

Deconstructing the Phenomenon of Apology

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Abstract

Within Alberta Health Services, the Alberta Provincial Patient Relations Department employs Patient Relations Consultants (PRCs) to assist unsatisfied patients, investigate healthcare related concerns, and facilitate resolution. The patients, who are referred to as complainants, interpret their experience and come forward with their complaint; the PRC 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. In this article, I deconstruct apology from a patient relations perspective. I draw upon concepts in Richard Kearney's *Strangers, Gods and Monsters* (2003), as well as the work of 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 PRCs, 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.

Keywords

Hermeneutics, deconstruction, Gadamer, Kearney, apology, patient complaints

Within Alberta Health Services, the Alberta Provincial Patient Relations Department employs Patient Relations Consultants (PRC) to assist unsatisfied patients, investigate healthcare related concerns, and facilitate resolution. In the process of managing concerns, the need for apology inevitably arises. In deconstructing apology in the context of patient complaints, I draw upon concepts in Richard Kearney's *Strangers, Gods and Monsters* (2003). One may think this is an odd selection since the phenomenon of apology that I am examining is in the context of

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healthcare; however, it is a particularly relevant text. In reading *Strangers, Gods and Monsters*, I noticed that I was experiencing a dichotomous relationship with the content. I was not reading of strangers, gods or monsters; they were patients, hospitals, and complainants.

I 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 PRCs, 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,” I examine the phenomenon of apology.

Initial Thoughts

I consider my “truths” and understandings of the phenomenon of apology in the context of patient complaints. I admit, 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 PRC 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.

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 PRC is much like that of an empty gesture or a campaign promise. If a PRC 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 is really sorry and what is the meaning or purpose of the apology?

In this paper, I deconstruct apology from a professional 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 not 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 reveals the multiple meanings of this word.

Hospitality

Hospitals are places 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 business man 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 caring nurses and doctors are prepared to address the needs of any stranger they encounter. Society is also lead to believe that hospitals are safe and that we must trust healthcare providers. Healthcare 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 the foreigner, a stranger, a guest, without any qualifications, including never have 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; 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 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 interpretations of their healthcare experience. In this regard, the PRCs can be viewed as another level of hospitality in the healthcare 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 PRCs, 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 hoping 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 PRC 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 PRC becomes a hostage on behalf of the healthcare organization of 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 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 healthcare 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, I speculate that the angry patient now becomes the host, and PRCs are the hostages. This relationship is contrary to the healthcare 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 healthcare 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 PRC is very formal and implies that the complainant is an outsider coming forth with a narrow and angry point of view. It could 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 healthcare system with their demands, media threats, and unavoidable desire to seek revenge. As Friedrich Nietzsche stated “It is impossible to suffer without making someone pay for it; every complaint already contains revenge” (n.d.). We label threatening patients as complainants, and we fear the existence of complainants in the healthcare system. The complainants no longer resemble the patient in need of caring; they are fierce and strong like monsters seeking revenge. 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).

In healthcare, 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 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 either try and 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 healthcare, 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 right or just ways. The healthcare 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 healthcare, 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)

Kearney (2003) wrote “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 healthcare.

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 am a PRC and know the healthcare 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 healthcare services.

Otherness

Following an unsatisfactory experience or adverse event, the role of a PRC is to engage in conversation and to understand the complaint. Gill (2015) suggested that “(t)he 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 situation less 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 PRC 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.

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 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 healthcare is necessary to redress complaints and acknowledge wrong doing (Carmack, 2010; Howley, 2009; Robson & Pelletier, 2008). Lazare (2004) offered the following.

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 healthcare discipline is not that simple. Difficulty arises because healthcare providers must 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 PRC to deliver. To offer apologies, PRCs are expected to achieve otherness. However, I argue that otherness cannot be achieved with monsters for two reasons: if PRCs 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 PRC to offer a defensive apology.

Absence of Openness

The PRC may very well be interested in what the complainant has to say, but is the information new or just “more of the same?” 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. Gill (2015) suggested that,

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

Considering that PRCs are offering an apology on behalf of another, are we really sorry? An apology should be both genuine and thoughtful. If PRCs are consistently apologizing, one would assume that they are really not sorry; considering there are in excess of 9,000 complaints per year, there would be too much to be truly sorry for. The openness required for 9,000 conversations would be extremely difficult, even impossible, for any human being.

Defensive Apology

When a PRC 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 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 PRC. There is no possibility for openness at this point on behalf of the consultant.

The ethical considerations of hospitality require that sometimes you have to say "no". We are often obligated to discern and discriminate; and so doing, one generally has to invoke certain criteria to determine whether the person coming in your home is going to destroy you and your loved ones or is going to enter in a way that, where is 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, p.177)

The PRC represents the healthcare organization, and, as such, the apologies offered and conversations held with complainants can be viewed as defensive strategies put forth by the organization. In other words, the role of the PRC is that of an apologist.

Concluding Thoughts

In healthcare, we will always encounter “monsters;” however, we need to understand these monsters 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 do not believe that, in healthcare, we are apologizing well; I propose that our apologies lack a sense of justice for others. I conclude that, as PRCs, we are apologizing according to its original intent: as apologists and, in this position of defense, we are obliterating the possibility of openness.

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