns Consultant (PCC), the Patient Concerns Resolution Process (PCRP), as well as identify how I was addressed by the topic.

Synopsis

For this research inquiry I have utilized a qualitative design of hermeneutic inquiry as guided by the philosophical hermeneutics of Hans-Georg Gadamer (1900-2002) to understand the experience of nurses managing querulous complainants. In this thesis, I demonstrate how philosophical hermeneutics has guided my research and establish how I interpret the historical, philosophical, and methodological underpinnings.

This thesis presents the challenges associated with managing complaints particularly querulous complaints by PCCs employed by AHS. Following a high-level overview of complaints management, the quandary contributing to querulous complaint management is identified and an exploration of information that exists about complainants and complaints management in literature is presented. A review of literature suggests that there is a universality

of complaints, and identifies that research has not advanced to examine complaints that cannot be resolved. The importance of this research is offered and, in order to address querulous complainants, I pose that the existence of querulous complainants in health care needs to be established, understanding the experience of managing querulous complains is imperative, and I impart the work that I have initiated to address the management of querulous complainants.

The analysis of my research is presented through the interpretive chapters which are intended to frame the topic and exemplify the experience of managing querulous complainants. My research relied on the concepts of the hermeneutic circle and fusion of horizons as a means to bring forth understanding through the interpretations of Apology, War, Monsters, Soldiers, Robots, Gods, and the Black Hole. In order to elevate the significance of the interpretive chapters collectively, I unite all of the interpretations to establish an overarching and inclusive interpretation of understanding the experience of nurses managing querulous complainants.

The analysis of this research suggests that there is a certain difficulty in the relationship between querulous complainants and PCCs and, in turn, understanding through communication can be impossible. Querulous complainants cause distress, suffering, and require a unique concerns management process. In order to substantiate why an alternate process is required, the ways in which politics and Groupthink influence the development of health care policies and procedures is tendered.

This study is the first known qualitative research inquiry intended to explore PCCs' experiences with managing querulous complainants. As a credible academic and researcher, I also provide a chapter to substantiate the validity, rigor, credibility, trustworthiness, and limitations of this research. As hermeneutic inquiry can never be conclusive, I present

considerations from this research as they relate to nursing education, practice, research, and legislation.

It is my belief that research which supports understanding querulous complaints, early detection or querulous behavior, and the development of a concerns management process specific to querulous complainants is imperative in order to establish any legitimate means to assist such complainants. With confidence, I present this thesis to demonstrate that philosophical hermeneutics has supported strong, evidence-based research, suitable to expose a novel understanding of the experience of managing querulous complainants.

Complaints Management

In Canada, the Federal government does not direct health care services (Health Canada, 2015). All provinces and territories in Canada are responsible for the administration and delivery of health care services to their citizens under the Canada Health Act. There is no standard health care concerns management approach in Canada, and each province is responsible for establishing a patient concerns management processes under their legislated Regional Health Authorities Act.

In Alberta, AHS adheres to Alberta Regional Health Authorities Act that legislates all patients must be provided with a fair and transparent process to bring forth their health care concerns (Regional Health Authorities Act, 2006). AHS relies on the Patient Concerns Resolution Process Regulation (124/2006) and the Health Quality Council of Alberta Patient Concerns Resolution Process Framework to provide direction on best practices for patient concerns management (Health Quality Council of Alberta, 2007; Regional Health Authorities Act, 2006). In 2006, the Patient Concerns Resolution Process (PCRP) was developed and implemented to serve the legislation (AHS, 2012).

PCRP Explained

Under the PCRP, a *complainant* refers to any person that brings forward a concern (Alberta Health Services, 2012). This includes any person acting on behalf of, or in the interest of, a patient who is either living or deceased. A *concern* refers to either written or verbal communication of dissatisfaction related to the provision of goods and services by AHS or a service provider under the authority of AHS. Complaints can also be made against anyone employed by AHS or the organization as a whole. Only leadership can be accountable to a complaint review, as such, a *reviewer* is defined as an accountable leader with appropriate level of responsibility to address the concern.

The PCRP begins with the complainant engaging with a PCC and providing the details of the concern, either verbally or in writing (Alberta Health Services, 2012). Once the concern is understood from the perspective of the complainant, the PCC is responsible to review relevant health records, interview staff, and obtain appropriate consent as well as, determine if any policies or standards of care relate to the concern. The PCC is also accountable to determine whether the concern should be reported to the police, Corporate Investigations, Human Resources, Legal & Privacy, or Communications. The PCC also makes the decision to report the concern to an external governing body such as Protection for Persons in Care, Office of the Alberta Health Advocates, or Minister of Health.

Once all pertinent information is collected, the PCC then documents the concern(s) in a formal request for review memo that is sent to the accountable reviewer (Alberta Health Services, 2012). The reviewer has 30 days to investigate and provide a response to the concerns. One the reviewer has investigated the concern, the PCC ensures that the response meets the

legislated requirement and comprehensively addresses the complainant's concern. It is the decision of the complainant as to how they would like to receive the outcome. The complainant may choose to receive the response in writing, verbally, or in a meeting with the reviewer and PCC.

If the review and response does not resolve the concern, the complainant is entitled to escalate their concerns to the next level accountable leader for additional review and response (Alberta Health Services, 2012). If the complainant remains unsatisfied the PCC will continue to escalate the complaint through the levels of leadership until all levels have been exhausted. The final level of escalation within AHS is to the Patient Concerns Officer (PCO). If a concern is escalated to the PCO, the PCO reviews the concern and all efforts are engaged to resolve the concern. If it is determined that all measures have been taken to resolve the concern and there is no resolution, then the complainant is referred to the Alberta Ombudsman.

Presently, this process fails to provide direction to the immediate and ongoing management of the behaviors of complainants under the PCRP whose grievances are perpetual and whose resolution is unattainable, meaning they are querulous. The process is meant to provide a structured and fair means to review concerns and for the majority of concerns to be resolved at the first level. However, it allows for querulous complainants to engage all levels of the process and leadership, as well as to have multiple concerns being escalated concurrently.

PCC Explained

Each year the Department of Patient Relations receives approximately 20,000 complaints, approximately 10,000 of these complainants engage in the formal review process (AHS, 2018). Once a complainant consents to having their concerns formally reviewed, a PCC is assigned to assist the complainant and manage the concern under the PCRP. The PCC is the accountable

AHS representative to the complainant and holds immense responsibility to ensure that the process is followed in accordance with the legislation.

The Department of Patient Relations employs 22 PCCs to assist patients, investigate health care related concerns, and facilitate resolution under the PCRP. The qualifications of the role require an individual to hold a degree in a health care discipline, Master's preferred, clinical experience along with management or conflict resolution experience. Although the department is multidisciplinary, the majority of staff are registered nurses (RN). When the department was established, it was a requirement that the incumbent be an RN however, currently there is no explanation for the majority of the employees being RNs. Despite the generalized qualifications, the role requires a particular personality that can work independently in a high stress environment with the ability to maintain an extraordinary degree of professionalism and integrity with the fundamental desire to support people in need.

Address of the Topic

The Department of Patient Relations has significantly evolved over the past 13 years to its current operational state and structure. In 2007, I joined the department as one of the first Patient Advocates to serve the Calgary Health Region (CHR). I embraced a new role for health care in Alberta. I began working with patients and families to resolve their health care complaints. As I managed hundreds of complaints, complainants for whom resolution was unachievable increasingly perplexed me. For the purposes of my research, I have adopted the term querulous to describe such complainants. Querulous is derived from the Latin *querī* meaning to complain, and describes a pattern of behavior relating to the persistent pursuit of complaints in a manner that is disruptive to organizations attempting to achieve resolution (Mullen & Lester, 2006).

The CHR was not prepared to manage complainants who presented relentlessly with unresolved disputes. All complaints were applied to the Patient Relations Resolution Process (PCRP) and the organization expected every complaint to be resolvable. However, in trying to live up to the expectations of the process, I would work tirelessly to resolve unsatisfied complaints without success. Spending hours attempting to identify the exact problem in my practice, I became convinced there was something I was not seeing or doing properly. I felt that since I was not successfully resolving all complaints, there was something that needed to be questioned and understood differently. According to Gadamer, understanding begins when something addresses us (Gadamer 1960/1989). "Address signals the complexity that lies beneath the surface of everyday activity" (Moules, McCaffrey, Field, & Laing, 2015, p. 81). I knew that there was more beneath the surface and that something needed to be awoken and explored.

Between 2008 and 2009, the CHR dissolved and the first provincial health care organization in Canada, referred to as Alberta Health Services (AHS), was established. With the organizational shift, my position changed from a Patient Advocate to a Patient Concerns Consultant (PCC). The public embraced the opportunity to voice their complaints with the provincial health care system and the number of complaints increased from 2,000 to an average of 20,000 complaints each year. As the number of complaints compounded, I was expected to provide advanced services to educate organizational leaders how to manage complaints.

My entire professional existence now consisted of complaints, resolving concerns, and being the bearer of bad news. It was not until I was requested to provide teaching on managing complaints and dealing with difficult complainants, that I became paralyzed. I was unsure of how I managed complainants and how to translate the experience. Even more so, I was not able to articulate the experience of managing querulous complainants. Moules, Field, McCaffrey, and

Laing (2014) stated that, "When a topic shows itself, it haunts us, because it also "hides" itself" (p. 2). I had obviously completed the requirements of my job but I questioned why my actions were so imperceptible to me. There was no training for the position or any set process to follow. I was working with patients and families to resolve their concerns but each situation was unique and I questioned how I could ever educate someone else to conduct themselves in the same way.

In these moments of rumination, I also questioned how I assumed such a role of which the occupation was exclusively complaints management. I scrutinized both the purpose of the process and my involvement in it. Perhaps I was just a nosey, officious nurse who enjoyed involving herself in flawed health care experiences. Why did I forge on through all of the sad stories and adverse events? Was there something unscrupulous about me or was I called to this work by a desire to make a difference for patients and health care professionals?

Aletheia

I find myself relying upon the core concepts of Gadamer's philosophical hermeneutics, such as *aletheia*, in reflecting upon how I am addressed by querulous complainants. According to Moules et al. (2014), "Hermeneutics is the practice of *aletheia"* (p. 5). Aletheia can be identified or characterized as, opening, enlivening, or remembering. "When topics address us, they open something, they call us to remember why it is that certain things matter, and they ask us to bring these things alive in the here and now of our lives" (Moules et al., 2014, p. 5).

> The address that occurs is a substantive one. We are hailed by subject matter, or better perhaps a *subject that matters* so that, when we are addressed, we are obligated to respond, not in "any old fashion," but to respond to the best of our abilities, to do the right thing, in the right way, as Gadamer would say. (Moules et al., 2014, p. 2)

This statement invites me to acknowledge that I was hailed by querulous complaints. I am drawn to a hidden phenomenon that is provoking me to seek understanding and to bring understanding to others. With every complaint, I visualize the context as a call for succor. I meet complainants within the dialogue they offer about their complaint. I validate that they are lost, engage to understand their map and, with my best efforts, attempt to escort them to resolution. However, in the context of a querulous complainant, our journey is most often endless and sadly, we remain disconnected and lost.

Ritualized Behavior

My address has also been influenced by the writings of van Manen (2002) related to ritualized behaviors. We do not acknowledge our ritualized behaviors because they are so entrenched in our everyday experiences. Ritualized behaviors are acts that we take for granted, such as greetings. These types of acts are so embedded within our reality that we do not question or reflect upon them.

The process of managing complaints became a ritualized behavior for me. When I would receive a complaint file I would acknowledge the concern, offer an apology, and then promptly put forth the concern for review to the most appropriate leader. Once the review was completed, I would then provide the response and conclude the file. It was very simple, methodical, and repetitious. It was only when I began to reflect upon the process and the concerns, especially in circumstances where the complaints could not be resolved, did my ritualized behaviors become prominent in my consciousness, and became questionable. I began to recognize that there was something uncertain about them. I began to question the ritualized behaviors and was curious about why they were repetitious in the first place and, furthermore, why were they ineffective in some cases. This was actually a frustrating place for me. I had managed thousands of files in the

exact same way so why was it that the process, and my approach was not working for all concerns.

Phronesis

In the context of my topic, I connect my observations of ritualized behaviors with Gadamer's concept of *phronesis*. In examining my ritualized behaviors in managing concerns I became uncertain when faced with a complaint that was difficult and could not reach resolution. In those circumstances, I struggled to utilize all of my acquired skills to manage the complainant and their concern. According to McCaffrey and Moules (2016), phronesis is a practical wisdom that "demonstrates the exercise of judgment in the moment, drawing upon knowledge of various kinds and applying it judiciously and helpfully according to the contours of the unique experience" (p. 4).

My experience of managing concerns had become ritualized. However, when faced with a querulous complainant I realized that I was unable to both figure out what to do or know what was worth doing. I knew what I had to do to work toward resolution of the concerns but I did not have any understanding of the complainant, or how to achieve resolution with them. I was certain that I had mastered the practical experience of managing complaints to the point of ritualization but managing a querulous complainant was beyond my capacity to ascertain the right thing to do. I often found myself confused and taking actions that were not reasonable because I was so perplexed about the right thing to do. I would allow myself to be held hostage on the phone for hours while a complainant yelled and was abusive. I would also spend hours persuading complainants to engage with me if there was even the slightest threat of media or legal action. If any of my complainants did go to the media, I would become devastated and even more baffled.

For me, routine complaint management became a ritualized behavior until I was challenged to reflect upon my practice. It was at that point I recognized my practical wisdom in managing concerns and began to appreciate the uniqueness of each complaint and complainant. I also began to question if, in Patient Relations, we are were taking the purpose, the process, and the concerns for granted and moving forward with business as usual, until we were faced with a complainant who could not reach resolution. Unresolved complaints are assessed and evaluated against what we perceive as normal complaints. What is normal? Why would any complaint have become ritualized or normal? These questions intrigue me and fortify the appeal of my attention to understand the experience of managing querulous complainants.

My address, the call to understand the management of querulous complainants, began on the day I became a Patient Advocate. The demands of the address became increasingly vociferous as my expertise in complaints management matured and commandeered me to complete this research study, through aletheia, ritualized behaviors, and phronesis. When there are no answers to your questions, you must answer the call to seek and uncover what the topic necessitates from you.

Chapter Two: Literature Review

Prior to indulging into the phenomenon of querulous complaint, I must first examine complaint. As Friedrich Nietzsche stated, "It is impossible to suffer without making someone pay for it; every complaint already contains revenge" (n.d.). When we experience a situation that we are unsatisfied with, it is natural to feel disappointment, verbally protest our unmet expectations, and seek resolution. Our complaints are a part of our everyday experiences and are embedded in the conversations we hold.

Complaints related to our health care experiences are significant because they are connected with our wellbeing and existence. When a complaint is made in response to health care, there is a more personal value attached to the experience and context of the concern. Society demands excellence in health care, but, unfortunately, for some patients, their health care experience is not always satisfactory and expectations cannot be met. Complainant behavior is important and must be understood by health care organizations. I propose that we should consider complaints as a significant and valuable resource that can be utilized to improve health care services (Scott, 2003; Wofford et al., 2004).

Although the public does not have ultimate control over health care experiences, we do hold expectations and beliefs of health and health care delivery. According to Wright and Bell (2009) and Wright, Watson, and Bell (1996), beliefs are the lenses through which we view the world; they distinguish one person from another and navigate our experiences. If complaints are viewed through an open lens, we can be invited to reflect on the perceptions of others and the impact of the context in which we experience our relationships (Pichert, Hickson, & Moore, 2008; Scott, 2003).

Complaint is not a new phenomenon. Complaints are embedded in our everyday discourses and are so common they can become invisible. Some individuals may not even realize that they are complaining in their attempts to find a common ground in discourse. A common way to begin a conversation is through complaining about the weather, your husband, wife, children, or traffic.

Pearson (1952) identified that, in ancient Greek writings, the concepts of complaint and response to complaint were evident. *Aitia* is defined as “accusation,” “complaint,” or “grievance” and *Prophasis* means the response to a behavior or situation. These terms were used in Greek prose to describe interactions related to war as well as in medicine. There is some debate about the logic and clarity of the terms in the Greek lexicon, but the fact remains that complaint and response to complaint were identified as far back in time as the ancient Greeks.

The book of Psalms is also a significant historical reference to the phenomenon of complaint. The book of Psalms (/sɑːmz/ or /sɔː(l)mz/ SAW(L)MZ; Hebrew: תְּהִלִּים, Tehillim, "praises") is a book of the Christian Old Testament and the title is derived from the Greek lexicon, ψαλμοί, psalmoi, meaning "instrumental music" and "the words accompanying the music" (Bullock, 2004; Harper, 2020). The book of Psalms is considred as a book of poetry and praise but, it is estimated that 60 of the 150 psalms are related to laments and grievances. The book offers a means to complain either individually or communally and is intended to guide followers to lament properly to God. This could also be considered true of querulous complainants; it can be argued that perhaps they are complaining in the wrong way or at the very least, the wrong way in terms of what the PCRP requires of them.

The structure of both communal and individual laments include the following: addressing God, account of the distressing situation, blaspheming who or whatever is responsible, protesting

innocence or admitting guilt, appealing for help, faith in God's reception, anticipation of response, and a hymn of thanks. This is particularly interesting because the psalm elements are similar to the PCRP and the processes of managing a complaint can be interpreted in the same way. The concerns are brought forward, complainants are suffering and angry, a request for review is made and a response is subsequently offered. In most cases complainants are thankful and satisfied with the response and outcome. This interpretation easily applies to the general concerns process, however, I cannot appreciate the same reflection in managing a querulous complainant.

The first service related complaint recorded in history is estimated to be documented in 1750 BCE and is on display in the British Museum (Hyken, 2015). The complaint was inscribed on a clay tablet by a Babylonian merchant. The complainant was writing about his discontent with a shipment of copper ore. The complainant was reaching out to the product distributer to inform them that he felt the product was of substandard quality, that there had been a delay in delivery, and that the goods were damaged upon arrival. The translation of this complaint mirrors a common customer complaint; the only difference being that, in this century, it would have been forwarded by more advanced means of communication for response. The manner by which complainants come forward has advanced since 1750 BCE; however, the motivators of complaints have remained the same throughout time.

Literature Review

In order to understand querulous complainants, we must acknowledge the reality of complaints in health care. In the following literature review, I present existing research related to patient complaints and complaint management systems. The intention of this review is to identify the universality of complaints, and to recognize that research has not advanced to examine

complaints that cannot be resolved. This review also describes the complaint management expectations in Canada, specifically Alberta. Following a high-level overview of complaints management, the dilemma contributing to querulous complaint management is identified, and an exploration of information that exists about querulous complainants in literature is presented.

Patient Complaint Research

Salazar, Quencer, Aran, and Abujudeh (2013) conducted a retrospective evaluation of patient complaints over ten years. The complaints were specific to the Department of Radiology at the Massachusetts General Hospital in Boston. The most prevalent complaint was the lack of patient centered care and concern with the attitudes of the care providers. These are not unique findings, considering that Anderson, Allan, and Finucane (2000) had also conducted a 12-month study of elderly patients' hospital experience in an Australian hospital, and had identified similar results. Recognizing that there was a 13-year gap between both studies, patient expectations remain the same.

In response to an increase of health care complaints related to two hospitals in Paris France, Veneau, and Chariot (2013) surveyed complainants who were referred to managers for review management and resolution to their concerns. The researchers found that complainants were concerned with communication, quality of care, wait times, and billing. Of interest to my research, these are the exact top complaints brought forward to the Department of Patient Relations in Alberta. Another component of this study that was of interest was the discussion of complainants that reported being dissatisfied with how the manager interpreted the physician responses. The managers were responsible to take the concerns forward for response and resolution. When the physicians provided their responses to physician related complaints, it was up to the manager to relay the information back to the complainant. Management of complaints

relies on interpretation of information to understand and address the concern properly and in this study the authors viewed these complaints as errors in interpretation due to lack of knowledge and understanding of medical information. I believe that the tenets of interpretation are much deeper when attempting to provide information that meets the expectations of a complaint. Perhaps the managers were not providing the information that the complainant wanted to hear rather than presenting incorrect information.

Moghadam, Ibrahimipour, Akbari, Farabakhsh, and Khoshgoftar (2010) conducted a retrospective study of patient complaints at a 442 bed teaching hospital in Tehran, Iran. The study was conducted over 30 months and reviewed 1,642 complaints. The most prevalent complaints were related to patient admission processes and communication. It was identified that the results were to be utilized to improve services at the facility. Moghadam et al. (2010) identified that complaints related to the facility or services were no different that complaints brought forward in more advanced countries. Even though the authors identified that the facility was not advanced by western standards, it is important to recognize that, once again, communication emerges as a leading complaint and patients are demanding improved communication.

Anderson, Allan, and Finucane (2001) presented a study examining patient complaints related to care at a 412 bed facility in Australia. Over a period of 30 months, 1,308 complaints were received. This study identified that communication, treatment, and access were the three most common complaints. It was identified that none of the complaints were forwarded to litigation and all complainants appeared to achieve resolution. The authors identified that, at the time of this research, there was a lack of published data available to compare the findings and recommended that organizations follow a standardized method to organize complaint data.

Siyambalapitiya et al. (2007) also conducted an audit of concerns that included 183 patient complaints over a 22-month period at a National Health Service (NHS) Hospital in the United Kingdom. The most prevalent complaints included medical and nursing staff attitudes, communication, and wait times. The audit in this particular facility identified that the majority of concerns were addressed in an expedited manner, and there was no indication of complaints that could not achieve resolution. Siyambalapitiya et al. (2007) also suggested that health care organizations establish a standardized approach to collecting complaint data in order to provide robust comparisons that may contribute to system improvements.

In 2014, Reader, Gillespie, and Roberts published a systematic review of patient complaints to establish a coding taxonomy to capture and categorize patient complaints. Fifty-nine studies and 88,069 patient complaints were reviewed. The coding was intended to provide a means by which organizations can evaluate complaints in a standardized way and identify system improvements. The research is valuable and offers a collation of the common complaints; however, there are advanced technologies in place that have incorporated such data to electronically code complaints. AHS utilizes a complaint management program identified as Feedback and Concerns Tracking (FACT). This program is utilized to capture and document all complaints brought forward. Data from the system can identify the most reported complaints and target specific areas for improvement. Despite the recommendations in literature that suggest complaints can be utilized for system improvements, AHS have not mobilized beyond the data collection phase. To date there has been no major effort made to utilize the 53,794 complaint files contained in FACT for system improvements.

The only study that has ever been completed utilizing the data captured for complaints brought forward to AHS was conducted by Kline, Willness, and Ghali (2008). Using the data

captured in the Department of Patient Relations, the researchers selected 586 complaints brought forward against 45 inpatient units, at four unidentified Calgary based hospitals, in 2005. The purpose of the study was to identify if the complexity of care and the patient safety culture of the units could predict the incidence of patient complaint. It was established that the safety culture of the units did not have an impact on patient complaint. Care that involved multiple providers and areas of services was more likely to hold value as a predictor of a patient complaint. It is unfortunate that no additional research has been conducted since 2005. This is related to continuous budget constraints and lack of funding to support research. The Department of Patient Relations continues to collect valuable data that can be utilized to impact quality improvement.

Although the majority of studies offer a means to quantitatively analyze complaint data, complaints are qualitative by nature and generalizing complaints may dismiss the experiences held by complainants. The importance and value of the complaint is unique and individualized to the complaint. What may be important to a complainant may not be considered in the same way as the health care provider. Wofford et al. (2004) conducted a qualitative analysis of patient complaints related to physician behaviors. The study was intended to determine the usefulness of patient complaints in improving patient care from a physician's perspective. Two hundred and twenty-two complaints were analyzed and seven categories emerged. The authors identified that that the results would be used to develop education for physicians targeted to improve professionalism, communication, and practice based learning.

Wofford et al. (2004) offered a foundation to improve physician practice based on complaint feedback. However, Cunningham (2004) researched the impact complaints had on physicians. In this study, 211 physicians were randomly selected to complete questionnaires to evaluate the impact of receiving complaints. The results of the study revealed that there is a

significantly negative impact on a physician's emotional well-being after receiving a complaint. Furthermore, receipt of complaints did not improve their delivery of care to other patients. This study offered the most relevant research that considered the experience of complaint from a care provider perspective. Although the researchers of this study did not review the impact of complaints on other health care professionals the research findings certainly demonstrates the impact that complainants can have on health care professionals.

Literature related to the evaluation of patient complaint appears to be consistent across the world; in the research, there are similar patient complaints and positive aspirations to improve health care delivery based on these complaints. However, there is evidence to suggest that not all health care systems are operating at the same level in terms of creating quality and health care improvement initiatives to improve health care based on complaints. For example, Hsieh, Thomas, and Rotem (2005) conducted an evaluation of the complaints management process at a 1,500 bed hospital in Taiwan. The evaluation identified that there was a complete absence of a complaint management process and an avoidance of addressing complaints. Staff acknowledged their fear of complaints because of incidences where they were physically threatened by complainants. This is an interesting component of the article because aggression is noted as a characteristic of querulous complainants. Unfortunately, this study lacks elaboration on this point and the context of the complaints is unclear. Perhaps the patients are so angry about the health care services available that they are being labelled aggressive. The review concluded that significant operational improvements needed to be made at this particular hospital.

Despite the lack of discussion thus far related to unresolved complaint and querulous complaints, this population of complainants does exist. Cunningham (2004) conducted a qualitative thematic analysis of 453 physician opinions related to patient complaints. The

analysis was conducted in order to propose a change to the current physician complaints system in New Zealand. The results of the survey identified the terms frivolous, vexatious, and malicious complainants. The physicians identified these terms when referring to unreasonable complaints and complainants with malign intent. It was identified that expedited attention to these complainants, and rapid resolution, was required. Although a robust discussion related to such complainants was not offered, it provided evidence of the terms.

Complaints Management Research

In collating the research related to the evaluation of patient complaints, I was hopeful that there would be more commentary related to difficult complainants, querulous complaint, or simply complainants that could not reach resolution. Unfortunately, there is a gap in the literature and the vogue is to focus on positive patient experiences. It is recognized that there are common patient concerns that identify areas most likely to improve patient care. Patients expect individualized attention, and complaints management, when it comes to their disputes. This validates what I know about the value of complaint, but it does not provide substantive support to querulous complaint management. Considering this, it is still important to explore what is known about complaints management in literature.

Friele and Slujis (2006) examined the expectations of complaints handling from the perspective of the patient. The participants, who were also complainants, were recruited from 74 hospitals in the Netherlands. It was found that complainants come forward with concerns in the hopes that future incidents can be avoided and so they can gain a sense of resolution or justice. Friele and Slujis (2006) identified that if the resolution system in place does not permit change then individuals are less likely to have their expectations met. No additional information was

offered as to what actions would be taken if expectations were not met, nor for the implications of unresolved complaint.

In 2006, the Health Care Commission of the NHS in the United Kingdom received over 23,000 requests for an independent review of the NHS complaint management processes (Cowan & Anthony, 2008). In response, the Health Care Commission completed an audit of the complaints management. Cowan and Anthony (2008) offered their interpretations related to the audit and the reasons why individuals are unsatisfied with the way complaints are managed. The review identified that it is important in complaint systems to establish an individualized approach, and that fostering an interpersonal relationship with complainants is imperative. Essentially, despite the processes in place, the NHS was prompted to acknowledge patient and public expectations. Patient satisfaction was unlikely to change in the absence of actions taken to improve the quality of complaints management processes that are available.

Kuosmanen et al. (2008) conducted an analysis of 4,645 complaints related to health care service across five state provinces in Finland between 2000 and 2004. The majority of complaints were made against physicians and related to medical error. Concerns related to prescriptions, behaviors, and certificates also emerged. The numbers of complaints brought forward over the four years steadily increased. According to Kuosmanen et al. (2008), in Finland the public have become more aware of their rights as patients, are now more educated, and physicians are no longer seen as authorities. The analysis highlights the value of developing processes where concerns can be addressed in the very places that they occur. It was also recommended that the Finnish health care system collaborate to establish a standardized complaints process.

Querulous Complainant Research

For the past 10 years, the executive leadership in the Department of Patient Relations have been exploring the terms “frivolous” and “vexatious” to describe concerns of complainants who cannot reach resolution since 2007. The term “frivolous” describes a lack of seriousness or sense, and the term “vexatious” is used to describe a “problematic” person who repeatedly makes unfounded complaints (Freckelton, 1988). The term vexatious is recognized by the specialization of psychiatry as vexatious paranoid, and is part of a broader category of “querulous” (Freckelton, 1988).

As previously stated, I have adopted the term querulous to describe the behavior of complainants who cannot reach resolution. I have chosen this term as it does not specifically label any one characteristic of an individual; it allows for the consideration of a multiplicity of behaviors and actions. Mullen and Lester (2006) identified that there was a virtual disappearance of the term querulous in psychiatry at a time when complaint procedures were emerging as a means for resolving conflict in social systems.

There is an absence of research and literature in the health care discipline related to querulous complaint conduct, early identification, and management in health care organizations. Despite the lack of related research in health care, querulous complainants are most prominent and well understood in the practice of law (Frekelton, 1998; Lester, Wilson, Griffin, & Mullen, 2004; Morisette, 2013; Mullen & Lester, 2006).

Lévy (2015) examined the history of querulous paranoia and vexatious litigation from the 19th to 21st century. Despite the long-standing insight of the nature of querulous behaviors, the legal system has not been successful in managing querulous litigants. Although consistent and predictable behaviors have been identified, the legal system assumes responsibility of unreasonable complainants and is resistant to involve psychiatry. The resistance to involving

psychiatry is due to the potential that some may misuse a psychiatric diagnosis to silence criticism in the law.

The irony is that health care faces the same dilemma. In the Department of Patient Relations, we are unable to diagnose or pathologize complainants. The complaints process is legislated and intended to objectively manage concerns brought forward by any patient or family. The following example was shared by a participant in this study. Details of the complaint and the complaint management process have been altered to ensure complainant confidentiality.

> A complainant came forward to the Department of Patient Relations alleging that she was discharged from a nursing unit without being assessed for discharge by the physician or social worker, not provided any clothing, or transportation home. According to the complainant, she was just told by the nurse to leave. The complainant left the department in her hospital gown and stated she hitchhiked home.

The complainant contacted media with her allegations. Once the media was engaged the Department of Patient Relations was triggered to contact the complainant to assist with her concerns because of the public outrage. Following the first level of review, it was found that the complainant was told by the RN that a Social Worker (SW) was to come to assist in making arrangements for a safe and coordinated discharge however the SW was attending to another family and would come to meet with her next. The complainant was upset that she had to wait for the SW and left the unit. There was only one SW working on the unit on that particular day also; a physician and the charge RN confirmed the conversation between the RN and the complainant.

The complainant was contacted by the PCC, management, and executive leadership to discuss her concern and was offered an apology for her experience. There was a discussion about

waiting for the SW but again apologies were offered to her for having to wait. The complainant was unsatisfied, did not accept the outcome and was adamant that the RN just told her to leave. Subsequently the complainant called the Department of Patient Relations approximately 10 to 15 times per day and sent multiple emails threatening further media and legal action. The complainant then requested a second level review; the same information was provided. The complainant remained unsatisfied, requested a review from the Patient Concerns Officer. The complainant brought forth concerns regarding the process with each level of review, and was assigned four different PCCs because she was displeased with all of the individuals that were attempting to resolve her concerns. The concerns were not founded, and at no time was this complainant informed that it was not the fault of the RN, SW, or AHS that she made the decision not to wait, apologies for her experience were just perpetually offered. This complainant was permitted to continue with the complaint process for over eight months until eventually she ceased calling.

Challenges with managing querulous complainants have been identified in both the legal and health care systems, yet no one has an agreed understanding or direction. There is valuable knowledge regarding querulous behavior that can be adopted to improve concern management services in the health care system. Morisette (2013) described querulous individuals as a having a personality disorder of affect not intellect. Querulous individuals are often narcissistic, intelligent and, most often, well educated. The behavior holds similar clinical characteristics related to Obsessive Compulsive Disorder (OCD) and is most common in men between 40 and 60 years of age. According to Campbell (2013), querulous complainants are often “characterized with pejorative epithets such as ‘crazy’, ‘mad’, ‘psycho’ and worse” (n.p.).

Mullen and Lester (2006) identified that there are characteristic anomalies in the format and content of written statements from querulous complainants within the legal realm. Querulous litigants require apology and compensation, but also demand vindication. Any possible compromise prompts the litigant to take the complaint to another level of complexity, often making settlement impossible. Querulous complainants in the legal system consume an excessive amount of time and resources to address concerns that do not justify intensive management; this is no different from complaints in the health care system (Lester et al., 2004; Mullen & Lester, 2006).

Professionals in the legal vocation who interact with querulous complainants are continuously undermined professionally and are at risk of having their safety threatened (Mullen & Lester, 2006). In western countries, health care professionals are at the highest risk of violence during home visits and in waiting areas. Pediatrics, psychology, emergency, and critical care are the most dangerous clinical areas where patients or their families may harm health care providers.

Violent attacks on court officials, claims officials, and politicians are not uncommon (Mullen & Lester, 2006). This statement holds true for PCCs in the Department of Patient Relations. As a result of threats of violence, the Department of Patient Relations has been relocated to a secure unidentified building. The identities of all PCCs are restricted to a first name only. If a PCC is required to meet with an individual displaying querulous behavior, an officer from Protection Services is always present. Furthermore, the Corporate Investigations Department is engaged to support PCCs when they are faced with threats of violence and may require Police and legal intervention.

Lester, Wilson, Griffin, and Mullen (2004) questioned if there was a connection between the way complaint professionals interacted with, and managed, unusually persistent complainants; they questioned if these interactions contributed to complainants' behaviors. The data were collected from questionnaires that were completed by complaints officers from six Ombudsman offices in Australia. The complaints officers completed questionnaires related to files that were considered unusually persistent against matched controls. A connection between the way complaint professionals managed unusually persistent complainants, and their persistent behaviors, was not established. Instead, they found that the existing complaint management processes were inadequate to manage the complainant's expectations.

Lester et al. (2004) suggested that early detection of querulous conduct and establishing processes specific to management of querulous complainants is imperative. Skilling and Gordon et al. (2013) also suggested that a tool is necessary for early identification of querulous complainants. Early identification could avoid counterproductive efforts to resolve the concerns, assist in establishing an individualized managed plan, and relieve the burden these complainants place on organizations.

In the literature available, there appears to be no leader with a gold standard when it comes to patient complaint and complaints management processes. It is clear that researchers are focused on the very basics of complaint and complaint management. The variation of information demonstrates that those who have published are still in the process of attempting to "get it right," so to speak. The impact that complainants have on the health care system, and health care providers, has not yet been considered. Furthermore, even considering research related to understanding a subset of complainants, such as querulous complainants, appears to be absent.

Addressing the Gap

It is evident that the PCRP fails to provide direction to the immediate and ongoing management of complainants whose grievances cannot reach resolution because of the inability to ever conclude the PCRP, the resources required to manage the concern as well as the emotional impact on PCC's and involved health care providers. Parallel to my academic research I also work as the Provincial Director of Patient Relations. I am passionate about complaints management and supporting my team, considering this, I was compelled to work towards addressing the challenges of managing querulous complainants. Recognizing that there was no means to pre identify querulous complainants and a lack of research and resources, I then utilized learnings from my PhD course work, components of this research as well as, practical experience, to start the conversation to refer to this population as querulous as well as, to develop the Querulous Complaint Assessment Instrument (QCAI) (Appendix E, Appendix F).

Redefining Labels

For 13 years, the Department of Patient Relations had considered the terms frivolous and vexatious to describe complainants who cannot reach resolution. However, there was never any action taken to further the application of the terms. Through my research, the Department of Patient Relations has since adopted the term Querulous as a reference term. Querulous does not label the complaint or complainant but describes a pattern of behavior relating to the persistent pursuit of complaint in a manner that is disruptive to organizations attempting to achieve resolution. This is very important because how can a PCC label a complaint as frivolous when it is the belief of the complainant? It is the pattern of behavior that is of consideration, not what the complainant is bringing forth. If we reflect upon the PCRP and definitions, any person can bring

forth any concern they wish, no concern or complainant is ever denied the opportunity of review and response.

Querulous Complaint Assessment Instrument

Considering that there was an absence of research related to querulous complainants, I was captivated by the recommendations that a pre identification tool for querulous complainants was necessary. Drawing upon the description of querulous behavior presented by Mullen and Lester (2006), I established a baseline of identifiers. To ensure that I was capturing the appropriate information, I also requested input from PCCs as to their perspective of querulous behaviors and recommendation of files that they would deem as challenging. In addition to the referred files, I randomly selected complaint files 10,000 from the date range of 2010 - 2017. I examined the initial concern, letters and emails related to the concern, the number of subsequent concerns, if the file was escalated to the PCO, media and legal threats, documentation of abusive behavior as well as PCC documentation of their interactions with the complainant. I then created a list of identifiers that were prominent in all files that would be considered querulous. Throughout this process I consulted regularly with the PCC team and leadership to refine the identifiers to create an instrument that would pre identify querulous behavior, both verbally and in writing.

The instrument was designed to provide early identification of querulous complainant behavior. Early identification is essential to provide appropriate management of querulous complaints, for both the PCC and the complainant. Querulous complainants do not benefit from generic complaint management processes and creates great challenges to AHS. Considering this, I piloted the QCAI at the Foothills Medical Center, South Health Campus, Royal Alexandra Hospital, and the University of Alberta Hospital from January 1, 2019 to December 31, 2019.

The pilot was intended to influence a reduction in the misuse of organizational resources and abuse towards employees while offering a fair process that addresses the complaints brought forward by individuals that were pre identified as querulous.

All complainants that brought forth concerns related to the selected facilities were evaluated against the QCAI. If the evaluation identified that the complainant was querulous, then an expedited concerns process was initiated. The expedited process was in alignment with the legislated requirements with the only difference from the PCRP being that the review and response had to be from the highest level of operational leadership. Although the process was expedited, the review maintained integrity as well as being fair, structured, and concise. Expedited high level response to querulous complaints was essential because querulous complainants demand high level attention to their concerns. Furthermore, if the complainant remained unsatisfied then the next step would be to the PCO.

The QCAI was utilized to evaluate 1913 complaints and successfully pre identified 17 querulous complainants. Which is interesting considering that Mullen and Lester (2006) estimated that 1% to 5% of all complainants are querulous. Preliminary evaluation of the pilot identified that the QCAI was not only being used as a means of early identification but also as a way to anticipate ongoing behaviors. The PCCs reported that felt that they were enabled by the tool because it gave them an understanding to objectively manage the complainant. When PCCs knew what behaviors to anticipate they were able to establish boundaries with the complainant and easily trigger the expedited process. I am currently in the process of concluding the evaluation, the QCAI has been copy written and I am determining the next steps for use.

Importance of This Research

Managing querulous complainants in health care has not been researched from a qualitative perspective. Furthermore, there is no evidence to suggest that research has been undertaken that engages Gadamer's philosophical hermeneutics to understand the experience of managing querulous complainants. There is an ethical demand to understand how to manage querulous complainants and their reactions to unresolved health care concerns. The terms and labels associated with querulous complainants can be unjustifiably applied; patients who may have legitimate concerns are at risk of being viewed as challenging, relentless, and insignificant. This calls for attention and research; describing querulous patients as "crazy" and "psycho" is most definitely contradictory to the foundations of health care in any organization.

Perhaps a different understanding of why complainants react in a manner such that resolution cannot be achieved, through investigating the ways in which they are responded to, might lead to improved outcomes for querulous complainants.

> The Buddha once asked a student, "If a person is struck by an arrow, is it painful?" The student replied, "It is". The Buddha then asked, "If the person is struck by a second arrow, is that even more painful?" The student replied again, "It is". The Buddha then explained, "In life, we cannot always control the first arrow. However, the second arrow is our reaction to the first. The second arrow is optional". As long as we are alive, we can expect painful experiences - the first arrow. To condemn, judge, criticize, hate, or deny the first arrow is like being struck by a second arrow. Many times the first arrow is out of our control, but the arrow of reactivity is not. (Fronsdal, 2001, n.p.)

The health care system cannot be perfect. It is filled with human experience and, as such, health care concerns will inevitably arise. The extent of querulous complaints in the context of all complaints is unknown. The issue is that Provincial Regulation legislates that AHS provide a

fair process to bring forth concerns. The PCRP does not exclude any concerns brought forward; every concern, despite the context, is investigated in the exact same way. The QCAI is only one component to improving the complaints management process. Establishing an understanding of the experience of managing querulous complainants is important to proclaim the mere existence in health care, how the complaints differ from what would be considered normal in complaints management, how PCC's are impacted as well as, how the complainants are not being served well.

Concluding Thoughts

The phenomenon of complaint is not a new revelation. Despite the common character of complaint in the world, there is an absence of research and literature in the health care discipline related to querulous complaint conduct, early identification, and management in health care organizations. Recognizing that querulous complainants do not benefit from generic complaint management processes, I have established a means to provide early identification of querulous behavior and have piloted a concerns management process specific to querulous complainants. However, this research study is essential to provide an understanding of the fundamental experience of managing querulous complainants. Through understanding the experiences we can continue to work towards creating evidence based resources to assist querulous complainants in health care.

Chapter Three: Understanding the Experiences of Managing Querulous Complainants: A Hermeneutic Research Inquiry

I have utilized a qualitative design of hermeneutic inquiry as guided by the philosophical hermeneutics of Gadamer to understand the experience of managing querulous complainants. In this chapter, I will demonstrate how philosophical hermeneutics has guided my research and articulate how I interpret the historical, philosophical, and methodological underpinnings.

Hermeneutics

Hermeneutics is a search for understanding, rather than explanation, and seeks to understand how individuals make sense of experiences and how individuals understand experiences (Carnevale, 2013; Chenail, 2011; Converse 2012; Crist & Tanner, 2003; Dowling & Cooney, 2011; Gadamer, 1985, 1960/1989, 2007; Grondin, 1999/2003; Koch, 1996; Moules, McCaffrey, Field, & Laing, 2015; Smith, 1999; Standing, 2009; van Manen, 1997). Moules (2002) identified that "hermeneutics is the tradition, philosophy and practice of interpretation" (p. 4). Hermeneutics is guided by the assumption that humans experience the world historically, dialogically, contextually, and reflectively (Carnevale, 2013; Crist & Tanner, 2003; Gadamer, 1985, 1960/1989, 2007; Grondin, 1999/2003; Koch, 1996; McCaffrey, Raffin Bouchal, & Moules, 2002, 2012; Moules et al., 2015; Smith 1999; van Manen, 1997).

Hermeneutics originates from the ancient Greek era and is derived from the Greek verb *hermeneuein* (Moules et al., 2015). The word *hermeneuein* is correlated with the actions of the Greek god Hermes who was the son of the legendary god, Zeus (Gadamer, 2007; Moules et al., 2015). Hermes was unique because he was able to move between the mortal and divine worlds. Consequently, the Greek gods would summon Hermes to bring forth messages to the ancient Greeks, the human world. Hermes was very mischievous and rather than deliver the messages

translated with accuracy he would deliver the messages in ways that made the mortals have to decipher the meaning (Gadamer, 2007; Moules, 2002; Moules et al., 2015).

From Hermes to *hermeneuein*, the term hermeneutics presented itself in the 17th century and was concerned with the Biblical exegesis (Corley, Lemke, & Lovejoy, 2002; Gadamer, 2007; Gorner, 2000; Moran, 2000; Moules et al., 2015; Zimmermann, 2004). Over the 19th and 20th centuries, hermeneutics evolved and is now considered to be a philosophy of interpretation fundamental to understanding that can be applied universally and not only to theological texts. Today, hermeneutics has become a philosophical influence for many disciplines and is largely known for its influences in philosophy, anthropology, nursing, education, psychology, arts, and religious studies.

There have been many influential scholars, theorists, and philosophers who have contributed to the evolution of hermeneutics. Understanding how Gadamer established his philosophical hermeneutics requires an appreciation of the historical influences of Friedrich Schleiermacher, Wilhelm Dilthey, Edmund Husserl, and Martin Heidegger. Following a brief description of each of these philosophers and their contributions to hermeneutics, I will elaborate upon Gadamer and the main underpinnings of philosophical hermeneutics as they relate to my research endeavor.

Friedrich Schleiermacher (1768 - 1834)

Friedrich Schleiermacher was a theologian, philosopher, scholar of language, and is considered the father of modern theology and hermeneutics (Gadamer, 2007; Grondin, 1994; Moules et al., 2015). Schleiermacher defined hermeneutics as a theory of understanding and transitioned the traditional use of hermeneutics from the theological context of interpreting texts to a universal level, which included all text and forms of communication. The work of

Schleiermacher offered the human sciences an opportunity to explore interpretation and understanding. Schleiermacher identified that language is a medium in which understanding occurs (Grondin, 1994; Moules et al., 2015; Palmer, 1969, 1999).

Schleiermacher's hermeneutics consists of a two components: grammatical interpretation and psychological interpretation (Grondin, 1994; Moules et al., 2015; Palmer, 1969, 1999). Grammatical interpretation is concerned with comprehension of text. Understanding text requires a knowledge of words, in sentences, in the context of the paragraphs, all within a common language. The idea of moving back and forth within the context of the words and the text as a whole led to the concept of the *hermeneutic circle*.

Psychological interpretation was concerned with *authorial intent* (Gadamer, 2007; Grondin, 1994). According to Schleiermacher, it was essential to understand the author through biographical and historical contexts. Gadamer was critical of the idea of authorial intent and proposed the concepts of pre-understanding and subjectivity.

Wilhelm Dilthey (1833-1911)

Wilhelm Dilthey was a historian, sociologist, psychologist, and philosopher. Compounding with the work of Schleiermacher, Dilthey moved beyond the concepts of understanding related to text and authorial intent to consider the historical elements (Grondin, 1994; Moules et al., 2015; Palmer 1969, 1999). The main components of Dilthey's work were related to his questions of historicism and the problem of method. One of the most important contributions Dilthey made to the evolution of hermeneutics was the concept of *lived experience*. According to Dilthey, lived experience characterized the process of making meaning and connections.

According to Dilthey, historicism is the concept that any phenomenon must be

understood in relationship to its own time (Gadamer, 2007; Grondin, 1994; Moules et al., 2015). Essentially, he established that the values and beliefs considered normal at one point in time might not hold importance at another point in time. Historicism questions how to objectively place history within natural sciences. Natural sciences is concerned with explaining phenomena and human sciences is concerned with understanding and creating meaning.

Dilthey is also recognized for his contributions in distinguishing the human sciences from the natural sciences and differentiating between interpretation and scientific explanation. He did, in fact, try to mimic the natural sciences by developing a method of hermeneutic interpretation that would in theory lend credibility to the human sciences. However, according to Moules et al. (2015) “what limited his thought was his purpose of trying to establish a methodological foundation for the human sciences” (p.16).

Edmund Husserl (1889-1938)

Edmund Husserl is known as the father of phenomenology (Gadamer, 2007; Grondin, 1994; Moules et al., 2015). Although he was not a philosopher of hermeneutics, his work contributed greatly to hermeneutics. According to Husserl, human experience and knowing are directly correlated. Husserl’s phenomenology was concerned with what he termed the *life world*. According to Moules et al. (2015), “The idea of the life world was a further working out of the idea of the natural attitude, of the world, of everyday experience things and experiences” (p. 21).

Husserl believed that objectively examining the experiences of everyday life was the science of the life world (Gadamer, 2007; Grondin, 1994). The concept of intentionality was also central to Husserl’s phenomenology and referred to the experience of consciousness as that which provides meaning. Husserl identified that, by thoroughly examining human experiences, we can remove or peel away at the layers to reveal the essence of a phenomenon.

Although Husserl's phenomenology contributed to the evolution of hermeneutics, there are competing ideas (Gadamer, 2007). According to Husserl, it is essential to capture, isolate, and describe a phenomenon with as much depth as possible. However, for hermeneutics the experiences of a phenomenon cannot be isolated and are continuous, reflexive, relational, and consistently changing.

Martin Heidegger (1889 - 1976)

Martin Heidegger is considered to be one of the most influential philosophers in the 20th century (Gadamer, 2007; Grondin, 1994; Moules et al., 2015; Palmer, 1969). Heidegger was a celebrated student of Husserl and, in turn, he became the teacher of Gadamer. Many of his ideas are presented in the 1927 publication, *Being and Time* (Heidegger, 2010). *Being and Time* is complex and divided into two parts that explore the temporality of existence and the concept of time as the transcendental limit for questioning the meaning of being. According to Heidegger, hermeneutics is not determined by the method, rather, it is committed to the phenomenon and sought to identify that the ontology of a subject matter is part of experience.

Heidegger was concerned with the use of language to describe life as it is lived (Gadamer, 2007; Grondin, 1994; Moules et al., 2015). Heidegger identified that being in the world, *dasein,* correlated with *phronesis*, practice wisdom, which he identified as the knowledge that transpires from our experiences (Heidegger, 2010). According to Moules et al. (2015), "*Dasein*, or being in the world, as a thereness of being that is distinguished by the capacity for self-reflection; people are situated in, and constituted by, their worlds" (p. 23). Although Heidegger and Gadamer had a complicated relationship, Gadamer respected his scholarship and philosophy. Gadamer furthered the work of Heidegger to conceive his own philosophical hermeneutics.

Hans-Georg Gadamer (1900 - 2002)

Hans-Georg Gadamer was a German philosopher, known for his work related to metaphysics, epistemology, language, ontology, and aesthetics however; his most important engagement was with hermeneutics (Gadamer, 1960/1989, 2007). Gadamer's education was grounded in neo-Kantian scholarship and classical philology. Gadamer formulated his ideas related to philosophical hermeneutics in *Truth and Method* (Gadamer, 1960/1989). In the following sections, I will introduce philosophical hermeneutics and the components that are most relevant to my research.

Philosophical Hermeneutics

Gadamer's endeavor in *Truth and Method* was to provide a philosophical justification for the experience of truth, truths that transcend scientific method and insist that other understandings of phenomena are also valid (Gadamer 1960/1989). *Truth and Method* is divided into three parts that address the experience of truth in art, the experience of truth in the understanding of human science, and the ontological foundation of hermeneutics in language.

Historical Awareness, Pre-Understanding, and Prejudices

In order to begin to understand experiences, it is recognized that our consciousness is not independent of our history (Gadamer, 1960/1989). Understanding considers the effects of the past upon the present. Our past is constantly changing as we encounter new experiences and, as such, understanding is ever changing. Historical awareness is imperative for knowledge and understanding; the meaning of research phenomenon would be oblivious without holding pre-understanding. "Our historicity and tradition form the basis of our prejudice in Gadamer's conceptualization of the concept" (Gill, 2015, p.13).

According to Gadamer (1960/1989), understanding originates, in part, from our prejudices. “Gadamer claims that prejudices or prejudgments constitute our being. To understand does not necessitate that we somehow become prejudice free” (Gill, 2015, p.13). Prejudices are inherited fore-structures of understanding and consist of everything we as human beings discern consciously or unconsciously. We are not always cognizant of our prejudices, but they are present and can be invited into consciousness. Prejudices are neither positive nor negative until an alternate or new conclusion is offered.

Language and Tradition

According to Gadamer, language is of the utmost importance when examining understanding (Gadamer, 1960/1989). “Gadamer argues that language and understanding are not two processes, but one and the same” (Gill, 2015, p. 21). According to Gadamer (1960/1989), understanding is linguistically mediated. Gadamer offered that language is not the way in which we engage with the world, rather the medium for the engagement. Gill (2015) stated, “Gadamer postulates that understanding is dialogic, and thus intersubjective, including the relationship between the agent and the world” (p.1). We are in the world through language, and only through language are we given the platform to discover truths, meanings, and reality.

Gadamer (1960/1989) imparts that *tradition* is our personalized language and way of communicating. “Gadamer asserts that humans are finite beings, as such our knowledge and language are always framed within, and constituted by, our historicity and tradition” (Gill, 2015, p.12). Tradition is composed of our language, religion, and culture, essentially everything that has raised us to be who we are (Gadamer, 1960/1989). Considering this, our thinking and communication is also derived from our tradition.

Hermeneutic Circle and Fusion of Horizons

Hermeneutics refers to the shared understandings that we establish with each other and this shared understanding occurs through language and dialogue (Gadamer, 1960/1989). This view can be understood through the metaphor of a fusion of horizons. Fusion of horizons refers to the different interpretations of phenomenon that are brought together through dialogue. Understanding is achieved through openness, participation in dialogue, and fusion of horizons.

The hermeneutic circle represents the space where the interpreter transfers and shifts between and within the whole and part of the context (Cohen, Kahn, & Steeves, 2000; Binding & Tapp, 2008; Gadamer, 1960/1989; Grondin, 1999/2003; Moules, 2002; Moules et al., 2015). In order for understanding to transpire, the interpreter must experience the parts and entirety of the context being examined. We are constantly understanding and interpreting experiences; therefore, we do not have a fixed horizon and truth can never be absolute.

Defining fusion of horizons and the hermeneutic circle is important in structuring the topic of understanding the experiences of managing querulous complainants. These metaphors allow a way of considering the conversations held with the complaints. Despite the inherent difficultly in conversing with querulous complainants, Hermeneutics allows for interpretation to reveal how understanding can occur and also, by negative inference, of how it can be delayed or denied.

Research Question

I proposed to understand experiences of nurses managing querulous complaints. I questioned the relationship formed with the complainant as well as successes or failures in conversations around the complaint. How does the difficult nature of these kinds of conversations affect nurses themselves as well as their practices? What can we learn from these experiences to improve quality patient care and querulous complaint management? If we are

inviting concerns to improve patient care, it is necessary that we hold a more informed and insightful understanding of our relationship with querulous complainants. Should we not be extracting the rich information embedded within these experiences and conversations? As such, my research question was: How might we understand experiences of nurses managing querulous complainants?

Research Design

Method

I utilized a qualitative design of hermeneutic inquiry as guided by the philosophical hermeneutics of Gadamer. Often our practices go unnoticed or taken for granted; therefore, hermeneutics is well suited for nursing research because it seeks to uncover, unconceal, and reveal the assumed (Moules et al., 2014; Moules et al., 2015).

There is no prescriptive method when undertaking hermeneutic research but there are certain principles that are required to be authentic and attentive to the philosophy. Gadamer's philosophical hermeneutics is well suited for understanding experience of managing querulous complainants because

> The goal is not to carve away all the extremities of the phenomenon of interest to reach the essence or core, to achieve an uncontaminated description of it stripped of its context. Rather the desire to conserve the topic in all of its complexity. (Moules et al., 2014, p. 4)

Managing querulous complainants is complex and there must be an attempt to understand the experience in its entirety.

Ethical Considerations

Prior to initiating research involving human participants, ethics approval was required. Therefore, in proceeding with this research study, I applied for approval from the University of

Calgary Conjoint Health Research Ethics Board (CHREB). In addition to CHREB approval, I obtained approval from the Executive Leadership of Quality and Health Care Improvement at AHS, which included the Patient Concerns Officer and Executive Director of Patient Relations. These approvals allowed me to conduct my research within the Department of Patient Relations.

Considering that the Department of Patient Relations is a small group and at the time of my recruitment I was also a PCC, I was perceptive to the possibility of coercion in recruitment. At no time were any of the staff approached independently and it was up to the participants to contact me with their interest in participation. However, I was informed by two staff that they wanted to participate but feared that discussing their experiences managing complainants would negatively impact their employment. The staff believed that leadership would retaliate if they spoke about their truths. As for the participants who voluntarily participated, it is not my impression that social desirability was a factor. The openness of the conversations allowed the participants to disclose their experiences and there was no indication that they were attempting to provide desirable information because it was all so unique and personal.

Recruitment of Participants

I recruited five Registered Nurses (RN) who have been employed by AHS as a PCC in the Department of Patient Relations. The participants must have had held a full-time position in the department for a minimum of 12-months during any period between 2007 and 2016.

To recruit participants, I distributed a recruitment poster to the Executive Director of Patient Relations for display on the staff bulletin board and submission to a monthly staff e-news update. I also spoke at the Department of Patient Relations staff meeting where I presented the recruitment letter. According to the posting of information process for AHS, the recruitment poster was provided to the Office of Volunteer Resources for posting in all main elevators at the

Foothills Medical Centre (FMC), Peter Lougheed Hospital (PLC), Rockyview General Hospital (RGH), and the South Health Campus (SHC).

At the time I recruited participants for this research inquiry, the Department of Patient Relations was a small branch of Quality and Health Care Improvement with 10 PCC positions in the Calgary Zone. Taking this into consideration, the projected number of potential participants was between 5 and 10. Hermeneutic inquiry does not require an abundant number of participants and is more concerned with the selection of those who are able to enrich our understanding (Cohen et al., 2000; Moules et al., 2014; Moules et al., 2015).

Consent and Confidentiality

The University of Calgary CHREB consent form was used to gain informed consent from all participants. The consent form is only part of the process of informed consent. A full discussion of the content was provided to the participants if they had any questions. The participants were also provided a copy of the consent form. All participants were informed that there is the potential that they may recall upsetting events related to their experience in managing querulous complainants. However, participants were informed that services were available to participants if the need arose.

The participant responses from the interviews were kept confidential and pseudonyms were used in all written information for future publication and presentation of the study results. It was identified that there was a risk that information discussed during the interview will be quoted in material used for publication or teaching. These quotes were used in a way that did not disclose identity; however, the possibility of being recognized exists considering the Department of Patient Relations is small specialized area. For this reason, anonymity was not promised.

The participants were made aware that the interview would be audio recorded and transcribed. Written notes and audio recording of interviews were kept in a locked drawer in the Principal Investigator's Office at the University of Calgary (U of C). Electronic transcripts were saved on a password-protected computer and will be kept for five years and then destroyed. All audiotapes were erased once the study interviews were transcribed. Only the supervisory committee and I have access to complete transcripts. However, all participants were informed that it is possible that a member of the U of C CHREB will view the information for audit purposes.

It was clearly identified that participants were under no obligation to participate in this study. Participation in this study was voluntary and the participants were informed that they may cease the interview at any time up until data analysis was initiated. At that time, it was not possible to eliminate any information that may have been amalgamated with the other participants' information. The participants were assured that if they withdrew from the study, any information from the interview would be destroyed and would not be used in the study.

Historical Awareness, Pre-Understanding, and Prejudices

As the researcher, RN, and a PCC, I arrived at this inquiry with my own historical awareness, pre-understanding, and prejudices. Having worked in Quality and Health Care Improvement for 13 years as a PCC, I have managed thousands of complaints brought forward by patients and families who have experienced unsatisfactory health care experiences. Unfortunately, for some of these patients and families, they remained unsatisfied with their health care experience and could not reach resolution.

In reflecting on my practice and bearing witness to the practice of my colleagues, I was called to explore and understand how to best serve querulous complainants and their unresolved

concerns. Querulous complainants challenge even the most experienced clinician and appeal for an alternate understanding. I believe my insights and historical challenges are valuable and I recognize that my prejudices are not seen as negative but, instead, as crucial to understanding.

Interviews

The data for my research was audiotaped and generated through well-planned, skillfully conducted, semi-structured interviews with participants (Cohen et al., 2000; Moules, 2002). The interviews were conducted as an open process and were not be defined by closed-ended questions. In order to elicit rich narrative data, interviews resembled engaged conversations (Cohen et al., 2000; Moules et al., 2014; Moules et al., 2015). This approach allowed me to listen and be open to the participants' understandings of their experience with querulous complainants. According to Moules et al. (2015), the experience of hermeneutic interviews can be poignant and compelling for the participant and the interviewer. "The interviewer brings something to the interview, as does the participant, and it is unlikely that either will depart from the interview unchanged as a result" (p. 98).

Although the intent of the interview was to resemble a purposeful and skilled conversation, there were times when I relied on predetermined questions to guide the interview process. The intention of the interviews was to invite the participants into conversation about the ways in which they experience their work and conversations with querulous complainants. According to Gill (2015),

> Hermeneutics would be undermined if the interpreter is to concentrate on the other person, rather than on the subject matter. Gadamer clarifies that it is not a matter of looking *at* the other person, but looking *with* the other at the thing that the dialogue partners communicate about. (p. 20)

A conversation is a dialectical exchange and can never be completely under the control of either participant in the conversation, because the matter of conversation determines it. It is not in the best interest of the topic to allow the participant to lead the conversation and interview (Moules et al., 2015). “Participation and conduct, engagement and distance, focus and flexibility are at constant play in the navigation of a good interview” (Moules et al., 2015, p. 90).

Analysis and Interpretation of Data

All audiotaped interviews were transcribed verbatim and, because hermeneutics considers setting, context, and other external factors, all observations and interpretive memos were included as data and considered in analysis (Moules et al., 2015). Interpretive memos were essential to capture details, ideas, theoretical hunches, and impressions that the researcher experiences during the interview process (Cohen et al., 2000; Moules et al., 2015).

Following transcription, through a process involving reading, reviewing, and reflecting, a generation of interpretations evolved. The objective of the analysis was to produce a substantial description that convincingly and responsibly demonstrate an understanding of the nurses' experiences working with querulous complaints (Cohen et al., 2000; Moules et al., 2015).

“Hermeneutic analysis is a very deliberate attempt to listen for particulars of experiences and thoughts that are not based on repetition to authenticate their authority to speak to the topic” (Moules et al., 2015, p. 119). According to Gadamer (1960/1989), authority occurs when one is able to understand information and translate it into other own contexts. Just as I assume authority in writing this thesis, I will also do so in the analysis and interpretation of my research.

Fusion of Horizons and Hermeneutic Circle

My research relied on the concepts or metaphors of the hermeneutic circle and fusion of horizons in order to understand and bring forth interpretations (Cohen et al., 2000; Binding &

Tapp, 2008; Gadamer 1960/1989; Grondin 1999/2003; Moules 2002; Moules et al., 2015).

Fusion of horizons. According to Gadamer (1960/1989), when our horizon has extended, we become open to interpretations and greater understandings. However, in order to maintain an extended horizon, we must stay open through asking questions. Questions motivate the dialectical movement of conversation and good questions lead to greater knowledge and understandings.

In order to ensure that I was asking meaningful questions and eliciting information related to the topic of conversation, I relied on my established skill set of asking questions. As a PCC, questions were the foundation of my work. The following example identifies how I interpret fusion of horizons in the context of complaints management.

> A complainant contacts the Department of Patient Relations with the complaint that a Public Health Nurse was inappropriate when informing her that her daughter was obese. The complainant identified that the nurse repeated the word "obese" 12 times and in the background her daughter kept asking what obese meant. The complainant was so upset that she left the clinic without completing the appointment.

In this situation, the PCC listens to the recollection of events and attempts to understand the complainant's position. Questions are presented and horizons are expanded through conversation between the PCC and the complainant. The PCC explains the role of the public health nurse. The complainant identifies that she now understands that conversations related to height and weight are a function of the public health nurse and that it is a platform to offer nutrition related services. Through the conversation, the PCC understands that the complainant was offended by the conversation because she has struggled with obesity, was uncomfortable with the conversation and believed that the nurse was judging her weight and relating that to her

parenting. According to the complainant, the word "obese" was previously never used in the presence of her daughter and her family holds their own values related to body image and weight. Taking all of the information into consideration the PCC makes recommendations to the Public Health Clinic related to conversations regarding the use of the word obese and the potential that this word holds a sensitivity to some clients. The fusion of horizons has allowed the two individuals to understand the concern and exit the conversation with changed understandings.

Hermeneutic circle. For my research, I utilized the metaphor of the hermeneutic circle in my conversations with participants as well as the interpretation of data. The following is an example of how I interpret the metaphor of hermeneutic circle in the context of patient concerns.

> A PCC receives a complaint related to the attitude and practice standards of a nurse. According to the complainant, the nurse was rude, administered the wrong medication to the patient and then refused to apologize.

By all accounts, this sounds like an unfortunate situation. The PCC asks questions of the complainant, asks questions of the nurse, speaks to all employees present during the incident, and reviews the chart. In completing the review process, the PCC is going back and forth between the pieces and the whole to create context and new understanding. The investigation of a complaint is a hermeneutic circle, where all parts are considered in the context of the whole situation or complaint.

Concluding Thoughts

PCCs are, by all accounts, hermeneuts. The PCC role is inherently interpretive; consultants are employed to engage in conversation and to understand unsatisfactory health care experiences. The complainants interpret their experience and come forward with their complaint

and the PCC is responsible to then interpret the complaint and take the complaint forward for redress.

Grondin (1994) cited “The possibility that the other person may be right is the soul of hermeneutics” (Gadamer, July 9, 1989, Heidelberg Colloquium, p. 124). In my opinion, this statement also describes the soul of patient relations and my nursing practice. Managing concerns requires openness to identify the complainant’s truth and bring forward their experience against the health care system for redress.

Based upon my experiences as a PCC, I am proposing that the phenomenon of querulous patient complaints presents an immense challenge to PCCs. As such, there is an ethical responsibility to understand the experiences of managing querulous complainants. PCCs may not consider the philosophical underpinnings of their practice as it relates to concerns management. However, they depend upon scholars, researchers, and educators to provide them with the best resources to inform their practice.

I am confident that philosophical hermeneutics has supported strong, evidence-based research, suitable to expose a new understanding of the experience of managing querulous complainants. As such, my research will promote an awareness of the phenomena of querulous complainant behavior and the impact of the experience according to PCCs who are health care providers.

Chapter Four: Deconstructing the Phenomenon of Apology

Apology is a crucial component of the conversations held with querulous complainants. All of the participants who participated in this research inquiry disclosed that at no time is an apology effective or successful. This was perplexing and compelled me to refer back to a paper that was written in preparation for my candidacy. This paper was published in the *Journal of Applied Hermeneutics* and is necessary to include in this thesis to substantiate the importance of apology and to examine the notion as it applies to querulous complainants.

In order to deconstruct apology, I must present the context that requires the presence of apology. To help achieve this goal, I draw upon concepts in Richard Kearney's *Strangers, Gods and Monsters* (2003). One may think this is an odd selection based on the fact that the phenomenon of apology that I am examining is in the context of health care; however, it is a particularly relevant text. In reading *Strangers, Gods and Monsters*, I felt an analogous relationship with the content. I was not reading of strangers, gods or monsters; they were patients, hospitals, and complainants.

Throughout this chapter, I will also draw upon the work of philosophers, Hans-Georg Gadamer and Jacques Derrida, to present an interpretive account of how the hospital is a host to strangers, and to patients. Following an unsatisfactory experience or adverse event, the patients become complainants, or monsters. The PCCs, who are also considered hosts, receive the monsters at their door and, in turn, they can become hostages to the monsters. In attempting to achieve "otherness" with the monsters, the phenomenon of apology is examined.

Initial Thoughts

In preparing to present apology in this chapter, I held a conversation with myself about my truths and understandings of the phenomenon of apology in the context of patient complaints.

I concluded, with the hesitation of insulting others, that I dislike the word and the notion of apology. In the past, I suppose that I viewed apology as a positive way to take accountability and repair relationships. However, my experiences with apology as a PCC have left me with an alternate view of the word and the contexts in which it is used.

As I assess the actions of my colleagues, tucked away in our cramped cubicle spaces, busy taking complaints like a call center, I am drawn to the sounds of apologies.

> I apologize, I am so sorry that this has happened to you, I would like to apologize, please accept my apology. We apologize, we are so sorry that this has happened to you, we would like to apologize, please accept our apology.

Even more so, I am disconcerted by the appearance that these apologies have as I watch my colleagues drawing the phones from their ears as complainants yell with vengeance. I observe consultants placing their heads on their desks or gazing out the window in a moment of solitude after each interaction. It is from these observations that I somehow have grown to dread the word apology or the very words, “I am sorry,” or, “We are sorry.” In my opinion, apology from the perspective of a PCC is much like that of an empty gesture or a campaign promise. If a PCC was pressured into answering the question, “Are you truly sorry?” I predict that the answer would undeniably be, “No, I am not.” If we consider this plausible response, then who really is sorry and what is the meaning or purpose of the apology by algorithm?

In this chapter, I deconstruct apology from a patient relations perspective. According to Rolfe (2004), “deconstruction is the enemy of the authorized/authoritarian text, the text that tries to tell it like it is” (p. 275). It is by no means intended to undermine the power of apology within other contexts. Deconstruction of a complex phenomenon such as apology is no easy feat, but an attempt to do so importantly reveals the multiple meanings of this word.

Hospitality

In Canada, hospitals are a place for individuals to seek medical attention for whatever may ail them. The word hospital is derived from Old French meaning *hospital*, *ospital,* "hostel, shelter, lodging," from Late Latin *hospitale,* "guest-house, inn, noun use of neuter of Latin adjective *hospitalis* "of a guest or host." As such, a hospital, by its historical meanings, implies a place that is welcoming and hospitable. If a hospital is a hospitable space, then it has some connection with hospitality. Interestingly, hostis is the Latin root for both hospitality and hostile and can be used to identify both invitation and invasion (Kearney, 2003).

When patients arrive at the hospital, they are strangers at the door; they presume to be met hospitably. One would assume that this is, in fact, absolute hospitality, because no patient is ever turned away. Absolute hospitality "requires one to give all one has to another without asking any questions, imposing any restrictions, or requiring any compensation" (Westmoreland, 2008, p. 3). The hospital treats every being, from the wealthy businessperson arriving at the door with a heart attack to the wounded gang member left at the door, shot or stabbed. As Kearney (2003) identified,

> Absolute hospitality is a 'yes' to the stranger that goes beyond the limits of legal conventions which demands checks and measures regarding who to include and exclude. It defies border controls. By putting in such a hyperbolic way, Derrida bids us make a leap of faith toward the stranger as '*tout autre*'. A stranger always unknowable and unpredictable. A stranger of radical alterity. (p. 174)

The hospital is representative of a trusting place where it is presumed that nurses and doctors are prepared to address the needs of any stranger they encounter. Society is also led to believe that hospitals are safe and that we must trust health care providers. Health care

professionals are obligated by their professions to unconditionally respect all patients and their needs. “When there is a knock at the door, you don’t know whether the person is a monster or messiah” (Kearney, 2015, p.174). Essentially, the hospital represents absolute openness and caring of all strangers and it does not matter if they are sinner or saint.

According to Kearney (2015), respect for the individuality of each stranger is required for absolute hospitality to occur. “The master of the home, the host, must welcome in a foreigner, a stranger, a guest, without any qualifications, including having never been given an invitation” (Westmoreland, 2008, p. 4). Absolute hospitality does not restrict the host to follow any particular laws or demands to permit the guest to enter. It is an unspoken, free, and open invitation without any boundaries.

Patient as the Host

Unfortunately, for some patients, hospital care does not meet their expectations; providing health services is human and errors can be made when providing care to patients. The hospital, as a host, has not provided the hospitable services that were expected. According to Westmoreland (2008), the risk of absolute hospitality is that it permits the possibility of violence. The act of being unconditionally welcoming or hospitable opens up the door to violence. When an adverse event or unsatisfactory experience occurs, these can be considered acts of violence and, as such, absolute hospitality is disturbed. “Interruptions. That which makes unconditional hospitality possible also allows for the impossibility of hospitality” (Westmoreland, 2008, p. 6).

As a result of adverse events or unsatisfactory experiences, patients are transformed; they may leave the hospital with altered bodies and emotions that cause them to become hostile. When this occurs, the patient is no longer a patient; he or she is now a complainant. The hospital

is now held responsible for their physical and emotional injuries and, as such, is responsible to address the complainant's concerns.

Complainants contact the Department of Patient Relations to bring forth their interpretation of their health care experience. In this regard, the PCCs can be viewed as another level of hospitality in the health care system that welcomes any stranger. It is understood that individuals contacting the Department of Patient Relations are considered complainants; however, they are also strangers to PCCs, as they have never met before. "The ethos of hospitality is never guaranteed. It is always shadowed by its twin hostility. In this sense, hosting others – aliens, foreigners, immigrants and refugees - is an ongoing task; never a *fait accompli"* (Kearney, 2015, p. 173).

Many complainants are only wanting to provide feedback related to their experiences. However, for others who have been harmed, they are angry, demanding apologies, and seeking personal justice. It is at this juncture that the PCC is no longer a host, but a guest or hostage to the complainant.

> The wager of hospitality then becomes the wager of "hostipitality" (a coinage of Derrida). We can't talk about hospitality without the possibility of hostility and vice versa. In sum, host is a double term at the root of both hospitality and hostility. (Kearney, 2015, p. 178)

Considering that host is a double term, it is important to recognize that even though a PCC becomes a hostage on behalf of the health care organization to the complainant, there is an expectation that the consultant remain hospitable even in the face of hostility. "The host becomes the guest. Likewise, the guest becomes the master of the home" (Westmoreland, 2008, p. 6). "The host has welcomed into his home the very thing that can overturn his sovereignty. In

welcoming the new arrival, the host has brought about that which takes him hostage" (Westmoreland, 2008, p. 7). It is unknown which complainant will become the hostile hostage taker, and perhaps this unknown is just the nature of welcoming strangers into complaint.

According to Westmoreland (2008), "in welcoming the other the host imposes certain conditions upon the guest" (p. 2). This would be considered conditional hospitality. I pose that complainants offer conditional hospitality. They do not, and cannot, offer absolute hospitality because they are unsatisfied and suspicious of the health care system. Complainants are seeking answers to their questions and are making demands for a sense of self-justice.

Complainants or Monsters

In a complaint conversation, the angry patient now becomes the host, and PCCs are the hostages. This relationship is contrary to the health care provider and patient relationship and begs the question, what have the patients become? The patients who have become angry complainants are now even more strange to health care professionals. "The disassociation of identity and presence and the concomitant juxtaposition with a new background are likely to occur whenever naming and identity labelling are involved" (Gurevitch, 1988, p. 1192).

Through language, we can make others strangers. To call someone an angry complainant is not only implying fury; it also implies that the individual is not a patient anymore, and that he or she is no longer deserving of hospitality. Not only does the label of complainant create a stranger, the language of complaint management is also a contributor. The three most common phrases documented in patient complaint files are: the complainant alleges that, the complainant remains unsatisfied despite all levels of the review process, according to the complainant the care was unsatisfactory because. The tone and the choice of words documented by the PCC is very formal and implies that the complainant is an outsider coming forth with their narrow and angry

point of view. It can be further argued that when an angry complainant comes forward, they are treated as less reliable historians of the complaint context and there is always an underlying questionability of how they may have contributed to their own situation.

Angry complainants evoke fear in the health care system with their demands, media threats, and desire to seek revenge. We label threatening patients as complainants and we fear the existence of complainants in the health care system. The complainants no longer resemble the patient in need of caring; they are fierce and strong like monsters seeking reprisal. According to Kearney (2003), we "attempt to simplify our existence by scapegoating others as "aliens". In so doing we contrive to transmute the sacrificial alien into a monster" (p. 5).

Perhaps we fear their existence because they represent our failure in some way and the unpredictability of what they may do. Despite efforts to provide safe and quality care and services, it is inevitable that complaints will be made. Unfortunately, when it comes to querulous complainants we become paralyzed in knowing what to do with the complaints when the care or services are appropriate and meet the standards for care expected. As many participants of the study told of their experience with complaints brought forward and their irritation because they felt caught in the middle knowing that there is no right answer so to speak and there is nothing that can be done to satisfy their concerns.

> *It is like this… how can you convince some one the sky is blue and they believe it's purple …despite review after review we are just wasting our time and not really recognizing that despite all the evidence in the world that will not convince someone otherwise. (Nurse B)*

One participant shared a story of an angry complainant sharing his experience of finding an elderly woman struggling to open the doors in a stairway of a parkade. He came forward with the complaint and then also made suggestions of how the doors could be automatic and that

perhaps there could be advanced monitoring by security or parkade staff. The PCC described feeling extreme anxiety in listening though the complainant "rant." She stated that she knew in the first minute of the conversations that he would not receive a response that would satisfy him. The PCC attempted to explain that there is a requirement for fire doors but the complainant cut her off and was adamant that security be increased to monitor stairwell, then went on to demand to know about video surveillance, then moving into how he wanted to know about the allocation of funds for the site and his belief that staff are overpaid. There are just so many concerns and opinions with no answer that would be satisfactory. This complainant demanded that he receive a formal review of all of his concerns.

In health care, we do subconsciously reference angry and demanding complainants as monsters. For obvious reasons we do not refer to them as monsters but the fear and anxiety that angry complainants provoke makes them the antithesis of what we deem a good patient. According to Kearney (2003),

> Strangers, gods and monsters represent experiences of the extremity, which bring us to the edge. They subvert our established categories and challenge us to think again, and because they threaten the known with the unknown, they are often set apart in fear and trembling. Exiled to hell or heaven; or simply ostracized from the human community into the land of aliens. (p. 3)

Kearney (2003) suggested that monsters draw attention to how we perceive what is familiar and how we see the differences between same and other. Monsters give us the choice to try either to understand what is strange to us or not to acknowledge or accept anything that is unfamiliar. According to Kearney (2003), "we often project onto others those unconscious fears from which we recoil in ourselves" (p. 5). In health care, the complainants or monsters are

intimidating and rather than understand what is strange, it is common to dismiss or avoid the anger and conflict.

"No matter how many times we demonize, divinize or simply kill off our monsters, they keep returning for more" (Kearney, 2003, p. 34). This statement is elaborated upon by Kearney referencing the work of Timothy Beal, and suggests that these monsters keep returning because they have something to say to us. "The key perhaps, is not to kill our monsters but to learn to live with them" (Kearney, 2003, p. 62). I propose that this is why complainants return over and over again to the Department of Patient Relations. Angry complainants have something to say and it could be argued that we are not hearing or addressing the monster in the right or just ways. The health care system is not making improvements to satisfy the complainants and in turn creating more monsters.

Myths of using monsters as scapegoats for things we fear is not limited to ancient times. In health care, we need to invite these monsters to tell us how we can be better and improve.

> Scapegoating myths fail. A society can only pretend to believe in the lie because it is the same society that is lying to itself! Hence the ultimately self-defeating nature of ideological persecution. This is born out of the need for constant renewal of the sacrificial act. The reliance on the alien-scapegoat never subsides - at least not until such time we renounce our desire to always covert what the other has, and to accept one's other as oneself. (Kearney, 2003, p. 39)

According to Kearney (2003), "for now what is needed, when confronted with extreme tendencies to demonize or defy monsters, is to look at our own psyches, and examine our own consciousness in the mirror of our own gods and monsters" (Kearney, 2003, p. 43). "We refuse to recognize the stranger before us as a singular other who responds, in turn, to the singular

otherness in each of us. We refuse to acknowledge ourselves as others" (Kearney, 2003, p. 5). I offer that I, too, have been a monster, and would wager that we all have been, or will be, monsters in the context of health care. Even with all of my knowledge of the health care system and complaints experience, I have had the experience of becoming a monster.

> My 3-year-old daughter was ill and screaming in pain, by all accounts her symptoms resembled that of appendicitis. As any parent would do, we went to the hospital. As I waited patiently for hours in the waiting room of the Emergency Department, I could feel my anger intensify. As feelings of frustration overwhelmed me, I approached the triage desk with a limp screaming child; I became a monster, demanding care. I was no longer satisfied with my host and lost the sense of absolute hospitality.

In this situation I felt a physical change, one that turned me into an aggressor. I moved from a stranger to monster, a complainant. I was not seeking hospitality at this point I was demanding my position as the host. After the incident, I felt perplexed by the encounter. I was a PCC and knew the health care system as well as the most effective ways to bring forth concerns. However, I was transformed and believed that I was righteous in my demands for health care services.

Otherness

Following an unsatisfactory experience or adverse event, the role of a PCC is to engage in conversation and to understand the complaint, which is different from understanding the complainant. Complaints are based on events which may be a series of events that can factually be arranged into a coherent representation of what occurred. Unlike understanding the complainant which is relational, nuanced and emotive rather than factual. It is through the

conversation about the complaint that the PCC can begin to understand the complainant and their perspective, engagement occurs throughout the conversation.

According to Gill (2015), “The first condition of hermeneutics is an encounter with otherness. An encounter brings our attention to something alien which, in turn, makes us become acutely aware of the situationless of our understanding and knowing” (p. 15). When we attempt to understand something, we need to be prepared for it to tell us something new; however, this involves “an acceptance that the other person in his/her perceptive count in the dialogic deliberation” (p. 15). According to Gill (2015), Gadamer asserted that “openness to otherness calls for one’s capacity to attend to and listen to what addresses us in conversation” (p. 15).

The complainants interpret their experience and come forward with their complaint; the PCC is responsible to then interpret the complaint and take it forward for redress. In doing so, offering complainants an apology is unavoidable. Patient relations is an interpretive practice, however, and there are shortcomings when apology is inserted into the conversation with an angry complainant, a monster.

In my pursuit to deconstruct the phenomenon of apology, I was surprised to discover that the word “apology” is actually an etymological fallacy (Sihler, 2000). Apology is derived from the Greek, ἀπολογία, *apologia,* with the prefix *apo-*, meaning “away or off” and combined together with *logos*, or “speech.” The original meaning of apologize was "a speech in defense.” Over time, the meaning had shifted as a self-justification to an expression of regret or remorse; “I am sorry,” which most often includes an explanation or justification.

The literature in this area explicitly states that patients expect apologies and that apology in health care is necessary to redress complaints and acknowledge wrongdoing (Carmack, 2010; Howley, 2009; Robson & Pelletier, 2008). According to Lazare (2004),

> One of the most profound human interactions is the offering and accepting of apologies. Apologies have the power to heal humiliations and grudges, remove the desire for vengeance, and generate forgiveness on the part of the offended parties. For the offender they can diminish the fear of retaliation and relieve the guilt and shame that can grip the mind with a persistence and tenacity that are hard to ignore. The result of that apology process, ideally, is the reconciliation and restoration of broken relationships. (p. 1)

Considering this statement, apology, one simple gesture, appears to be both modest and powerful. However, apologizing in the health care discipline is not that simple. Difficultly arises because health care providers have to consider the litigious nature of the complaints. In Alberta, the provincial legislature passed the *"Apology Act,"* which was an amendment to the existing *Alberta Evidence Act*, R.S.A. 2000, c. A-18 (Apology Act, 2015). This statute was instituted to protect the actual act of apologizing from legal liability, and does not constitute an implied admission of guilt or fault.

I pose the argument that, in the very act of placing protection around apology, a part of the intended meaning is stripped away. Apology is no longer genuine and placed in the hands of the PCC to deliver. In order to offer apologies, PCCs are expected to achieve otherness. However, I argue that otherness cannot be achieved with monsters for two reasons, if PCCs are managing thousands of complaints per year, how can otherness be achieved in every conversation and, further to this, how is apology authentic? The other reason is that otherness cannot be achieved with a monster because the monster does not hold an openness to apology and is therefore provoking the PCC to offer a defensive apology.

Absence of Openness

The PCC may very well be interested in what the complainant has to say, but is the information new or just more of the same?

> *Some days I just feel like a factory hearing the same things over and over… yup.. we are sorry for your experience … one after another, after another. It is like I say "Oh we are sorry"… then put up my hand and say "NEXT". At times I do not listen to the concern because I am maxed and I have heard it all before. I just want to stuff the apology in and move on. (Nurse B)*

Considering the multiplicity of complaints, I propose that there is no space for openness when the consultant is preparing for the opportunity to apologize and move on to the next concern that is in queue. The openness to work with the individual is lost when we only offer apologies because we believe that is what he or she wants to hear.

Considering that PCCs are offering an apology on behalf of another, are we really sorry? An apology should be both genuine and thoughtful. If a PCC were consistently apologizing, one would assume that they are not sorry; considering there are in excess of 10,000 complaints per year, there would be too much to be truly sorry for. The openness required for 10,000 conversations would be extremely difficult, even impossible, for any human being. It is not their actions or omissions for which they are apologising. They are doing a third party or generic apology "I am sorry you are upset. I am sorry this happened" and apologizing for the person's reaction to the event. Apology becomes a standard statement not unlike a cashier asking if you found everything, or a stranger asking "How are you?" Similar to the apology, it is a discourse that conveys interest without actually being interested.

Defensive Apology

When a PCC is presented with the monster who is angry and abusive, it begs the question, is the consultant now in defense mode? Similarly, is the monster allowing the openness to receive an apology? “Otherness and our openness to the other are absolute prerequisites for dialogic understanding to take place” (Gill, 2015, p.16). Apology is offered but in a defense and well beyond the context of otherness.

Early Christian scholars identify that “apology,” in its original sense, was a function of “Apologetics,” which was the discipline of defending a religious position (Sihler, 2000). The term is still utilized today in politics and religion. In the political realm, Apologetics is viewed as negative and is used to describe the defense of contentious actions or policies. According to Apologetics, apologies are posed by an "apologist.” An apologist is considered to be an individual who provides justification for a belief.

In being held hostage to the monsters, apology is used in its original sense, as the manner of defense for the organization. Apology moves from the “I am sorry,” to the “we are sorry.” “We” identifies the system, and the authority of the hospital. This is a symbol of authority and removes the responsibility from the PCC. There is no possibility for openness at this point on behalf of the consultant.

> The ethical conditions of hospitality require that sometimes you have to say “no”. We are often obliged to discern and discriminate; and, so doing, one generally has to invoke certain criteria to determine whether the person coming into your home is going to destroy you and your loved ones or is going to enter in a way that, where possible, is mutually enhancing. One never knows for sure, of course, what the outcome will be. It is always a risk. To cite Derrida once more, the stranger who arrives into your home could be a murderer or a messiah. Or sometimes, a bit of both! (Kearney, 2015, n.p.)

The PCC represents the health care organization, and, as such, the apologies offered and conversations held with complainants can be viewed as defensive strategies put forth by the organization. As such, the role of the PCC is that of an apologist. According to Gill (2015),

> In a highly politicized world, there are competing ideologies, values and embedded power imbalances, all decisions are finite and limited knowledge constrained by cultural contexts, historical references and individual and institutional narratives. The project of hermeneutic ethics can help us to recognize differences, to negate meanings and to seek understanding in order to reach out to one another. (p. 24)

The following is an excerpt from a patient complaint case study that I use for education and training purposes. In this example, the author of the letter wrote to the Department of Patient Relations after her concerns had been reviewed at all levels of the PCRP.

> I have dealt with patent relations and have the findings of their investigation, as far as, I am concerned, I am done with patient relations. At no time had I been sent a copy of their investigation, at no time was I informed that there was another level that I could go it if I was not happy with the first stage, at no time have they issued an apology to the family. I am not satisfied at all by the totally apathetic non-compassionate apology by the powers that be. One would wonder how and what action would be taken if it was their brother who had died.

From this statement, it would appear that there was no effort made to resolve this complainant's concerns, and most importantly, that there was no apology made. However, in reviewing the supporting case study documentation it was identified that a verbal apology was offered to this complainant on 13 occasions. In this case, the complainant was aggressive and abusive to all individuals who interacted with her. By all accounts, the concern was reviewed

thoroughly and the standard of care was met. There was no fault for the death of her brother on the part of the hospital. Perhaps the apologies offered were not genuine, because there was a lack of openness either by the PCC or by the complainant, the monster. It could also be proposed that apologetics was at play, and the apologist was just acting defensively on behalf of the organization.

Concluding Thoughts

In health care, we will always encounter “monsters,” however, we need to understand these monsters in order to establish otherness and make change. Kearney (2003) suggested that,

> If we are to engage properly with the human obsession with strangers and enemies – is a critical hermeneutic capable of addressing the dialect of others and aliens. Such a hermeneutic would have the task of soliciting ethical decisions without rushing to judgement that is, without succumbing to overhasty acts of binary exclusion. (p. 67)

I believe that, in health care, we are not apologizing well; I propose that our apologies lack a sense of justice for others. I conclude that, as PCCs, we are apologizing according to its original intent; as apologists, and in this position of defense, we are obliterating the possibility of openness.

Chapter Five: Switching off the Human

> *You know, the robotic nature that comes with listening to it, hearing it. The minute you get this call, you immediately go on standby. Your heart ... physically, your heart rate, increases, you really have to watch your tone, because, we've all been there, they're very accusatory, threatening, scary ... I shut down and go right into robotic mode. (Nurse B)*

In the Department of Patient Relations, PCCs are in place to heed the stories of complaint. In attending to the experiences of PCCs managing querulous complainants, there was a lingering phenomenon of shutting themselves off from being human to enter a purely automated, robotic mode. Three of the five participants referenced transforming to a robotic state. Considering this, I reflected upon conversations with my coworkers over the past 13 years, I actually had never heard of the term robot or robotic mode being referenced when managing complainants. However, I admit that is exactly how I have felt in challenging conversations with querulous complainants. This was intriguing to me and a defining moment of interpretation that revealed how PCCs experience the management of querulous complainants.

> *I can just really feel myself going, kind of, like, almost robotic, where I'm doing ... I'm putting in my pieces, and I'm doing my due diligence, but my heart isn't in it in the same way. (Nurse A)*

Considering this statement, there is the possibility that as a PCC, if you switch yourself off from being human, then you are protected from querulous complainants. Furthermore, if you are protected then you are no longer vulnerable to anger and abuse. As Nurse A stated, her "heart isn't in it" however, in managing complainants who are not querulous, you do in fact use your heart. Your heart allows you to be empathetic, hold a moral compass, and offer the human side of caring and concern for the complainant's experience.

In this chapter, I will explore human vulnerability and phenomenon of shutting off to enter a robotic mode. I also discuss how turning on the robot absolves PCCs from moral agency and provides protection. The protection of PCCs as humans will be elaborated upon to further postulate that the PCCs become robots to protect not only themselves but also the organization.

Robotic Protector

There is a link between robotics and ancient Greek Mythology. The Greek legend of Talos (‘Τάλως’) offers the first “robot-like” creature in mythology (Parada, 1993). Talos was constructed of brass and the only mortal characteristic was a single vein spanning from his neck to his ankles, which perfused liquid metal that represented his lifeblood. In each ankle, a bolt was in place to prevent the liquid metal from escaping which would cause him to perish.

Talos was gifted to King Minos by Zeus to protect the island of Crete (Parada, 1993). However, protecting Crete was not his only operation; he was also responsible to ensure that the divine laws were being followed by all citizens. According to Greek legend, Talos was eventually conquered by Jason and the Argonauts through trickery. Medea, a sorceress, engaged Talos by using incantations to persuade him to remove the bolts from his ankles. Talos conceded and the liquid metal poured out leading to his ultimate demise.

PCCs hold striking similarities to Talos in the way that they are responsible to protect the organization. PCCs are consistently circling the organization warding off and protecting the organization from querulous complainants. The PCC does not allow the complainants to go beyond them and are expected to take the brunt and violent force of the complainant. However, to do so, the PCCs transform to a robotic mode.

Just as Talos, PCCs are not purely robotic; there is always a human vein. Querulous complainants have the potential to remove the bolt from the PCC and make them human again.

Talos was destroyed by trickery; this can also occur when managing querulous complainants. It is characteristic of querulous complainants to be ingratiating and attempt to draw PCCs close. When this occurs, the PCCs become physically and mentally vulnerable to the distress that is associated with managing querulous complainants.

Turning on the Robots

> *Well, I could probably win an Academy Award for my ability to go into robot mode. I'm monosyllabic, I completely change because the more you engage, the longer this is going to go on. (Nurse M)*

A robot can be defined as a being that resembles a contrivance in appearing to function automatically or in lacking common feelings and emotions (Breazeal, 2003). If PCCs are operating in a robotic manner, then perhaps, a robot is that is all that is needed to manage querulous complainants. Artificial intelligence has been utilized for decades to replace the necessity of humans in many areas requiring customer service.

According to Gale and Mochizuki (2019), the hospitality industry in Japan had attempted to completely convert to a robotic management structure when the Henn na, or Strange hotel, made headlines in 2015, with the world's first robot hotel. Unfortunately, the robots were not advanced enough to meet the needs of the guests. The robots were eventually dismissed because of guests complaining that they were not answering questions, not listening, and not understanding.

Although PCCs may be robotic in their approach, humanity is still necessary. More importantly, the human side of PCCs is essential to be unguarded to the complainants whom are not querulous. There is a necessity to be open, curious, and vulnerable. In examining the experiences of PCCs, the phenomenon of becoming robotic appears to be rooted in survival.

It's survival, and purely to do things the same way, the same process, every time, keep saying it the same thing over and over, and hopefully they'll stop if you have that consistent robotic way. (Nurse M)

Becoming robotic is not just about sheltering their humanity by shutting down or erecting an impenetrable façade, but also a way of shutting down the complainant. When the PCC cannot engage with the complainant, or just terminate the interaction, it is the only thing left to do.

Human Vulnerability

The intention of the Patient Relations Department is to take complaints from patients and families. No complaint or complainant is dismissed and every complaint is formally investigated. The public have the right to voice their concerns under legislation (Regional Health Authorities Act, 2006). However, this legislation does not support the challenges that it welcomes and allows for violent and abusive conduct. There is no ancillary legislation or process that can be initiated to support and protect the PCCs. If a complainant was declined the right to voice concerns or a review of their concerns, they can engage the Ombudsman or Human Rights. It is impossible to hold an individual accountable to their behaviour when it is their right to complain.

We are all abused. I've been called everything from the C word to B-I-T-C-H. I've been threatened and hung up on more times than I can count. (Nurse M)

This participant provided graphic detail of the verbal abuse she has experienced when dealing with querulous complainants. Considering that a genuine conversation would allow a person to be open and acquiescent of the other point of view it is clear that this would not apply in this circumstance. Being verbally abused prompts the PCC to shut down as so many participants described.

According to Moules et al., (2015), conversation is an open social form of dialectic and allows new understanding to emerge as each person is open and accepting that each other's point of view is valid. Genuine conversation is validated when both participants in the conversation find themselves subordinated in the flow of conversations led by the topic. Gadamer was setting out the conditions for understanding not implying that all conversations are reciprocal and productive. According to Flemming (2013),

> Gadamer argues that we do not successfully show respect by holding ourselves back in conversation as though supposing that the other is too weak for us, or that we know all about him already. Quite the contrary: the true dialogic attitude is an attempt to maintain complete openness, which extends to our interlocutor precisely because it starts with ourselves. The goal, meanwhile, is not to obtain or maintain good relations, but to understand something what the dialogue is about, its subject matter. For the other's view of the subject matter is the indispensable confirmation, or disconfirmation, of our own. (para. 2)

According to Flemming (2013), conversation is the game that we must play if we want to know. It is imperative to recognize that conversation is a space of risk and to take that risk opens the PCC to be vulnerable and to be vulnerable is to be human. According to Liberati and Nagataki (2018), the world could be a ruthless, amoral arena, without accepting we are essentially vulnerable.

> *I think one thing I tend to do is if somebody is continuously bringing something forward to try to get under your skin. To get you really upset, and anxious. "You people don't do anything," "You people are a bunch of lazy bitches." Instead of letting that get to me, I almost mentally go into more of a robotic mode in my mind. I don't pose questions and I*

don't argue a point that I can tell they're trying to argue. I just basically don't say anything because I need them to get off the phone. If you are not mentally protected, then you're basically going to be destroyed. (Nurse M)

In reflecting upon the experience of engaging with querulous complainants, it is understandable that PCCs are utilizing the analogy of a robot to describe how they manage the conversation and protect their vulnerability. Robots are mere instruments that are controllable, break-proof, and robust. A robot would not be vulnerable and could withstand the test of anger.

One-sided Morality

According to Singer (1975), moral agency is the ability to make judgments based on the notion of right and wrong and can only be attained if we are mindful of our vulnerability and social dependence. Morality is important to consider when participants articulate that the behavior of a querulous complainant is wrong but they have to endure the abuse because it is their job. PCCs hold morality, they know right from wrong, and they know that the querulous complainant behavior is not acceptable. More so, they struggle with the fact that the organization condones the behavior of querulous complainants. It does not outwardly condone the behavior but through expecting that situations are "handled" and that extra attention is given when legal and media threats are made.

The irony is that all employees are indoctrinated and expected to be diligent in understanding and living the mission, vision, and values of the organization. However, there is no reciprocity when it comes to patients and families. There is no expectation that patients or families hold their own morality when interacting with health care professionals.

The organization may have values but there is no moral agency. AHS is a corporate entity that claims “values” while actual moral agency does not reside anywhere, although PCCs are expected to present as moral agents of AHS.

The absence of morality can be appreciated from examining the perspective of the querulous complainant.

At least twice a week I am told “I am a tax payer and I pay your salary so you will do as I say.” There are times that this comment just makes me feel so degraded. (Nurse L)

If morality was in play and the querulous complainants were held accountable to their behaviors that would most certainly create a different playing field. If an individual were abusive to a store clerk, the police would be called. In such instance, the individual has no investment or ownership in the store and therefore they are customer, a visitor, and their behavior would be held accountable. According to Ghosh (2018), excessive demands, expectation of immediate diagnosis, and blaming physicians for their conditions were indicated in the literature as the most frequent origins of violent behavior from patients. Ghosh (2019) questioned what can be done to reduce violence against health care professionals and made a very interesting point, “in violence as is seen in western countries is how quickly the verbal abuse becomes physical assault and vandalism and how rare it is that other patients and their relatives or third party make no efforts to stop it” (p. 132).

In Canada, if you are a complainant, you are a taxpayer and, for that, some people feel as though they can behave without consequence in health care. If a complainant was declined the opportunity to be abusive, we actually do not know what that outcome or experience would be because we have never tried.

Concluding Thoughts

Vulnerability is a state of all human beings however, as a PCC, shutting off and entering a robotic mode offers a perceived sense of protection from querulous complainants and that makes the work questionably achievable. However, PCCs represent the protective layer that keeps unwanted attention to the faults of the organization contained. Just as Talos protected Crete, PCCs protect the political governance. As long as PCCs remain in their robotic mode, querulous complaints are silenced from the public but their behaviors are condoned and accepted.

Chapter Six: Playing a Game of War

It is important to acknowledge that, when Gadamer is speaking of dialectic, he is referring to dialogue (Gadamer, 1960/1989). All genuine dialogue is inherently dialectical and Gadamer views the context of dialogue similar to the structure of a game or play and the course of the game that dominates the individuals in play. Dialogue is determined by the play of the dialogue and not isolated with each individual. Both individuals must be open and comply with the movement the discourse and authentically interested in each other's position in order for truth to emerge. When players find themselves completely immersed and caught up in play, they become subordinate to the phenomenon of the game and it is the subject that leads (Moules et al., 2015).

When considering play in dialogue with a querulous complainant, the dialogue is not shared and there is an absence of dual interest. The dialogue can be described as inequitable, argumentative, and hostile.

> *They're yelling a lot on the phone, and I'm not saying that I never yell, but when every conversation turns into a war, that tells me that something's just not quite right. (Nurse A)*

Articulating that something is "not quite right," draws attention to the nature of the dialogue and the context in which it occurs. Throughout the research interviews, participants candidly discussed the act of yelling that occurs between the querulous complainant and the PCCs. In conversing about the context of yelling, the essence of being under attack was clear from the participants. Considering the references to being under attack and the terms that would be associated with a battle, I utilized the overarching metaphor of war to bring forth interpretations of the PCCs' experiences.

In this chapter, I will explore the phenomenon of dialogue at war. I am questioning what exactly the phenomenon of war is; I am also questioning who we are fighting for and exploring the impact of the war on nurses who are PCCs. More importantly, I will also examine a potential solution to end the war and return to play.

Phenomenon of War

It was ostensive that, when engaging with a querulous complainant to discuss their concerns, the complainant held strength and authority.

> *"It is common to be told that I am not important enough and the complainant demands to speak to my Manger or a "Boss." (Nurse L)*

Furthermore, the playground of a dialogue with a querulous complainant is occupied with yelling and obliterates common ground for understanding; the phenomenon of the dialogue is a war zone. The dialogue is a hostile dispute and brings truth to the statement "war is what happens when language fails" (Margaret Atwood, n.d.).

In order to postulate that the phenomenon of war is the dialogue with querulous complainants, it is important to retreat to the meaning of the word. The word war is related to Old High German werran, and the German verwirren, meaning "to confuse," "to perplex," and "to bring into confusion" (Harper, 2019). Considering that the warfare is the dialogue with a querulous complainant, the terms confuse and perplex are critical. I further purpose that the dialogue represents asymmetric warfare. Asymmetric warfare describes the context of war between combatants whose power, strategies, or tactics are significantly disproportionate (Tomes, 2004). The war involves a formal military group and an informal, less equipped and supported, but highly resilient, motivated opponent. The weaker opponent utilizes tactics to exploit weaknesses of the stronger opponent.

The biblical story of David and Goliath in 1 Samuel 17, can also be considered when interpreting battle in the context of complaints. In the story of David and Goliath, Israel was summoned to battle the Philistine army in the Valley of Elah. A Philistine giant named Goliath approached the battle line each day for forty days and taunted them to fight but King Saul and the Israelite army were terrified and did not retaliate. Until, a young Shepherd named David was sent by his father to visit his brothers, who were part of the frightened army. While visiting the frontline, David overheard Goliath challenging the Israel army. David bravely volunteered to fight Goliath and refused to wear any protective armor. Armed with only a sling and stones, David announced that he intended to battle Goliath in the name of the God of Israel. Using only the sling, David struck the giant with a stone and he fell to the ground. David then used Goliath's sword to destroy and behead him.

The account of David and Goliath can also referred to in a nonreligious sense to emphasize a situation where a weaker opponent faces a much stronger rival. The moral of the reference to the story being that the weaker opponent can win in unexpected ways. Perhaps complainants distinguish themselves as David taking on the might of the health care system, the Goliath. According to Bebe and Appel (1958), "One of our cultural myths has been that only weaklings break down psychologically and that strong men with the will to do so can keep going indefinitely" (p. 164). In conversation the weaker opponent, the complainant utilizes exhaustion as a means to gain control in dialogue. This could be understood as the unexpected means of the querulous complainant, the David, attempting to win in a battle with the health care system, the Goliath.

The Dialogue of War

Considering the term war in the context of querulous complainants, the war is between the organization and querulous complainants, who can be considered the weaker opponent. The PCCs are merely the soldiers fighting on behalf of the organization. The attributes of dialogue with a querulous complainant mirror the characteristics that describe war. Conversations with querulous complainants are imbued with violence, aggression, and destruction; the warfare is the dialogue.

Querulous is derived from the Latin *querī* meaning to complain, and describes a pattern of behavior relating to the persistent pursuit of complaint in a manner that is disruptive to organizations (Harper, 2001; Mullen & Lester, 2006). The disruptive behavior is through the use of not only aggression, and threats of violence; they can also be complementary and ingratiating in their attempts to achieve the desired outcome (Frekelton, 1998; Lester, Wilson, Griffin, & Mullen, 2004; Morisette, 2013; Mullen & Lester, 2006). As such, these tactics confuse and perplex the PCC and the conversation. The complainants are engaging asymmetric warfare and utilizing *verwirren* to manipulate the stronger force to their advantage. The querulous complainants are attempting to exploit characteristic weaknesses and the PCCs as the soldiers are at the front line managing the warfare. Complainants are entrenched in emotion and their perception of the experience rather than facts. PCCs are facing the complainants knowing the factual context of the concern, considering this aperture, miscommunication and conflict is inevitable.

The First Blast

"No physician, however conscientious or careful, can tell what day or hour he may not be the object of some undeserved attack, malicious accusation, black mail or suit for damages…" (JAMA, 1892 p. 400). Dispute, uncertainty, and misunderstandings can be all triggers to war.

When a PCC engages with a complainant, the conversations are initiated over the phone. The complainant has called with concerns related to their health care services and I suggest that this first call begins the war.

The first call is the first encounter, and that is when you get your first belligerent blast. (Nurse A)

As Nurse A described, the war begins in dialogue as a first belligerent blast. The first blast references the yelling and aggression, which immediately begins when the PCC picks up the phone.

It is a daily occurrence. Just this morning I picked up the phone and before I could say hello the caller was yelling "Just who the fuck do you people think you are? I have been waiting for 4 hours to see a fucking doctor and if you do not do something right now there is going to be hell to pay in this waiting room." He also went on to say "you best do something about that bitch peering at me through her glass window." When I attempted to find out what was happening he kept interrupting me saying "Now you tell me, are you a fucking idiot too?" and then I just gave up, he kept hammering at me. (Nurse A)

Belligerence is characteristic in a dialogue with a querulous complainant. The term is not intended to be insulting towards complainants, it is actually well suited because according to the definition, belligerent is derived from the Latin word bellum, for "war" and if someone is labeled belligerent, this means that they are eager to fight. Not only is belligerence used when referring to the opponents taking part in war, the term also describes the psychological disposition of a person. Therefore, the querulous complainant is belligerent in war and utilizes belligerence as their warfare. The use of the term belligerent is not intended to be insulting to complainants nor

to diminish the legitimacy of their concerns. The term belligerence is presented to capture the experience of being faced with a complainant that is already ireful.

Whom Are We Fighting For?

The health care system is a staple of debate in Canada. The provinces and territories are responsible for the actual administration and delivery of health care; however, health care policies are established at the federal level of government. The Canada Health Act is the official federal legislation that sets conditions by which individual provinces and territories in Canada are allocated funding for health care services (Canadian Health Act, 2018).

AHS is the provincial health care system in Alberta and is directly embedded within the provincial government. The Health Minister is at the helm and holds ultimate control. PCCs are in place to receive the concerns brought forth by the public. When a complainant contacts the Department of Patient Relations with concerns, they are often concerns against the corollaries of a system that is defined by the provincial and federal government.

> *I am told every day "I am a tax payer" by at least one complainant. I am always irritated by the accusations of "you people," "you people." (Nurse L)*

Complainants view PCCs as representatives of the government. Unfortunately, the system is so layered and bureaucratized that the Department of Patient Relations is not the appropriate venue for the concerns that are provincially and federally driven.

> *We are all under the control of the government when it comes to our health. Complainants are in one corner standing off, I'm in the other corner representing, and it is hard because they are not wrong. (Nurse E)*

One concern the PCCs frequently deal with is wait times. Waiting for care and

treatment is a common concern in Canadian health care. Patient relations receives thousands of calls related to wait times every year. The conversations about wait times are never easy and especially difficult when the complainant is querulous. The wait time conversations with querulous complainants is a guaranteed war. The PCC is defending the organization, provincial and federal legislation. In turn, the complainant is utilizing asymmetrical warfare to achieve victory.

Unfortunately, in such cases the querulous complainants will often also use media and legal threats as warfare. The organization does not want attention to be drawn to issues that may escalate to the public. In such cases the querulous complaints are expedited and given attention to what they want while complainants who are not viewed as a threat are expected to accept the circumstances of their complaints. Such cases are difficult to accept because fairness amongst all is not revered because of politics. As such, I pose that the way querulous complainants are managed under the PCRP needs to be evaluated.

The PCRP was derived from the Canada Heath Act and the Regional Health Authorities Act (Canadian Health Act, 2018; Regional Health Authorities Act, 2006)). I pose that AHS policy makers at the time failed to consider whether a universal approach to managing complaints would even be successful and did not broach the possibility of the negative outcomes. Under the process, there is nothing to address behavior that is disruptive or abusive. It is expected that all complaints and complainants can be served and we should always be tolerant of any interaction while working with complainants. Essentially the manner of which we manage patient complaints is an outcome of Groupthink and continues to be so.

In 1953, William H. Whyte Jr. derived the term Groupthink from the novel written by George Orwell, Nineteen Eighty-Four (Turner & Pratkanis, 1998). Irving Janis then established

the initial research on Groupthink theory. Groupthink is described as a phenomenon that transpires within a group of people who make decisions because of the expectation of accord (Irving, 1971; Ramsey, Chater, & Frith, 2009). I pose that the PCRP was established under the influences of Groupthink because there is no alternative to the one size fits all concern management process and the idealistic expectation that every concern can be resolved with a positive outcome for every complainant. Despite knowing that the PCRP is ineffective for querulous complainants, there has never been any action taken to revisit the policy or process. There is a tendency not to speak of the complainant behaviors, only just to keep escalating them through the process knowing it is ineffective. Groupthink is evident in the way that leaders avoid the "elephant in the room," so to speak, and do not exhibit any enterprise to establish other solutions. The organizational leadership needs to begin the conversation with AHS policy decision makers and stakeholders to acknowledge that anger and aggression is a reality in managing complaints as well as, to advocate for reconsideration of the policy and processes that was established in 2006.

As William Westmoreland (n.d.) stated "The military don't start wars. Politicians start wars." The wars fought by PCCs are essentially political and as soldiers they keep the peace for the majority of complainants and then go to battle with querulous complainants. The reality is that PCCs do not embark in battle to win or lose but to demonstrate that they have done their due diligence because they are obligated to.

Impact of the War

According to Frederic Clemson Howe, "War demands sacrifice of the people. It gives only suffering in return" (n.d.). Interactions with querulous complainants do not go without suffering; suffering through dialogue and recognizing the powerlessness in the situation.

> *You have no control over anything … There should be a place where you can say, "Okay, that's enough. We're done". You know? Type thing. I'm not saying that's always the route, but there's no place to go, you're suffering through it, and you can't stop it. (Nurse E)*

PCCs are suffering in silence and suffering at the mercy of politics. Querulous complainants want someone to suffer for their perception of wrongdoing; unfortunately, they are not aware that the only suffering that occurs is the suffering of the PCC. It is the expectation that all interactions are directed and dictated by the complainants. A PCC can never conclude a conversation or take the stance that a dialogue is abusive.

During the research interviews *Nurse B* stated, *"We are all trying to, you know, respectfully abort the mission, because these are outright horrific situations, or accusations, or comments."* However, respectfully aborting the mission is not the mandate because it is the right of the complainant to bring forth their concern in whatever way that may be. According to Gadamer (1996),

> Ever since the development of modern science with its tense relationship with concrete wealth of lived experience humankind has found itself confronted by special tasks and responsibilities, we live, on the one hand, in an environment which has been increasingly transformed by science and which we scarcely dare to term 'nature' anymore and, on the other hand in a society which has its self been wholly shaped by the scientific culture of modernity. Here we must find our own way. Yet we are surrounded by the innumerable rules and regulations, which ultimately all point towards an ever-increasing bureaucratization of life. How in the face of all this are we to sustain the courage to determine for ourselves the course of our own lives? Human beings like all living

> creatures must always defend themselves against constant and threatening attacks on their health. (p. 104)

This is applicable to complainants who wish to have their concerns reviewed under the PCRP. Unfortunately, for querulous complainants, determining the course is difficult when they have determined that revenge against health care is the preferred path.

Concluding Thoughts: Ending the War and Returning to Play

As previously stated, dialogue allows new understanding to appear as each one speaks and more importantly listens to the other. However, this does not mean that all conversations are mutual and productive and does not distinguish a phenomenon that applies to every actual conversation. This allows permission for conversations to be unproductive. If we know that holding dialogue with a querulous complainant means going to battle, perhaps we should take a different approach.

Ultimately, the Patient Relations Department is the lowest level of the bureaucracy and cannot influence changes beyond bringing forth concerns related to frontline care provided by our health care providers. The system related concerns are the politics of health care. Barricades need to be established to protect heath care staff from the abuse of the disgruntled public. There will always be a war; it is the nature of concerns and dispute. However, an alternate understanding of managing querulous complainants can generate some protective armour; knowledge is power and can equip PCCs to be better prepared to manage complainants.

Chapter Seven: Renouncing the Black Hole

> Don't search for answers which could not be given to you now because you would not be able to live them. And the point is to live everything. Live the question now. Then perhaps then someday far in the future, you will gradually without even noticing it live your way to the answer. (Rilke, 1903)

Initial Thoughts

I was captivated throughout the research process by the stories of PCCs feeling abused and suffering while endeavoring to resolve the concerns of querulous complainants. I found myself immersed in the transcripts and I was lured into a negative realm, the shadow of what could be understood differently about managing querulous complainants was becoming distant. This was not obvious at the time and only after receiving feedback from my supervisor about my analysis and interpretations, did I pause and acknowledge that this was occurring. It was as if I was being taunted to descent and only pronounce the anger and darkness. I was inert within the negative experiences, the negative words, a black hole.

I posit that the proverbial black hole I had experienced also obstructs PCCs from moving beyond their current understanding of the experience of managing querulous complainants. In this chapter, I will present the difficulty of being situated in pessimism and offer an alternate understanding of the black hole. Prejudice from a pejorative view is rendered and further examination of prejudices form a philosophical hermeneutic perspective is offered to call upon the potential for new understanding of negativity in the experience of managing querulous complainants.

Deconstructing the Black Hole

The participants in this research inquiry were given the opportunity to speak freely. The dialogue and essence of the experience was nothing like I had borne as a nurse, a PCC, or researcher. The dialogue was raw and honest and I do not believe that the PCCs would ever disclose this information in any other context. This was their opportunity to reveal their truths without boundaries and judgement.

The interviews were wrought with negativity but this was not intended to be exposed as something new. Negative interactions and negative language is ordinary to the labor of patent relations. The participants held an expectation of me, as the researcher, to utilize hermeneutics to capture the essence of the negativity and reveal a new or alternate understanding. However, I was cloaked in darkness of the negativity. It was at this juncture that I was called to question where I was situated within my research and to question my responsibility to the black hole.

"Hermeneutics is organized around the disruption of the clear narrative, always questioning those things that are taken for granted" (Moules, 2002, para. 9). The phenomena of managing querulous complainants is a profoundly forceful and mysterious aperture. "Hermeneutics calls forth the ordinary … and makes it stand out" (Moules 2002, para. 9). I was called to face an obscure ordinary of negativity in order to uncover, reveal, and expose.

Through analyzing the interviews, transcripts, and field notes, I was captured by the narrative and drawn to the disparaging energy. However, I could not articulate the feeling of being drawn into this negative space. Unknowingly, I was encountering negativity, that was erecting a powerful energy and my potential for new or alternate understanding was narrowed. This was a perplexing sentiment and not an experience of unknowing what was expected of myself in the hermeneutic inquiry.

Without Words

According to Akerjordet and Severinsson (2007), it is challenging to transform non-linguistic experiences into plausible dialogue. “Of course, the fundamental linguistically of understanding cannot possibly mean that all experiencing of the world takes place only as language and in language” (Gadamer, 1985, p. 179). Understanding is embedded within and behind the words and emotional experience itself. Acknowledging the negative emotional experience of being situated within a black hole was essential to the research process. A phenomenon which occurs without language is significant and it is essential to uncover the language of the phenomenon. Therefore, acknowledging the experience of being situated in a black hole awards importance to the phenomenon of understanding the experience of managing querulous complainants.

In order to pronounce the black hole of negativity, I examine the etymology of the terms “black” and “hole” from their linguistic association. The associative meaning of “black” is defined as "fierce, terrible, wicked” and the figurative sense of the word originates from the notion of "without light" (Harper, 2019). According to Cirlot (1971), black is representative of desolation, the unknowable, and death. The term “hole” is derived from Old English and is defined as "hollow place; cave; orifice; perforation, with origin to the PIE root *kel- "to cover, conceal, save" (Harper, 2019).

Physically, a black hole is defined by the presence of space actuated by an event horizon (Chassion, 1990). The event horizon in my experience occurred with the collision between all of the negativity, subsequently creating a black hole. The study of astrophysics suggests that when objects of extreme density unite, more power is emitted than all the stars in the space (Clavin, 2019). Now, one may presume from a hermeneutic perspective that the event horizon was a fusion of horizons however there was no fusion, a fierce cataclysmic collision occurred.

Scientifically, black holes are absolute and defined by no escape (Chassion, 1990). However, Stephen Hawking purposed that black holes are not captive and there is an exit (Choi, 2014). In a lecture at the Hawkin Radiation Conference, the physicist stated that he now believes that black holes do not abolish everything that enters. It was purposed that all information that is drawn into a black hole still exists but is changed and may not be recognizable as it once was. The reasons why black holes can store so much information remains ambiguous, however, Hawking's indicated there is potential that black holes direct information back into our universe in altered or different forms.

The black hole in this research inquiry represents negativity as a deluging unknowable and it was concealed in order to be protected and preserved against new understanding. That was the precise difficulty, the strength of the concealment was so powerful that it was with great tenacity that I was able to challenge the impenetrability to reveal the existence and potential for new, changed, or an alternate understanding. If through a black hole, as Hawkins purposed, information can be returned back not as it once was, I am respectfully open with the succor of hermeneutics to continue to unconceal the negative ordinary. However, this union must begin with attending to the possible foundations or underpinnings of the negativity.

Professing Prejudices

In conversation with a participant, she stated that she had reflected about how to change her practice in managing querulous complainants but at the end of the day, she felt that:

They should all be sent to their own little island far far away from society. (Nurse L)

This comment could be viewed as inappropriate or even prejudiced. Prejudice utilized in a pejorative sense is defined as being preconceived, unfavorable, feelings towards a person or group member based solely on that person's group membership (Wedgwood, 1855). In this

research study, the term is being applied to the negative evaluation of another person based upon their complaint behaviors.

Being a PCC is not an intolerant role and, as such, we are accountable to caring for, and listing to, complainants without bias or bigotry. I do not believe that any of my colleagues or participants of this research are prejudiced in the pejorative sense of the word. I adduce that because of the nature of the work involved with managing complaints PCCs are changed over time and are comfortable to live alongside negativity in health care. Negativity becomes part of the expected, anticipated, or ordinary world of the PCC.

The traditional view of prejudices as a narrowing interpretation is contrary to philosophical hermeneutics which revels prejudices as the foundation of understanding (Gadamer, 1960/1989). Understanding does not begin without some influence; there is already pre understanding to the context.

> The term prejudice is meant to underline the degree to which all our anticipations and expectations of meaning are grounded in the expectations we acquire from our history, from the views, concerns, interests, and assumptions of past generations, from our training and education, and from the categorical frameworks we inherit from the cultures and traditions to which we belong. Prejudices, comprise the orientation to that which we are trying to understand without which we would be unable to understand it as anything at all. (Warnke, 1997, p. 90)

According to Moules et al. (2015), existing prejudices assist understanding of a particular matter as well as the ways in which the particular prejudices originated. Existing prejudices inspire attention to the possibility of other prejudices and appreciates the potential for new understanding (Spence, 2004). According to Moules et al. (2015), prejudices are not neutral:

"There are, however, good and bad prejudices, those that leave us open to dialogue and new possibility and those that would close off dialogue, taking new information only as either conformation or contradiction of an established position" (p. 43).

Prejudices and Health Care History

Health care providers do not choose their occupations knowing everything there is to know about interacting with patients. We also hold our own history, traditions, and existing prejudices. New understandings are integrated as we establish our knowledge and practice. The phronesis or practical wisdom that is brought forth from other health care professionals influences our practice and understandings. When experienced health care providers inform us that a patient is difficult or is measured against what a good patient may emulate, we complement and extract from what we already know to uncover our own understandings. If the entire system of health care professionals declares querulous complainants as negative, then possibly this is what we have also integrated into our prejudices.

Managing querulous complainants is not well documented or researched. However, information related to our current conceptualization maybe traced back to a 41-year-old article. In 1978, Groves published an article in the prestigious *New England Journal of Medicine* titled "Taking care of the Hateful Patient."

> "Hateful patients" are not those with whom the physician has an occasional personality clash. As defined here they are those whom most physicians dread. The insatiable dependency of "hateful patients" leads to behaviors that group them into four stereotypes: dependent *clingers*, entitled *demanders*, manipulative *help-rejecters* and self-destructive *deniers.* (Groves, 1978, p. 883)

Groves (1978) categorized patients to distinguish ways that practitioners have an aversion to certain types of patients. In 1978, the article was a means to provide guidance to manage patients that presented a certain difficulty in managing. Groves presented a basis to affirm the existence of patients who were not fitting into the category of a conventional patient. However practitioners interpreted this article, it was a basis for understanding and rationalizing difficult interactions with patients at that time.

The word hateful originates from Old English hate, "hatred, spite, or malice." Its earliest meaning was "full of hate," and by the late 1500s, the definition expanded to exciting hate, evoking, or deserving hatred (Harper, 2019). The word hate is also connected to emotions and can provoke feelings of animosity or resentment, toward individuals, behaviors, or concepts (Reber & Reber, 2002). The term hate is the antithesis to the ways in which nurses or PCCs would define caring for patients. However, the participants of this study have described the feelings of animosity and resentment.

In 2018, Gunderman and Gunderman published an article in response to Groves (1978), redefining the hateful patient as the difficult patient. I would further this characterization by proposing that querulous patients are difficult. Querulous allows PCCs the ability to identify the type of complainant based on the pattern of behavior and not label the complainant as difficult or hateful. Avoiding labels is challenging because practitioners do not have a definitive term to capture the type of complainant they are faced with but, at the very least, the term querulous attributes to a behavior pattern rather than a defined term that has negative associations

Alternate Perspective

I pose that we consider that querulous complainants do have something to say and it was prejudices embedded within health care that created the phenomenon of hateful or difficult

patients. “It is the tyranny of hidden prejudices that makes us deaf to what speaks to us in tradition” (Gadamer, 2004, p. 272). Throughout the research process, the phenomenon of not listening and not hearing what querulous complainants have to say because of the negative impact was palpable. However, returning to the premise that possibly they do have something to say needs to be called into question. How did we actually come to understand querulous complainants and what is it that we are not hearing?

Through these questions, we can contemplate that querulous complainants are presenting with their own history, tradition, and prejudices which is governing their behavior, and it is our history, tradition, and prejudices that informs us they are hateful and have nothing to say. This may appear to be a simplistic rationalization but it does originate with us, we must examine how our own prejudices and how our understanding and expectations of querulous complainants came to be.

"frustrated"

frustrated at...

- the family who refuses to accept any recommendations

- the parents who don't bring their child for immunizations

- the patient who keeps calling for narcotics

- the obstetrical patient who will not take the treatment for her STD

- the psychotic patient who refuses counseling

- and in a way, myself

(Moyer, as cited in Stien, 2016)

The undertaking of hermeneutics calls upon understanding the nature of relations and being (Gadamer, 1960/1989). Certainly, prejudices authenticate our understanding and self-

understanding is important however, it is not a task of private soul searching (Moules et al., 2015). Self-reflection is required to validate the subject matter and acknowledge other possibilities. Prejudices orientate us to seek out answers to the questions can challenge even our most deeply engrained understandings.

Concluding Thoughts

"To call one to thinking is not to 'tell' but rather to take the reader on their own journey of seeing, that they too may have their own call to think" (Smythe & Spence, 2012, p. 21). Acknowledging the black hole of negativity is a profound starting point to reflect upon how prejudices have influenced the understanding of querulous complainants in health care today. The black hole is not absolute and does allow for new understanding in the way that information that is concealed and protected can be exposed and understood differently.

The participants in this study were not prejudiced according to the literal sense of the term; they were captivated by the darkness of negativity and desperate for a new understanding. Prejudices from a hermeneutic perspective offers consideration that historical prejudices in health care influenced the current understanding and potential for openness. If we have been informed and educated to understand querulous complainants as negative, unwanted, or hateful, then recognizing our prejudices, calling them forward and challenging a new understanding is necessary. In this chapter, I presented an alternate proposition of how PCCs are unknowingly influenced by the darkness of negativity and it is my hope that the premise of historically influenced prejudices in health care may enliven an alternate possibility for health care professionals.

Chapter Eight: Elucidations and Apparitions

As I commenced this research endeavor, I proposed to understand experiences of nurses managing querulous complaints. I intended to question the relationship formed as well as successes or failures in conversations. I was curious about how the difficult nature of conversations personally affected nurses as well as their practices. My intention was to learn from these experiences and establish an understanding that may potentially improve querulous complaint management. I was resolute that, if health care organizations invited concerns to improve patient care, it was necessary to hold a more informed and insightful understanding of the relationship with querulous complainants. Furthermore, I was convinced that there was rich information embedded within the experiences but required hermeneutics as a means to extract the concealed information.

The interpretations and understandings that developed through the research process are insignificant when they are secluded within their specified chapters. In order to bring forth the significance, I will return to the original question and reveal how the information extracted from the research process unites creating an alternate interpretation of understanding the experience of nurses managing querulous complainants.

Returning to the Question

When I began my research, I was curious but not credulous about experiences, relationships, and conversations with querulous complainants. On the outset, my research question appeared to be the key to a very positive endeavor that may expose a powerful nursing phenomenon in complaints communication. However, I unconcealed arduous and menacing experiences. Despite the austere presentation, I was committed to the difficulty, which is the very

nature of hermeneutics, "hermeneutics is a theory that the most important things are possible only under conditions that make them impossible" (Moules et al., 2015, p. xxi).

What I attained from examining the experiences collectively was that the PCCs were following a prescribed process to manage querulous complainants. All participants of this study disclosed that the current process for managing concerns was ineffective and held a powerful negative impact on not only themselves but also other health care professionals. This was significant to me as I reflected upon the first two pages of the *Conducting Hermeneutic Research: From Philosophy to Practice* (Moules et al., 2015). In the very foreword of the book stood a segment that was so fitting and brought forth support to enhance what was occurring. "In hermeneutics – I offer this as a working definition- it is not a matter of applying universals to a case but instead of applying cases to universals" (Captuto, in Moules et al., 2015 p. x). Interestingly when a PCC is assigned to a complaint, it is referred to as a case and the case is expected to be managed under a set of universal processes.

> Universals make handy but relatively empty place-holders, thin, schematic signifiers constituting an efficient short hand useful for exchanging information. Trading in universals is like passing along linguistic containers which require unpacking to see what they really contain when we get down to the cases. There it is again! We don't get down to cases – we raise to them! (Caputo, in Moules et al., 2015, p. x)

The cases and the experiences that the PCCs describe were no longer dormant and were ready to be unsealed. However, when the boxes were opened they did not unleash rainbows and joyous revelations. The contents of the boxes were not immediately obvious and what I found inside was obscure, dense and difficult, at first glance, it was like an unwanted gift you tape backup and hide in the basement. However, this was the gift I received and when undertaking a

hermeneutic inquiry "…we must go where it is impossible to go. Only when we experience this paralysis may we dare to proceed" (Caputo, in Moules et al., 2015, p. xxi).

When I muse over my transcriptions and the conversations held with the participants of this inquiry, I see the importance of assisting patients and families in achieving resolution to their concerns. However, when I consider a complainant that cannot reach resolution and halts the PCCs, I envision meaningless disorder as continuous attempts are made to achieve resolution with the complainant.

Albert Einstein is credited for the famous quote, "Insanity: Doing the same thing over and over again and expecting different results." Acknowledging Einstein's definition of insanity is very suitable as I endeavor to bare the experience of managing querulous complainants. If you consider the impact on the PCCs and the failure to reach resolution with the complainants who are also referred to "crazy," "mad," "psycho," it really is complete insanity (Campbell, 2013). The querulous complainants are suffering because of an event or experience that they perceive warrants complaint; however, the PCCs are suffering in their endeavors to manage the complaint.

However, it is important to consider that the experience of managing querulous complainants is a symptom of Groupthink. The health care system, which consists of the organization and government, establishes the processes and overarching expectations. The PCC has no choice but to participate in an impossible relationship with querulous complainants. I am suggesting that the insanity of doing the same thing repeatedly and never reaching resolution while accepting aggressive behavior has been normalized as the standard. AHS has a zero tolerance for abuse policy however it is very difficult to apply because health care providers tend to rationalize abusive behaviors in the context of a person's health and the stresses associated.

Through my interpretations, I pose that the participants of this research study have brought forth rich experiences and information that calls the standard into question. "In individuals, insanity is rare; but in groups, parties, nations and epochs, it is the rule" (Nietzsche, n.d.). Realities and expectations that cultivate within groups, organizations and systems can foster perspectives that accepts and even encourages erroneous behavior that would otherwise be viewed as unacceptable (Irving, 1971; Ramsey, Carter, & Frith, 2009). It is through the articulation of individualized experiences that we can begin to deconstruct the standard that has been set by Groupthink and establish a new or alternate perception.

Working with complainants is not glamorous and a role that is situated in negative experiences. To be open to this research inquiry, it is important to take into account that health care is evolving and embrace the possibility that this research can positively influence nursing and health care. Expectations, resources, technology and care have changed from the time where back rubs, and a tot of whiskey before bed kept all of the patients happy. Health care practices advance because of research.

Although some of the historic health care beliefs and practices sound absurd by today's standards, it does take many years and even centuries to make change in health care. For instance, the ancient Greeks attributed every female mental and emotional ailment to the uterus (Tasca, Rapetti, Carta, & Fadda, 2012). Hysteria was a popular conclusion that originated from the ancient Greeks and was used as a diagnosis in western medicine until the 20th century when research devised the term Pre-Menstrual Syndrome (PMS) as a medical diagnosis. Thankfully, health care has advanced and practitioners no longer believe that female cognition is controlled by the uterus. Perhaps one day we will reflect upon complaints management in health care and praise the advances.

With the expectation of health care providers to practice patient and family centered care, only positive outcomes are highlighted by management to motivate and inspire practice. Although it is human nature to be interested in negative situations, no one is interested in uncovering the descent of querulous complainant behavior and impact. Perhaps I am completely esoteric in my perspectives surrounding complaints, or perhaps I am at the vanguard in bringing forth new information. Overall, my interpretation of the experiences articulated by the PCCs managing querulous complainants represents an alternate perspective, displaces the standard, and bears experiences that readers may or may not concede.

Insanity: Robots, Gods and Black Holes

In this section, I will articulate my perspective of how the previous interpretations related to gods, monsters, robots, apologists and black holes, accrete. As I draw upon the preceding chapters, it is important to acknowledge that the sequence of chapters is not relevant. The interpretations and terms utilized throughout the thesis are brought together to display an overarching elucidation that links back to the original question.

Tête-à-tête to La Guerre

There is no warning signal that identifies when the war will begin. The war initiates when the first blast is targeted at the PCC as they engage in conversation with a stranger. The belligerent blast places the PCC in the grips of a stranger that is actually an avenging monster. The conversation immediately transforms to a battlefield and the language is the weapon. Stepping back and bracing from the first blast, PCCs have now transformed into soldiers at war for the health care organization, the god. However, the soldiers should not be in combat because they were intended to be apologists. The soldiers are not a well-trained infantry and there is no supporting commander or tactical team to rescue the injured.

The only recourse to the blast and ensuing battle is an apology. This is always the first line of defense and peace offering because there is not otherness; it is the monster that has declared the war. Unfortunately, apology is a known failure and it perpetuates aggression with the monsters. However, the monster is not stronger or ferocious, that is an enigma. The monster appears to be fierce only because the monster actually has fear as a weapon and protection. The fear is actually over the god, the organization, who holds an immense fear of the opinion of the commoners which represent the public and the possibility of campaign against the organization and government. Therefore, the monsters need to be kept at bay and silenced. There is no plan to protect soldiers from monsters or retaliate, the monsters must be appeased and provided the space to exercise their immoral conduct. Without any protection, the soldiers are powerless and suffering because of their vulnerability.

To endure the suffering, the soldiers must become unhuman to protect themselves from vulnerability. Entering a robotic mode and dawning their robot suit, they now have a self-made protection physically, mentally, and emotionally. With the protection, the robot does not hold morality and can face the monsters. The monsters are not held accountable to have morality and the god believes that they cannot be controlled or tamed. The monsters must never be caged because of the fear of what may happen when they are released and how the commoners will be influenced. Consequently, the monsters are silenced by the robots in order to contain the monster from the commoners. Conversely, the robots are also silenced because they are expected to maintain the pathological lull, carrying out business as usual. Being at war and vulnerable is the expectation of the god who fears the unknown and sacrifices the soldiers. With everyone silenced, change is impossible. The god remains in power and there is no choice to approach monsters differently or to hold an alternate understanding of the warfare and combat.

Concluding Thoughts

In several points during the research process, I found myself contemplating the interviews and appreciating that, when your occupation is to manage complaints, there is a certain difficulty in explaining to others how there is even a distinction between complainants and the experience of managing them. With all the information that I was elevating a collision occurred. In this context, I offer that the collision created a black hole, which consumed all of the information generated. My inquiry was consumed with gathering information within the black hole and only through analysis and interpretations could I exit the black hole with plausible insights. What ejected from the black hole was alternate or new information that supports how we may understand the experiences of nurses managing querulous complainants.

Due to the nature of the work in the Department of Patient Relations, verbatim encounters and specific details about interactions with querulous complainants cannot be shared because of privacy legislation. However, when collating the interpretations of the god, strangers, monsters, apologists, soldiers, robots, the experience of managing querulous complainants can be represented.

Chapter Nine: Philosophical Hermeneutics as Strong, Evidence Based Research

In the preceding chapters, I have demonstrated use of the qualitative design of hermeneutic inquiry as guided by the philosophical hermeneutics of Hans-Georg Gadamer to understand the experience of managing querulous complainants. In this chapter, I substantiate the validity, rigor, credibility, trustworthiness, and limitations of this research. I will also reflect upon lingering suspicions, and as the hermeneutic inquiry is not conclusive, I will present the considerations as they relate to future research possibilities.

Validity

This hermeneutic research inquiry is validated through understanding and the ways in which the topic disclosed itself. In qualitative research, the term validity is used to identify how the study convinces others that the study is sound and of quality. According to Moules et al. (2015), “To make something valid in the traditional scientific sense, is to make it repeatable” (p. 172). However, the intent of hermeneutics is not to proclaim validity thorough repeated information, rather to “free the topic for conversation as well as to discover something new” (Moules et al., 2015 p. 172).

The purpose of hermeneutic research is not to verify but enrich understanding and cultivate a different relationship with the truth (Freeman, 2011). Hermeneutics does not offer a method that can determine if interpretations are valid. “Gadamer seeks for us to hold off on validating because to accept that which makes most sense to us closes the conversation and does not seek to allow “truth” to have its say” (Freedman, 2011, p. 549).

According to Gadamer (1960/1989), hermeneutics does not represent a strict method to achieve understanding simply because we are not seeking a concrete means to establish a final outcome. Process more accurately describes the series of events or contributors that align to

achieve understanding. Process does not have a defined end and allows us to establish new ideas and understandings.

Rigor

Rigor refers to the ways in which researchers abide by the standards of inquiry (Armour, Rivaux, & Bell, 2009). According to Moules et al. (2015), "Hermeneutic research happens with the same structure of ethical standards as any other kind of research involving humans" (p. 177). Rigor can be defined as strict adherence to the rule, but Moules et al. (2015) preferred to use the other definition of rigor as "the quality of being careful" (p. 171).

Throughout the research process, I strictly followed all standards of inquiry. It was my responsibility as the researcher to demonstrate the trustworthiness required and now it is the responsibility of the readers to determine if the study holds merit.

Credibility and Transferability

Credibility is affirmed from the perspective of the participant; as only they can speak to the truthfulness of the results. "The veracity of hermeneutic work, or in other words, its truth value and credibility, depends upon the power of interpretations to offer faithful and recognizable descriptions of the topic that rings true to others" (Moules et al., 2015, p. 174). As a researcher, it was my responsibility to bring forward robust interpretations with depth that is true to hermeneutics.

Hermeneutic research is not focused on replication, rather the applicability of the findings to other circumstances or situations where the research is considered meaningful. According to Moules et al. (2015), transferability or generalizability is "a question of whether or not the findings of a study can be readily applied to other contexts" (p. 175).

The transferability of the findings in this research study may bring attention to the challenges in managing querulous complainants and inform all levels of health care organizations. Querulous complainants do not only exist within the Department of Patient Relations and the understandings that will be presented may be meaningful in other contexts of health care and beyond. However, this will depend upon the meaningfulness of the research to others.

Strengths

There is a plethora of information that can be learned from examining the experiences of managing querulous complainants. Managing querulous complainants in health care has not been researched from a qualitative perspective. Furthermore, there is no evidence to suggest that research has been undertaken that engages Gadamer's philosophical hermeneutics to understand the experience of managing querulous complainants.

It is difficult to understand querulous complainants in health care when there is an absence of evidenced based research that can assist to identify the patterns of behavior. Each case that is brought forward for review under all levels of the process is unique and further complicates the ability to capture the essence of defining a querulous complainant. However, PCCs are acutely aware of querulous complaint behavior. It is through their experiences that we can begin to understand. Furthermore, there is a lack of research that captures the experience of nurses managing complaint in health care as an occupation.

Limitations

According to Moules et al. (2015), "it could be argued that hermeneutic research is sometimes constrained by its very openness that resists solid conclusion" (p. 180). Fleming, Gaidys, and Robb (2003) also presented an argument that some researchers misuse and

misunderstand hermeneutics. Unfortunately, misuse and misunderstanding results in unreliable research and can be incongruent with the original intentions of the philosophy. McCaffrey and Moules (2016) stated that “One of the weaknesses that much research in nursing that claims to be hermeneutic is that it misses this point and resides too much in the personal” (p. 2).

Despite potential misinformed research, Fleming et al. (2003) offered that nursing could benefit from hermeneutics if utilized properly. However, in doing so we must consider that “Nursing is a condition of interpretative instability, saturated with possibility and concomitant anxiety; in the moment it is both academic discipline and practice profession” (McCaffrey & Moules, 2016, p. 4).

As hermeneutics is only concerned with the number of participants that are able to enrich our understanding, I chose five as my sample size (Cohen, Manion, & Morrison, 2000; Moules et al., 2014; Moules et al., 2015). At the time, I conducted my research the Department of Patient Relations was not operating as a provincial entity and my potential sample size was 10. To date there are 22 PCC’s employed to manage complaints. The change in organizational structure was not within my control but could have influenced the outcome of my research.

Implications of the Findings

I had anticipated many implications because of my research and as such, the information and findings may inform future practice and research in nursing. I am confident that philosophical hermeneutics has supported strong, evidence based research, suitable to expose a new understanding of the experience of managing querulous complainants.

Implications for nursing education. This research will promote an awareness of the phenomena of querulous complainant behavior and the impact of the experience according to nurses. Perhaps the importance of complaints in health care will be upheld by nursing educators

to enhance the edification of managing patient complaints from the front line to executive leadership. Health care providers work diligently to provide quality care but there is an absence of expertise in addressing patients and families when their expectations are not met. The Department of Patient Relations is viewed by the organization as the center of experience for complaint management. It is not uncommon for management to request in-services or education for their staff related to managing difficult patients and aggressive complaints. Unfortunately, there is no in-service or "quick fix" education that can prepare staff. There is an underlying problem of inadequate preparation of health care providers to manage conflict and we have only just begun to understand the fundamental experience of managing querulous complainants.

Implications for nursing practice. I am confident that philosophical hermeneutics has supported strong, evidence-based research, suitable to expose a new understanding of the experience of managing querulous complainants. This research study has already contributed to my development of the Querulous Complaint Assessment Instrument (QCAI). The QCAI has been developed from my research to date, analyzing 10,000 complaint files with a focused on the narrative notes as well as complaint descriptions. Consistent themes emerged and specific identifiers were examined to create the verbal and written assessment tool. The Department of Patient Relations has successfully piloted this tool as a way to pre identify querulous complainants. Perhaps the utilization of the QCAI will also lead to future complaints management research in health care.

Implications for nursing research. This study is the first known qualitative research inquiry intended to explore querulous complainants which creates a platform for new and exclusive health care complaint research in the future. The extent of querulous complaints in the context of all complaints is unknown.

Apology emerged as a significant product of the research. Hermeneutics allowed the phenomenon of apology to be deconstructed and represented through revisiting the components of Strangers, Gods and Monsters (Kearney, 2003). Apologists represented PCCs and monsters the complainants to reveal that, in health care we are not apologizing as intended, further suggesting that apologies in health care lack a sense of justice for others when considering complainants. In terms of querulous complainants, further reach is required. According to PCCs, apologies are ineffective and querulous complainants are not deserving. That being said, the phenomena of apology and worthiness does merit further investigation.

Implications for legislation. Provincial regulation legislates that health care organizations provide a fair process to bring forth concerns. The PCRP does not exclude any concerns brought forward; every concern, despite the context, is investigated in the exact same way. Complaints data is being collected but there is no focused attempt to translate the data. This research study is credible and could contribute to inform and change legislation that acknowledges the need for suitable management of querulous complainants in health care.

Concluding Statement

I am enthusiastic about the future of research related to complaints in health care especially querulous complainants. There are endless opportunities and it is an area of health care that is calling for attention. As nurses, we are not trained as conflict experts and ill prepared to face the consequences of complaint. Without the ability to openly discuss the complaints and interactions, very little is actually known about managing querulous complainants. Perhaps new understandings and future research will occur as a result of my curiosity and the address to examine the experiences of nurses managing querulous complainants.

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Confidentiality Agreement for Research Assistants / Transcribers/Translators

Principal Investigator: **Dr. N. J. Moules**, RN, PhD
University of Calgary, Faculty of Nursing Professor

Name of Researcher: **Amie Liddle**, RN, MN, Doctoral Student
University of Calgary, Faculty of Nursing PhD Program

Title of Project: Understanding the Experiences of Managing Querulous Complainants

Before transcription of research interviews, we must obtain your explicit consent not to reveal any of the contents of the tapes, nor to reveal the identities of the participants.

If you agree to these conditions, please sign below.

Print Name: ______________________

Signature: ______________________

Ethics ID: REB17-0753
Study Title: Understanding the Experiences of Managing Querulous Complainants
PI: Dr. Nancy Moules

Appendix B

UNDERSTANDING THE EXPERIENCES OF MANAGING QUERULOUS COMPLAINANTS

A Hermeneutic Research Inquiry

The Research:
Managing querulous complainants is both challenging and complex for Patient Relations Consultants. This purpose of this research study is to understand the experiences of managing querulous complainants.

Participants:
Any individual who has been employed as a Patient Relations Consultant at Alberta Health Services for over 12 months from 2007 to 2016.

Why you:
There is limited information related to the management of querulous complainants in health care. You have valuable experiences that can allow us to understand the experience of managing querulous complainants, how your experience has impacted your practice, and how we can influence querulous complaint management.

Researcher:
Amie Liddle BscN MN: PhD Student, Faculty of Nursing, University of Calgary
Dr. Nancy Moules: Supervisor,Professor,Faculty of Nursing,University of Calgary

Expectations:
Approximately one hour to participate in a one-to-one interview.
The interview would be conducted at a location and time convenient for you.

Contact:
If you would like to participate, or require additional information, please contact Amie Liddle directly at: aemilio@ucalgary.ca/587-897-2643

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Appendix C

CONSENT FORM

TITLE: Understanding the Experiences of Managing Querulous Complainants

INVESTIGATORS: **Dr. N. J. Moules**, RN, PhD
University of Calgary, Faculty of Nursing
Professor (403-220- 4635)

Amie Liddle, RN, MN, Doctoral Student
University of Calgary, Faculty of Nursing
PhD Program

This consent form is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something mentioned here, or information not included here, please ask. Take the time to read this carefully and to understand any accompanying information. You will receive a copy of this form.

BACKGROUND

The Patient Relations Department at Alberta Health Services employs Patient Concerns Consultants to manage complaints on behalf of the organization. The Patient Relations Department utilizes the most sophisticated complaints management process in Canada. In recent years there has been an increase in complaints who cannot reach resolution and have been labelled querulous. Managing querulous complainants is both challenging and complex for Patient Concerns Consultants. There is limited information related to the management of querulous complainants in health care. This Hermeneutic research study will focus on the experiences of managing querulous complainants, how the experience impacts practice, and how we can influence querulous complaint management in health care.

WHAT IS THE PURPOSE OF THE STUDY?

This purpose of this research study is to understand the experiences of managing querulous complainants.

WHAT WOULD I HAVE TO DO?

You are eligible to participate in this study if you have been employed as a Patient Concerns Consultant at Alberta Health Services for a minimum employment period of 12 months at any time from 2012 – 2016.

Amie Liddle will interview you about your experience. The interview will be approximately 1 hour and will be conducted at a location and time convenient to you. The interview will be tape recorded and transcribed by Amie Liddle.

WHAT ARE THE RISKS?

There is the potential that you may recall upsetting events related to your experience in managing querulous complainants which may make you feel uncomfortable and may leave you feeling worse than before you participated.

Should you experience any distress and feel you need support to overcome these feelings, you can speak to the principal investigator who is an experienced family therapist. Should you (or the principal investigator) feel it is necessary; the researchers can refer you to a range of counseling services, including the Employee and Family Assistance Program or the Grief Support Program of Alberta Health Services.

All responses from the interview will remain confidential. A pseudonym will be used in any written information, publication, or presentation of the study results. There is a small risk that the something that you discussed during the interview would be quoted in material used for publication or teaching. These quotes would be used in a way that does not disclose your identity.

WILL I BENEFIT IF I TAKE PART?

If you agree to participate in this study, there may or may not be a benefit to you. The information obtained from this study may help us to better understand the experience of managing querulous complaint in the context of health care.

DO I HAVE TO PARTICIPATE?

You are under no obligation to participate in this study. Participation in this study is voluntary. You may stop the interview at any time. You can withdraw from the study at any time up until data analysis has initiated. At that time there will be no way to extract your information as it will all be blended in with other participants' information.

You may withdraw from the study in the following ways:

- By contacting the principal investigator or doctoral student with your decision to withdraw;
- By not attending, or canceling, your interview appointment;
- By stopping an interview and advising the researcher that you cannot stay, wish to leave and/or withdraw from the study.

In the event that you withdraw from the study, any information from your interview will be destroyed and will not be used in the study.

WILL I BE PAID FOR PARTICIPATING, OR DO I HAVE TO PAY FOR ANYTHING?
You will not be paid for participating in this study.
If you have parking expenses the co-investigator will reimburse you for the costs incurred.

WILL MY RECORDS BE KEPT PRIVATE?
No identifying employment details, patient or colleague names will be used in this study. The interview is confidential, and your name will be removed from the typed interview and substituted with a pseudonym. The only exception is, if urgent risk to self or others is reported. In which case, the appropriate legal authorities will need to be contacted. Written and audio recording of interviews will be kept in a locked drawer at the University of Calgary. Written transcripts will be kept for five years and then destroyed. Audiotapes will be erased when the study is complete. Only the research team will see the complete transcripts. It is possible that a member of the University of Calgary Conjoint Health Research Ethics Board will view the information for audit purposes.

SIGNATURES
Your signature on this form indicates that you have understood to your satisfaction the information regarding your participation in the research project and agree to participate as a participant. In no way does this waive your legal rights nor release the investigators or involved institutions from their legal and professional responsibilities. You are free to withdraw from the study at any time. If you have further questions concerning matters related to this research, please contact:

Dr. Nancy Moules (403) 220 - 4635
Or
Amie Liddle (587) 897 - 2643

If you have any questions concerning your rights as a possible participant in this research, please contact the Chair, Conjoint Health Research Ethics Board, University of Calgary at 403-220-7990.

Participant's Name	Signature and Date
Investigator/Delegate's Name	Signature and Date
Witness' Name	Signature and Date

The University of Calgary Conjoint Health Research Ethics Board has approved this research study.

A signed copy of this consent form has been given to you to keep for your records and reference.

Appendix D

Draft - Guiding Interview Questions

- Can you tell me about how you engage or attempt to form a relationship with querulous complainants?

- Querulous complainant is only one word that is currently used to describes the population that we are discussing. How does this word fit for you and what word would you use to identify this type of complainant, and why?

- Has managing querulous complainants affected you personally and (second phase of the question) professionally? (If yes, please explain. If no, please explain why you believe that it has not?)

- How would you describe your practice of querulous complaint management compared to complainants who are not labelled querulous?

- In the Department of Patient Relations experiencing verbal abuse is part of the complainant's management role. How does being sworn at, yelled at, and personally demeaned impact you? How do you respond during these interactions?

- How are you affected when your safety and the safety of your family is threatened? How do you respond to these threats?

- How would you describe your interactions to an individual or health care professional who has no experience with querulous complainants?

- What would be the most important thing you think I should know about your experiences with querulous complainants?

- What would you want other health care professionals to know about interacting with querulous complainants?

- What are the ways in which you are supported or would like to be supported by your department or health care organization in relating to managing querulous complainants?

Appendix E

Identifiers	Yes	No
Media Threats	☐	☐
Legal Threats	☐	☐
Difficult to interrupt	☐	☐
Evidence (photos, video, recordings)	☐	☐
Defensive	☐	☐
Intimidating	☐	☐
Excessive length of conversation	☐	☐
Accusatory (organization)	☐	☐
Blaming (individuals)	☐	☐
Pedantic	☐	☐
Tangential	☐	☐
Ingratiating	☐	☐
Unable to reason	☐	☐
Repetition	☐	☐
Rhetorical Questions	☐	☐
Misuse of terms	☐	☐
Referring to self in the third person	☐	☐
Threats of violence	☐	☐
Ultimatums	☐	☐
Expecting high level attention	☐	☐

Not Querulous

7 or Less

Challenging behaviours that are more reactive and unlikely to continue for long periods of time. Individuals may frequently bring concerns forward and not follow through with seeking resolution.

Moderate Querulous

8 to 9

Moderate querulous and would require re-evaluation for increase or decrease in behaviour. Consider a management plan for concerns and behaviour depending on the circumstance and context of care. The behaviours are challenging for providers but the predictability allows for a minimal level of engagement to be sustained.

Querulous

10 to 20

Querulous Behaviours that require individualized management plan.

Appendix F

Identifiers	Yes	No
More than 4 pages	☐	☐
More than 3 attachments/references	☐	☐
Copied to more than 2 recipients	☐	☐
Media threats	☐	☐
Legal threats	☐	☐
Inconsistent format	☐	☐
Highlighting	☐	☐
Underlining	☐	☐
Capitalization	☐	☐
Repeated use of punctuation (!!!,***)	☐	☐
Rambling	☐	☐
Repetition	☐	☐
Accusatory (organization)	☐	☐
Blaming (specific individuals)	☐	☐
Rhetorical Questions	☐	☐
Misuse of terms	☐	☐
Referring to self in the third person	☐	☐
Ultimatums	☐	☐
Threats of violence	☐	☐
Expecting high level attention	☐	☐

Not Querulous

7 or Less

Challenging behaviours that are more reactive and unlikely to continue for long periods of time. Individuals may frequently bring concerns forward and not follow through with seeking resolution.

Moderate Querulous

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Querulous

10 to 20

Querulous Behaviours that require individualized management plan.