

ADVERSE EVENTS

When Clinicians Drop Out and Start Over after Adverse Events

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Background: The impact of adverse clinical events on health care workers has become a growing topic of research. Previous research has confirmed that after adverse clinical events, clinical staff often feel as though they failed not only their patient but also themselves, resulting in second-guessing of their clinical skills, competencies, and even career choices. This exploratory study reports on the experiences of health care providers who changed career paths as a consequence of an adverse clinical event.

Methods: The authors designed a 39-question survey capturing personal and professional demographics, participant recall of the clinical event, insights into their lived experiences, health care institutions' response(s) to the event, decision-making influences relating to future employment, and insights into interventional strategies.

Results: Consistent with prior research, clinicians reported a pattern of inadequate social support after the event. Results further show the salience of emotional labor as a driving force among those who changed roles. In clinicians' own assessments about the lasting impact of the event, many felt less joy and meaning in their new clinical roles, but others thrived by rededicating their careers toward implementing patient safety initiatives and enhancing peer-support networks. Clinicians reported a desire for more transparency and support to help them recover.

Conclusion: Clinicians aligned their emotional displays to be consistent with organizational expectations, resulting in suppressed feelings of guilt and shame that may have contributed to burnout, changed roles, or even premature retirement. Study findings highlight the need to develop better support systems for clinicians who are party to an adverse clinical event.

In 2008 the Institute for Healthcare Improvement developed a framework known as the “Triple Aim” as guidelines for optimizing the health care system by focusing on three dimensions of medicine: enhancing the patient care experience, improving population-level health outcomes, and reducing costs.^{1,2} Recently, however, in what has become known as the “Quadruple Aim,” there has been a growing movement to incorporate wellness of the workforce as a fourth pillar of health care quality.^{3,4} This addition acknowledges the importance of improving clinicians' work life by providing a supportive work environment that is responsive to their needs. It also acknowledges that efforts to improve the health care system have, until recently, largely overlooked how the well-being of the workforce connects to patient outcomes. In this article, we examine one of those points of connection; namely, how clinicians' career paths are affected by their involvement in an adverse clinical event.

Because it is a growing topic of international research,^{5–10} we now have documented evidence that clearly shows the harmful impact of adverse clinical events on providers, which has been largely known as the “second victim

phenomenon.”^{11–16} Second victims have been defined as “healthcare providers who are involved in an unanticipated adverse patient event, in a medical error[,] and/or a patient related injury and [who] become victimized in the sense that the provider is traumatized by the event.”^{13(p. 326)} Although there is some disagreement related to the appropriateness of the label “second victim,” until a suitable alternative is identified, most health care researchers continue to use this term to guide related research.¹⁵ Regardless of the terminology, after an adverse clinical event clinicians often feel as though they have failed both not only the patient but also themselves, which can result in second-guessing their own clinical skills, competencies, and even career choices.^{17–23}

This exploratory study examines the experiences of clinicians who changed career paths after their involvement in an adverse clinical event. Such events can have a serious impact on clinicians' lives and careers.^{24–28} Recent studies suggest a complex recovery path, which, as Scott et al. have proposed, may consist of six stages (not necessarily experienced in a step-like sequence): (1) chaos and accident response, (2) intrusive reflections, (3) restoring personal integrity, (4) enduring the inquisition, (5) obtaining emotional first aid, and (6) moving on.¹³ Research has demonstrated that clinicians move on after adverse clinical events in different ways: some thrive in the same role, others just get by, while still a third group drops out of their clinical role.¹³ In this article, we examine the experiences of this third group—those who

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embarked on an intentional career transition that included, for example, moving to a different clinical practice, transitioning to a different patient population, taking on a new role with less patient exposure, or even leaving health care altogether.

Being party to an adverse clinical event can raise a powerful set of emotions, such as shame, guilt, fear, and stigma, that may affect a clinician's career long after the event itself.^{9,10,29} Yet health care organizations often overlook how the psychosocial impact of these events shapes the experience of work. When the emotions workers feel misalign with what employers or coworkers expect, workers typically perform what is known as "emotional labor" to bring their emotional displays into agreement with normative expectations.

Emotional labor is a social-psychological concept developed by Hochschild that describes how workers bring their emotions into alignment with organizational demands on how they should or should not emote on the job.^{30,31} Emotional labor is particularly salient among workers who provide nurturing, supportive care to the sick but is a feature of work throughout the service sector of the economy.³² It has a dual role of managing the emotional displays of the worker while also inducing an emotional response or feeling in others such as employers, coworkers, and customers.³³ For example, a recent study found that neonatal intensive care unit nurses engage in emotional labor to shape how patients' family members behave during their loved ones' medical crisis.³⁴ Studies also show that physicians do emotional labor to cultivate empathy toward patients.³⁵ When workers feel empowered to share their feelings with coworkers about troubling events, the psychosocial burden of emotional labor is reduced.³⁶

In this study, the first that we know of to examine the experiences of this population, we show first that, consistent with prior research, clinicians reported a pattern of inadequate social support after an adverse clinical event. We take the analysis one step further, exploring the salience of emotional labor as a driving force among those who changed career paths. In clinicians' own assessments about the lasting impact of the event on their careers, many felt less joy and meaning in their new clinical roles, but others thrived in re-dedicating their careers toward implementing patient safety initiatives and enhancing peer-support networks.

METHODS

Survey

With Institutional Review Board approval for this study, which did not receive funding, in 2016 we designed a 39-question survey to capture personal and professional demographics, participant recall of the clinical event that contributed to a new career path, insights into the lived experience, health care institutions' response(s) to the event, decision-making influences relating to future employment, and insights into potential interventional strategies to lessen

the negative impact of the second victim experience (Sidebar 1). The survey included numerous open-ended response options for respondents to describe their experiences in more detail. Items for this survey were developed by a subject matter expert [S.S.], using insights from prior research in which the stages of clinician recovery were initially identified.¹³ The three items about components of emotional labor (surface acting, deep acting, and suppressing negative emotions) were adapted from the validated Emotional Labor Scale.³⁷ None of the items were required, thus allowing participants to skip the question if desired. Several health care workers who have experience with second victim research pretested this survey, providing feedback for tool revisions prior to distribution to study participants.

Participant Recruitment and Survey Administration

Because of the unique characteristics of the second victim dropout population and limited ability to reach out directly, in March–May 2016 we partnered with six patient safety-focused professional organizations to publicize the research project and recruit potential participants via newsletters, listserves, and websites (Sidebar 2). We created an announcement to recruit potential participants that was forwarded to these organizations, which was posted with a link to the secure, anonymous Web-based survey. Potential participants were provided with researcher's contact information in case they had any questions. This survey was accessible for 16 weeks, from May through August 2016.

Data Analysis

Simple counts and proportions for demographic items and categorical variables were performed with iterative review of the submitted narrative responses for additional insights. Both authors conducted a separate preliminary analysis of the data and then conferred to compare our findings and examine the consistency between the quantitative and qualitative response data. Quantitative responses and demographic data were summarized using counts and proportions. We also conducted a thematic analysis of the open-ended qualitative responses. Qualitative analysis began with open coding of all responses and then proceeded to more focused subcodes as the data were analyzed and the codes were refined.^{38,39} Throughout the analysis, we discussed findings in conjunction with the relevant literature as we made interpretive judgments about the data.

RESULTS

Participants

A total of 105 individuals responded to the Web-based survey. Twenty-seven responded to the initial question indicating that they had not been involved in an adverse clinical event that changed their career path, which identified them as ineligible for the survey. One participant was excluded from

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