

Résumé

Le traitement des plaintes contre les infirmières, une approche éducative axée sur le consommateur

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Dans cette étude, on s'est fondé sur une méthode d'évaluation participative pour établir l'efficacité des médiations entreprises par l'Ordre des infirmières et infirmiers de l'Ontario. À l'aide de méthodes qualitatives, on a passé en revue 34 cas traités entre 1994 et 1998; sur ce nombre, 23 ont été couronnées de succès et 11 se sont soldées par un échec. Dans le but d'établir des comparaisons, les chercheuses ont mis au point un modèle d'entrevue après avoir consulté le personnel de l'Ordre et les documents, tout en tenant compte de la philosophie de l'association et des attentes à l'égard du processus. On a mené des entrevues semi-structurées auprès de 44 participants à la démarche de médiation. De plus, on a tenu des groupes de discussion réunissant des enquêteurs et des conseillers en matière de pratique. On a analysé les données résultantes à la lumière du modèle et dégagé certains thèmes : il s'agit d'une démarche angoissante pour toutes les parties, mais qui joue un rôle éducatif et sert à traiter les plaintes, atteignant ainsi les objectifs visés. On a en outre constaté que l'Ordre était impuissant à exiger une réforme des systèmes de santé et dépendait de la coopération de chacun des établissements.

Mots clés : plaintes, médiation, éducation, infirmières

Mediating Complaints Against Nurses: A Consumer-Oriented Educational Approach

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A participatory evaluative method was used to assess the effectiveness of mediation as carried out by the College of Nurses of Ontario. Qualitative methods were used to examine 34 cases between 1994 and 1998, of which 23 had been successful and 11 aborted. For purposes of comparison, the researchers developed a template of interviews with College personnel and documents, incorporating the College's philosophy and expectations of the process. Semi-structured interviews were conducted with 44 participants in the mediation process. In addition, focus group sessions were held with Investigators and Practice Consultants. The data were analyzed using the template and themes were generated. The process was found to be stressful for all parties but was also found to be educational, to address system complaints, and to achieve initial goals. The College was found to be powerless to demand system reforms and to be dependent on the cooperation of each facility.

Keywords: complaints, mediation, education, nurses, complainants

In Canada, health-care professionals are regulated through provincial professional colleges or associations, the organization of which varies by province. In the province of Ontario, patients with a grievance against a nurse can file a complaint with the facility or with the College of Nurses of Ontario (CNO) or, alternatively, can pursue the matter in the courts. Failure to achieve satisfaction at the facility may result in the complainant seeking other avenues, although few grievances become malpractice suits and only a minority result in formal complaints (Farber & White, 1994; Mulcahy & Tritter, 1998).

In 1991 a new administrative regime for the regulation of the health professions was instituted with the *Regulated Health Professions Act, Ontario* (RHPA). The RHPA requires that each college have 40% public representation on all its committees, that its Discipline Committee be open to the public, and that the proceedings of the Discipline Committee be published in the College's annual report or another of its publications. Decisions taken by the Discipline Committee can be appealed to the Superior Court of Justice. Complaint proceedings can continue in private, with decisions based on the written evidence. Decisions can be appealed, by the complainant or by the registrant, to the Health Professions Appeal and Review Board, which is composed of lay representatives.

In Ontario, as in other jurisdictions, complaints against nurses are few. CNO annual reports for the years 1983 to 2001 indicate that while the number of complaints escalated between 1983 and 1993, it remained relatively constant in the 1990s, at approximately 0.26% of all registrants. However, in 1999 this figure increased to 0.41%, which may reflect either recent restructuring or increased public awareness of the complaint system. Also, the primary source of complaints has changed from the employer to the public. In 1983, 9% ($n = 21$) of complaints were initiated by members of the public, whereas in 1993 the figure was 78% ($n = 274$). The situation is changing, however, as reports of termination (mandatory under the legislation) have increased, so that, in 2001, 67% of all complaints ($n = 605$) were from the public and 24% were from employers (College of Nurses of Ontario [CNO], 1983–2001).

Under the RHPA, all complaints must be investigated and disposed of by the Complaints Committee. The Complaints Committee can refer a complaint to the Discipline Committee or to the Executive Committee; require the member to appear before it; take no further action; issue a reminder, oral caution, letter of caution, or advice; or order the registrant to undertake certain remedial steps. Cases dealt with at this level are not publicized, but a record of the complaint and the action taken is placed in the member's file. Cases referred to the Discipline Committee are serious and/or a breach of nursing practice or conduct with *prima facie* evidence of misconduct, and are reported in the College's *Communiqué*. These cases are few in number, representing approximately 3.5% of all complaints between 1993 and 1997, 6.7% in 1999, 9% in 2000, and 6% in 2001 (CNO, 1983–2001).

In 1994 the CNO introduced the Participative Resolution Program (PRP) for less serious complaints at the intake point of the disciplinary process. The College controls the process. It chooses cases suitable for the PRP, a College representative acts as the facilitator, and the Complaints Committee must approve the agreement before it becomes binding. Specific goals are to rectify a situation, prevent its recurrence, and avoid assigning blame as in the formal proceedings. The process is flexible and usually takes the form of shuttle diplomacy rather than face-to-face meetings. If an agreement is reached, the formal letter of complaint is withdrawn and the member's file contains no record. If the parties withdraw from the process or an agreement cannot be reached, the complaint proceeds through the formal complaint process.

CNO staff use specific criteria for selecting complaints. There must be some substance to the concerns as well as a reasonable prospect of resolving the complaint consistent with the public interest and within an acceptable period. Also, staff must have screened the complaint according to the type and mitigating or aggravating circumstances. A complaint is

rejected if it can potentially be referred to the Discipline Committee or if it is “not serious” or has mitigating circumstances.

To ascertain whether the PRP was meeting the College's overall objectives of protecting the public's right to quality nursing services and improving nursing practice, the CNO commissioned a study of the program. The specific objectives of the study were to assess the perceived impact of the PRP on complainants, members, the CNO, and other parties such as lawyers and facility representatives; to determine whether the results improved nursing practice; and to assess the extent to which the parties involved understood the process and were satisfied with it. Additional objectives were to assess whether the process should be expanded or modified and to suggest possible changes.

Background

In today's health-care systems, the interpretive structures and values of professionals and their organizations are being challenged (Freidson, 2001). One challenge confronting systems is the contradiction between the goals of the employing institution, such as rationalism and efficiency, and the goals of the profession, such as maintaining professional standards and codes of conduct. Another is the increased demands made by clients that professionals be more accountable and that their organizations be more responsive to their concerns.

Possibly more than other health professionals, nurses are experiencing pressures that can encourage attitudes and actions that conflict with their professional ethics. They face increasing employer demands, client expectations, and demands by their professional organizations that they meet more rigorous standards — all within a context of resource and personnel shortages and an ideology of heightened efficiency. Failure to meet client expectations or professional standards can result in a complaint against one nurse or several, in which case the nurse or nurses enter the disciplinary process.

Most disciplinary systems follow a prosecutory/disciplinary model in which the individual practice of the health practitioner is assessed to determine whether professional standards have been breached. Preliminary assessments are conducted in private and proof of a breach of standards of practice and professional misconduct is required, so that only clear-cut cases are addressed. The onus is on the individual (who is punished if found guilty); no action is taken against the organization (Allsop & Mulcahy, 1996, p. 179). This disciplinary process is reactive — geared to searching out the “bad apple” to protect the profession — and is based on the assumption that individual professionals can control their practice. It cannot address cases in which there is no clear evidence that a

breach has taken place, though complainants who are dissatisfied may appeal. Neither does it address any problems inherent in the work situation, so that an incident that is system-based may recur with another nurse.

The prosecutory/disciplinary model may be appropriate when professionals have control over their working conditions or when they are able to influence policy, managerial practices, and the allocation of resources. It is inappropriate when there is a shortage of resources or personnel or when organizational goals conflict with professional goals. In these circumstances, while a complaint is a symptom of inadequate nursing care, punishment may not rectify the situation and the incident may be repeated with another nurse, especially under conditions of downsizing and re-engineering. Moreover, disciplinary decisions must be based on evidence of professional misconduct, incompetence, or incapacity, which may be vague and difficult to prove. This requirement means that the origins of less serious complaints are not addressed. The 1990s saw an increase in "take no action" decisions by the CNO Complaints Committee, which implies that many complaints were not proven or were deemed not serious.

In today's climate a consumer-oriented/learning type of regulation may be a more appropriate way to address complaints. In this model the complaint system has two goals: to satisfy the complainant and to use the complaint to improve the quality of the organization's services. Responsibility lies not with the individual but with the team or group, and complaints are viewed as a form of consumer feedback — an opportunity to improve practice and prevent a recurrence (Allsop & Mulcahy, 1996).

In the early 1990s the CNO became aware of considerable dissatisfaction with its disciplinary process, as the number of appeals to the Health Professions Board was increasing. There were 33 appeals in 1990, 63 in 1991 (excluding a matter involving 106 registrants), 67 in 1992, 56 in 1993, and then 150 in 1994. Also, it was questionable whether the goal of improving nursing practice was being met, because many complaints were resulting in a "take no action" decision, possibly because the complaint could not be substantiated. In 1993, for example, 61% of Complaint Committee decisions were "take no action." To address these issues, the CNO introduced elements of the consumer-oriented/learning model into the disciplinary process through the PRP, thereby adopting both a prosecutory/disciplinary model and a consumer-oriented/learning model. This represented a leap into unknown territory.

The literature on alternative dispute resolution (ADR) in health care is limited and rarely focuses on nurses. Authors do not examine whether ADR is an effective method for improving professional practice, satisfying the complainant, or preventing a recurrence. Most of the literature

originates in the United States and focuses on whether ADR is a suitable method for avoiding malpractice suits against physicians. It considers whether ADR should be mandatory before litigation proceeds, whether screening for mediation is useful, and why ADR has not been embraced as a malpractice reform (Kinney, 1995; Meschievitz, 1991; Metzloff, Peeples, & Harris, 1997). Less frequently discussed is the use of ADR in response to complaints, although Farber and White (1994) report on a case study in a US hospital and Feld (1995) describes the use of ADR prior to the establishment of the College of Physicians and Surgeons of Ontario's Discipline Committee.

The literature on complaints explores why patients complain or fail to complain and the effects of complaints or malpractice suits on the practice of doctors, nurses, and midwives (Allsop & Mulcahy, 1998; Annandale, 1996; Ennis & Vincent, 1994; Fielding, 1999; Mulcahy & Tritter, 1998). Some authors discuss the relationship between societal influences and systems of regulation and complaints, and suggest that state and societal pressures have forced the medical profession to accept a higher degree of accountability (Salter, 1999). The increase in malpractice claims is related to systemic changes (Fielding, 1999), and the increase in complaints against nurses in Ontario is related to the restructuring of the health-care system combined with increased consumerism (Beardwood, Walters, Eyles, & French, 1999). The literature does not consider whether changes in health systems require a different approach to handling complaints.

The present study addresses this gap. It examines whether the consumer-oriented/learning model can be used alongside the prosecutory/disciplinary model and whether it is a more suitable model for addressing some complaints in the context of downsizing and re-engineering, where managerial goals often supersede professional goals. Furthermore, the study explores whether the consumer-oriented/learning model increases the satisfaction of participants and contributes to improved nursing practice.

Methods

The CNO commissioned a study to examine the PRP from 1994 to 1998. This was a participatory evaluative case study using a parallel process model (Petras & Porpora, 1993). It can be described as action research in that it was context-specific and employed a critical and collaborative approach to investigating a process with the objective of improving it (Bowling, 1997). The methods and the final report were the result of collaboration between the PRP Steering Committee and the research team, which involved meetings to formulate the research objec-

tives, specific tasks, proposed design, and methodologies; to discuss the response rates to the initial contact; and to review the progress of the research.

These meetings resulted in several changes to the methods employed. The researchers' initial suggestion of a mailed survey of all participants followed by interviews with 15 selected respondents was dropped in favour of in-depth telephone interviews with as many respondents as possible. Comparison with the formal complaint system was also discarded; resources dictated that comparison would mean limiting the number of respondents interviewed, and it was felt that soliciting a broad spectrum of opinions was essential.

A participatory approach was maintained throughout the project. It included a meeting at which the initial findings were shared with the Steering Committee and representatives of the CNO's Quality Assurance, External Relations, and Professional Practice departments. At this meeting as well, gaps in information and the parts of the report that should be emphasized were identified and potential recommendations were discussed. In addition, the draft report was submitted for feedback to the College. Following submission of the final report, a workshop was held to review its substance and its recommendations, as well as to identify issues and make recommendations to the Complaints Committee, Executive Committee, and Council. This workshop was attended by members of the PRP Steering Committee; members of the Investigation and Hearings, Professional Practice, External Relations, Quality Assurance, and Research departments; and the research team. The findings were presented and workshop participants formed small groups in order to formulate feedback.

As comparison with the formal procedure had been discarded, a template was developed against which to compare the findings. In developing the template, the researchers reviewed the CNO's written materials, interviewed the Director and the Manager of the Investigations and Hearings Department, and conducted a focus group with the Complaints Committee. The object was to identify the PRP's philosophy, expectations with regard to process and outcomes, the decision-making process with respect to referral and participation, and the experience with the PRP and outcomes.

The final template comprised five goals: (1) to develop a humanistic process as opposed to the impersonal bureaucratic process of the Complaints Committee, and ultimately to improve relations between the public and the nursing profession; (2) to educate complainants about the profession and to help them realize that outcomes can be achieved in different ways; (3) to involve members in the process and to serve the membership by refraining from assigning blame, encouraging reflective

practice, improving access to the College's professional practice resources, and enhancing nursing practice by emphasizing learning as opposed to punishment; (4) to deflect attention away from individual nurses and towards departments and facilities, with the aim of addressing systemic problems through policy changes, educational in-services, and conferences; and (5) to increase the satisfaction of complainants, members, and the College with regard to outcomes.

The study began with focus group sessions attended by the PRP's Investigators — or facilitators — and Practice Consultants, who often have to facilitate the agreements. These sessions, which were audiotaped, took place on the College's premises and lasted from 60 to 80 minutes. The participants discussed their experiences with the PRP, their opinions about the process, and the future of the PRP. Questions posed included the following: What were the aspects that made a PRP case successful or unsuccessful? Did the involvement of legal counsel or the union make a difference to the process? Can common elements in the PRP cases be discerned?

Of the 34 cases handled by the PRP between 1994 and 1998, 23 had been successful in that the complaint was withdrawn and 11 had been aborted and entered the formal complaint process. Each case involved three parties: the member, the complainant, and the CNO. In some cases the employer had participated and the member was represented by legal counsel. Letters were sent to all parties (106 in total, excluding Investigators) involved in the 34 cases, inviting them to participate in the study. Of the 68 people (64%) who responded, 54 were contacted and 52 agreed to be interviewed; 8 of the 52, however, were unavailable at the time scheduled for the interview.

In depth semi-structured interviews with mostly open-ended but some closed questions were conducted with a final sample of 44 people: 18 registrants, 15 complainants, 6 facility representatives, and 5 legal counsellors. Interview guides for each category were developed by drawing on the research questions and the literature on complaints. These were pretested on members of the College not employed by the CNO.

The same interviewer conducted telephone interviews at a time convenient for the respondent. Interviews with members ranged from 56 to 139 minutes in length with a mean of 87 minutes. Interviews with complainants ranged from 43 to 133 minutes with a mean of 92.3. Interviews with facility representatives and legal counsellors were shorter, the former ranging from 28 to 49 minutes with a mean of 38.2 and the latter from 15 to 62 minutes with a mean of 32.4. The interviews were audiotaped with the exception of four of the five defence counsel interviews. All interviews were coded and the master list with contact information was stored in a secure place accessible only to the principal investigator and

the interviewer. The CNO confidential data did not leave the College's premises.

Data were collected on participants' experience with the instrumental and affective aspects of the PRP. All interviewees were asked about their decision to participate, their expectations, their degree of satisfaction, the outcomes, the impact, prior experience with ADR, the nature of the complaint and the resolutions, and ways in which the process might be improved.

Members were asked their main reason for participating in the PRP. Other questions posed specifically to members included: What was your reaction to the notification that a complaint had been made? Would you please describe the process? Would you recommend the PRP to other nurses who had a complaint lodged against them? Has participating in the PRP changed your feelings about nursing or the way nursing and nursing practice are regulated?

Complainants were asked such questions as: What did you hope would happen as a result of the complaint? What was your first reaction when you heard about the PRP? Given your experience, how would you rate your overall satisfaction with the outcome? Would you recommend the PRP to others who have a complaint against a nurse? Has participating in the PRP changed your feelings about nursing or the way nursing and nursing practice are regulated?

Questions posed to facility representatives focused on the strengths and weaknesses of the process, ways in which it might be improved, and how they would compare it with the formal complaint process. They were asked if the experience had affected their perspective of nursing, the College, and the way things are done in their organization, and how they would react to complaints in the future. Additionally, they were asked whether there were problems with resources and whether there was potential for long-term change.

Legal counsellors were asked what they saw as the role of lawyers in the PRP and were asked to describe their experience with the process.

The researchers assessed the information collected during the interviews and the focus group sessions against the template by analyzing it on the basis of the research questions and by developing categories or themes. As noted above, the findings were discussed with representatives of the College and recommendations were drawn up.

Findings

The 34 complaints handled by the PRP were categorized as follows: "nursing practice—nursing care" (36%) (the majority of these cases concerned the nurses' assessment of patients); "unprofessional conduct—

other” (rude behaviour, denying the complainant access to his or her health record, inappropriate comments, inappropriate behaviour, breaching trust in nurse–patient relationship, and taking no action) (18%); “unprofessional conduct–poor communication skills” (16%); “nursing practice–inadequate documentation” (10%); and “other” (behaviour or remarks of a sexual nature, verbal abuse, breach of confidentiality, breach of therapeutic boundaries, and medication errors) (20%). The distribution is comparable to the distribution of complaints addressed in the regular process.

One of the goals of the College was to humanize the PRP process and ultimately improve relations between the public and the profession. This goal was found to have been met to a certain extent, though at some cost to the parties concerned.

Costs to Nurses

All members portrayed the lodging of a complaint as having an immediate and devastating impact on their feelings about nursing and their confidence in their professional skills. They found the process stressful. Members confessed to being “angry,” “bitter,” “frustrated,” “anxious,” “worried,” and “concerned.” They were upset about the fact that the complaint had not been resolved at the facility and unhappy because they were forced to “second guess” and “question” their practice. One member believed that 15 years of nursing had been thrown away and was thinking of leaving the profession. Another described lying awake at night and going over the case again and again. Another said:

We were just angry, frustrated. It was nerve-racking. My family suffered. Mentally, it was exhausting. I could probably go through the whole alphabet and describe my feelings and what it did to us. I still feel that way.

Facility representatives expressed concern about the nurses' work during the process, commenting that they were “unstable,” “stressed out constantly,” and possibly incapable of “efficient and effective and safe practice.” One facility representative stated: “I wonder about their ability...because most of them are absolutely destroyed.”

One source of stress for members was fear that the complainant would abort the process. They waited for the final letter from the Complaints Committee, fearing the complainant would renege on the agreement and force the nurse to endure the formal process anyway, thus wasting endless time and emotional resources. For months one nurse “sat on pins and needles knowing that she [the complainant] could revoke going this route at any time, and I would sit in front of this panel down the road.”

Members suggested that their stress was compounded by a lack of support. They recalled being told not to speak to anyone involved in the incident, which reinforced their feelings of isolation. One member commented: "I don't know about the other nurse [but] I felt quite alone." Others were too embarrassed or ashamed to share the experience with colleagues, friends, or family members. One said, "This is something obviously that you really don't speak to other people about." Another refrained from sharing it with colleagues because work was "my only safe place, because it was the only place I didn't talk about it...it was important that I be happy at work." Still others were employed in organizations administered by non-nurses who failed to understand the implications of a complaint. One nurse stated: "What really upset me was that my immediate manager and her director thought this was a minor thing. They didn't give me the support I needed...shrugging it off as nothing, absolutely nothing." Even when support was forthcoming the nurses found the process stressful. One lawyer commented that her clients were sensitive to the amount of time their supervisor would be giving and that she would be entering into an agreement that would bind her and the hospital in the future.

Members also considered the College to be biased in favour of the complainant. One member described the process as "all very one-sided...they only look at what the complainant has said." Another said, "I still felt that my side wasn't believed, and that's really important when you're telling the truth." They also expressed the opinion that the College bureaucracy did not understand the reality of nursing practice in today's health-care environment and that the College's requirements were unrealistic:

A lot of the policies and standards that they send out — I'm really of the opinion that they do not have a clue what the hell is going on in the workplace. It seems as if you've got a person who sits up there with a PhD who has completely forgotten what got her there and has set up a lot of ideology that is absolutely impractical.

As a result of the complaint and the College's treatment of it, some nurses had lost their self-esteem, questioning their decision to enter nursing. Some took up casual employment or considered early retirement. They were cautious and defensive in their work and expressed feelings of vulnerability.

Costs to Clients

The complainants also found the process stressful. They described it as emotionally draining and were reluctant to recall the incident. One com-

plainant stated that the case involved “emotional turmoil and turning it over in your head at 3 o'clock in the morning.” Another felt that it would have been easier to let someone else decide than be personally involved. Those who were involved in face-to-face meetings with the member found the process even more stressful. One said that during the meeting “I was shaking; I had tremors.”

Some complainants admitted that they found it difficult to abandon their punitive goals and had to be counselled by the Investigators that these goals were unattainable in the informal and formal system. One complainant described the Investigator's role:

She explained what would happen and told me in her honest opinion that basically if I did go the complaint route...probably nothing would happen. I discussed it with her and she said, “If you're looking for her to get fired, it's not going to happen.”

Complainants who were health professionals considered the PRP too daunting for a lay person, explaining that they had the advantage of a knowledge base and understood the requirements of professional practice: “I think that it would be hard for someone who was not nursing or medically oriented to really know what to say and what to ask for.”

A few complainants believed that they had opened up their emotions but this effort was not reciprocated by the nurse, and that the letter of apology was unsatisfactory because it was guarded and constructed with legal help. Others wanted a different outcome, such as the firing of the nurse or a policy change, while some believed that the Investigator was biased. Several of these complainants abandoned the PRP and entered the formal process. The decisions were unanimously “take no action,” with the result that the complainant felt that the process had continued “the abuse” by favouring the nurse. These complainants felt scorned by the College.

Achievement of Goals for Members

Members' involvement in the process varied, with those who had lawyers being the least involved. Some could not even remember what had transpired. Their participation was mediated by their lawyers, who would advise caution and ensure that there was limited contact, either because they believed the Investigators would be intimidating or because they had seen nurses “burned” by the College.

Even among nurses who were considerably involved in their cases, few had face-to-face meetings. There are indications that many were encouraged to reflect on their practice in order to identify areas for improvement and growth. One facility representative put it this way:

I think it was excellent. I mean, it truly allowed reflective practice... It's exactly what we're all about.... I think it's integrating the whole professional practice model into care. And it's so much more positive than the complaints and disciplinary process... In a sense, it begins a modelling of behaviours that can be used again and again in a team relationship.

Several nurses and one facility representative commented that the PRP process had reminded them of the importance of accurate charting. One member admitted that the experience was “an eye opener,” making her realize “how vulnerable we really are in nursing, how it's so important to document.” Another advised her colleagues: “Watch yourself all the time.... If I hadn't charted the way I charted, they would've hung me.” Others also stated that the process had taught them to be more careful about keeping records and communicating with patients and families.

Some members had changed their perception of the College and now regarded it as a source of help, instruction, and mentoring. These nurses had also used the Professional Practice resources and had been provided with tools to help them avoid repeating their mistake. For example, after a session with the Practice Consultant, one member had learned appropriate ways to complain about her superiors, another had learned alternative options, and another had been instructed in how to avoid the incident in question; a further member said she now viewed the College as a resource.

One positive outcome of the PRP process was the CNO goal of improved education. Members stated that the PRP had created a learning opportunity for them. The CNO Practice Consultants offered education sessions, reflective practice, and consultation. Educational pursuits taken up by members independently included reading specific documents, taking refresher courses with an expert in the field, completing specific educational programs, preparing and providing an in-service session, and preparing a document that could be used in-service. For some, even writing a letter of apology was a learning experience:

It was therapeutic... It helped me formulate in my mind and put down in writing how I felt about it...so it was a good exercise for me... It's been a learning experience for sure in lots of ways. We're never too old to say, “Oh, I hadn't thought of it that way.” Just the whole process has been a learning experience. It's self-evaluations, looking at the way I do things. You think, “If I'd done this differently...” ...I think that it has taught me to pick up cues, to work with people. I think if I were to come up against someone, I would be more open and say: “We're having a problem here. Can we talk about it?”

Not all outcomes were those desired by the College. Some members felt blamed and victimized by the process. Instead of viewing the College as a resource, they felt betrayed and abandoned by it:

All I felt was that the College should be representing us. They are our governing body. Why are they not representing us? And then when they turned around and...said, "Well, it's to protect the public" — well, who's protecting us as nurses? We just felt really devastated. Who do we turn to? We didn't have a union.

Some nurses were still bitter about the College's role:

I'm probably going to retire in the next few months. It's left me quite bitter. I've only just been able to put it behind me. I feel that I have given a lot of my life to this profession, and then some ridiculous little thing is in my back pocket all the time. Any time someone can do that, and the College is going to support that, I don't want to do that any more.

Others practised defensive nursing and approached every client as a "potential complainer." Alternatively, they and their colleagues avoided conflict, upsetting patients, or assisting others:

It affects everyone you work with because everyone is looking out for themselves now instead of for each other, because it could happen so quickly and we're absolutely on our own. There's no "I'll help you." In fact you get comments like, "My name's not on that chart." You're basically on your own, and there's no support from the College and you're basically afraid. Everyone's afraid.

Achievement of Goals for Complainants

The majority of complainants viewed the College's role as regulating nursing in the public interest, but some had expanded the role to include continuous improvement in nursing practice so that learning was an alternative to punishment. Interestingly, complainants who were health professionals found the process enlightening as it served to make them aware of the College and assured them that there was indeed a process. Furthermore, it helped them to improve their own practice, to communicate more effectively, and to look at both sides.

When asked if they would participate in the PRP again, 21 of the 23 complainants in successful PRPs said they would. The other two did not know which option they would choose. One complainant expressed satisfaction because the alternatives would not have achieved real change:

I think it is a good process... If I had gone the legal route or the disciplinary route...subjectively I would have had satisfaction [but] objectively it

would not have accomplished anything and it probably would have made the situation worse. It probably would have made the two nurses even more bitter and jaded — the administration might even have fired them. They probably wouldn't have changed their policies anyway. It would have been just "two bad apples, out you go."

Achievement of Goals for the Workplace

The PRP resulted in some workplace changes. Managers stated that they had learned how to prevent the lodging of a formal complaint and had become more aware of the College's requirements. One employer demonstrated greater understanding of nursing standards and the conflicting responsibilities of the member. The member said: "I can pretty well say... 'I think that this compromises me or my relationship; I don't think I should be there,' and they'll listen to that."

The agreements with facilities resulted in changes that would not have otherwise occurred. One facility representative admitted that certain initiatives would not have been taken without a formal agreement with the College. The CNO provided education and counselling sessions for staff. Additionally, by consulting with the complainant, members, and the facility's representatives, the CNO Practice Consultant helped facilities to develop an education session and a document to be used by the facility's Education Department. Facility representatives viewed these actions as favourable. They believed the PRP fostered learning that was not limited to the member and that involved not just nurses but the multi-disciplinary team. They also stated that it met the needs of all parties while providing support for the member. One facility noted that the PRP resulted in the institution's accepting some accountability for the circumstances under which nurses work:

The hospital has to [accept] accountability because [many] of the complaints occur [in the] context of a tough environment to deliver care. So who's at fault? Is it the professionals? Is it the system? Or is it both? It comes...down to sometimes the individual can only be the weakest part of the system.

Other facility representatives were unsure whether the process would have long-term effects. Some complainants shared this uncertainty, believing that while outcomes for the College were positive, those regarding the facility were unclear. They questioned whether the agreement would affect the nurse's practice — "It's very difficult to change people's attitudes, and I don't know that I am convinced the PRP will do that, unless there is a concerted effort [by] the facility to monitor that on an ongoing basis" — or the system — "There's no guarantee that it's

going to change the system... That's the whole point. You just have an opportunity to try to change the system, but whether you do or not as a complainant you never know.”

Satisfaction

There are indications that the PRP has reduced the number of appeals to the Health Professions Appeal and Review Board, which may be construed as satisfaction with the process. There were 150 appeals in 1994, the year the PRP was introduced. The number of appeals declined to 89 in 1995 and 65 in 1996, increased to 153 in 1997 and 112 in 1998, and then declined to 81 in 1999, 66 in 2000, and 50 in 2001 (CNO, 1983–2001).

Most complainants said they would go this route again, but their level of satisfaction varied according to the Investigator and the degree of feedback they had received. Five out of 13 complainants would have preferred a different Investigator. Some complainants stated that they had received “no follow-up” from the College, whereas others said they had received a list of evaluations of meetings and events undertaken by facilities. On the whole, complainants were satisfied with the College but not with the facility.

Members were relatively satisfied with the process because it met their goal of avoiding a record and a potential appeal to the Health Professions Appeal and Review Board. One lawyer reported telling clients they were “darn lucky to avoid the Complaints Committee and a review by the Health Professions Board.” Members also favoured this alternative route because it made the complaint less serious and involved them in the agreement. However, several members believed it was a long, frustrating, unnecessary, and complainant-driven process.

Discussion

The study found that many of the CNO's goals were being met by the PRP but that the process was more complex than expected. Although complainants expressed satisfaction with the process, many did not consider themselves active participants in the PRP — which for them was not, paradoxically, a negative factor. They described themselves as “relieved” to “hand over” the issue because they were “emotionally exhausted” or because they were still angry and believed their rage would be counter-productive. Thus, some complainants may want more involvement than the formal system allows — even though this entails some emotional stress — but in a way that relieves them of the burden of complaining.

Members were satisfied because their file would not contain a record of the incident, as would be the case had they gone through the formal process. They also preferred it to the formal process because they (incorrectly) assumed that the latter would require their appearance before the Complaints Committee, which they did not distinguish from the Discipline Committee, and that their name might appear in the CNO's *Communiqué* — “going up in front of a court”... “name splattered all over the place in the *Communiqué*.” In reality, however, the PRP would not have been suggested to them had the complaint been serious enough to be considered by the Discipline Committee, and the *Communiqué* publishes only the names of nurses who appear before the Discipline Committee.

Many members were unaware that the College is required by law to investigate all complaints, is a regulatory body, and represents not nurses but the public. Some described the complaint in terms that suggested it was trivial and should not have been considered by the College. Others felt that the process was one-sided and that the College should be more supportive of nurses.

The high degree of emotional stress experienced by members seemed to be related to a lack of knowledge and fear of the College. Some members suggested that those who had experience with the PRP process should offer support to others who have had a complaint launched against them. Four members, five complainants, and one lawyer said the facilitator should be a neutral person from outside the College so that the member would feel less threatened.

The accounts of members suggest that the College was successful in promoting education and reflective practice and improving nursing practice, although some nurses were merely going through the motions to appease the complainant and avoid having a record. Some members did alter their view of the College, however, and did access the Practice Department. Furthermore, cooperation was achieved with most facilities with regard to promoting education and change.

Some facility representatives expressed concern about time and financial costs. One representative, although pleased with the outcome and its impact on staff, commented that cost might be a deterrent to future participation in a PRP. Facility-based PRPs took some time and effort to organize, and an initially simple process became a complex one requiring arrangements for in-services, conferences, department-wide meetings, and discussion groups. One representative commented that factors related to responsibility, content, methods, communication, and feedback become clearly defined only with time. Representatives also complained about delays: “Everything took longer...something [would arrive in the

mail] 10 days after we expected it.” Others complained about the time, organization, and delays entailed in educational sessions:

So you try to trace back and get people here involved and have them come to an educational session. They're going to say, "Okay, what's this about?" "Well, it was related to an incident that happened a year ago." It doesn't sound too good.

Given the shortage of resources and the current increase in non-nursing managerial staff, the issue of demands on resources does not bode well for the future of educational sessions, especially since positive outcomes require a commitment to long-term follow-up and change. The study also found that some facilities had been uncooperative, regarding the complaint as trivial and refusing to collaborate with the College. One nurse said: “My employer certainly wasn't going to go along with any of the College's recommendations. Not at all. They were not going to comply at all.” This exposes the weakness of the PRP. The College does not have the power to impose change at the facilities.

Conclusion

The College of Nurses of Ontario has responded to the present challenges by establishing a consumer-oriented/learning model for some complaints. Thus, it has created a form of mediation with the goal of improving nursing practice. This program has increased awareness of professional values in the workplace, has been relatively successful with members, complainants, and facilities, and is a useful tool in today's health-care environment. Complaints are treated as opportunities for learning, and the new approach can help to improve nursing practice and help nurses to cope with restructuring. However, the process is stressful and support mechanisms need to be provided for both the member and the complainant. Furthermore, members require more information on the disciplinary process and the legal obligations of the College. The College is, in fact, trying to increase members' knowledge concerning the complaint process by holding informal and interactive sessions in the workplace.

The main problem with the Participative Resolution Program is that the College lacks the power to enforce system change, and the cooperation of facility representatives, especially those who are not health professionals, can be difficult to obtain. Moreover, the College's mandate is to uphold the standards of one profession and address the mistakes of individual nurses. Yet complaints today are often rooted in an organizational context, even when the responsibility appears to lie with one person, and an incident can involve several health professionals. These

issues might be addressed if the facility were required to handle every complaint before it was submitted to the College. Alternatively, complaints could be filtered through a multidisciplinary organization with the power to censure the facility and impose system changes. One promising development in this area is the movement towards root cause analysis, a process in which the fundamental causes of a problem are determined and then improvements implemented or causative factors eliminated (Joint Commission on Accreditation of Healthcare Organizations, 2000; Kohn, Corrigan, & Donaldson, 2000). One hospital in Montreal, Quebec, has completely transformed its way of dealing with errors by adopting root cause analysis. Above all, facilities need to become aware of two facts: the environment they have created can put their nurses at risk of a complaint, and professionals are responsible not only to their employer but also to their profession.

References

- Allsop, J., & Mulcahy, L. (1996). *Regulating medical work: Formal and informal controls*. Buckingham, UK: Open University Press.
- Allsop, J., & Mulcahy, L. (1998). Maintaining professional identity: Doctors' responses to complaints. *Sociology of Health and Illness*, 20(6), 802–824.
- Annandale, E. (1996). Working on the front-line: Risk, culture and nursing in the new NHS. *Sociological Review*, 44(3), 416–451.
- Beardwood, B., Walters, V., Eyles, J., & French, S. (1999). Complaints against nurses: A reflection of the “new managerialism” and consumerism in health care. *Social Science and Medicine*, 48, 363–374.
- Bowling, A. (1997). *Research methods in health: Investigating health and health services*. Buckingham, UK: Open University Press.
- College of Nurses of Ontario. (1983–2001). [Annual Report for each year.] Toronto: Author.
- Ennis, M., & Vincent, C. (1994). The effects of medical accidents and litigation on doctors and patients. *Law and Policy*, 6(2), 97–121.
- Farber, H., & White, M. (1994). A comparison of formal and informal dispute resolution in medical malpractice. *Journal of Legal Studies*, 23(2), 777–806.
- Feld, L. (1995). Using mediation to resolve complaints about professionals: A creative alternative to the discipline process. *Canadian Journal of Dispute Resolution*, 5(ADR Forum), 11.
- Fielding, S. (1999). *The practice of uncertainty: Voices of physicians and patients in medical malpractice claims*. Westport, CT: Auburn House.
- Freidson, E. (2001). *Professionalism: The third logic*. Chicago: University of Chicago Press.
- Joint Commission on Accreditation of Healthcare Organizations. (2000). *Root cause analysis in health care: Tools and techniques*. Oakbrook Terrace, IL: Author.
- Kinney, E. (1995). Malpractice reform in the 1990s: Past disappointments, future success? *Journal of Health Politics, Policy and Law*, 20(1), 99–135.

- Kohn, L. T., Corrigan, J. M., & Donaldson, M. S. (Eds.). *To err is human: Building a better health care system*. Washington: Institute of Medicine.
- Meschievitz, C. (1991). Mediation and medical malpractice: Problems with definition and implementation. *Law and Contemporary Problems*, 54(1), 195–215.
- Metzloff, T., Peeples, R., & Harris, C. (1997). Empirical perspectives on mediation and malpractice. *Law and Contemporary Problems*, 60(1/2), 107–152.
- Mulcahy, L., & Tritter, J. (1998). Pathways, pyramids and icebergs? Mapping the links between dissatisfaction and complaints. *Sociology of Health and Illness*, 20(6), 825–847.
- Petras, E. M., & Porpora, D.V. (1993). Participatory research: Three models and an analysis. *American Sociologist*, 24(1), 107–126.
- Salter, B. (1999). Change in the governance of medicine: The politics of self-regulation. *Policy and Politics*, 27(2), 143–158.

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