ADVERSE EVENTS IN HEALTH CARE:

EXAMINING THE SECOND VICTIM EXPERIENCE

by

© Sheila Marchant-Short

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ABSTRACT

Adverse events are a common occurrence in health care. While much attention has been paid to the impact of adverse events on patients and families, little is known about the experiences of health care providers as "second victims." This study examines the experiences of second victims, using the example of one Canadian health region that had experienced a large-scale event that continues to shape how adverse events are understood and managed in that context. The methodology used is critical ethnography. The researcher uses her knowledge as an insider to health care organizational culture to explore the embodied and everyday experiences of health care providers. The study makes explicit the connections between culture and power to scrutinize the normative assumptions, values and beliefs that shape, and are shaped by, the experience of adverse events.

Staff feel powerless to speak up about adverse events; and by resisting the oppression that they fear will result if they were to speak out, they perpetuate the relations of power. Staff blame a constructed monolithic health care organization for the oppression, a story of responsibility and blame that is reinforced by the public via the media. Power is hidden and implicit in the system. Key findings are: (1) Health care providers involved in adverse events need to be given the opportunity to talk about their experience; (2) The best way to provide support is to recognize that support is needed quickly; and (3) In order for an organization to appropriately support the second victims of adverse events and their subsequent patients, a systems approach -- with attention to organizational culture in its relation to power -- is required.

The specific organizational features that shaped the experiences of health care providers in this study are not unique to the organization that was the site of the study. This study illustrates the magnitude of the trauma and the expanse of the possible experiences and helps us to understand more fully the second victim perspective and how a health care organization can mitigate the trauma to second victims.

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List of Abbreviations

AETF – Adverse Events Task Force

ARNNL – Association of Registered Nurses of Newfoundland and Labrador

ATIPPA - Access to Information and the Protection of Privacy Act

CEO – Chief Executive Officer

CMPA - Canadian Medical Protective Association

CNA – Canadian Nurses Association

CPSI – Canadian Patient Safety Institute

CRM – Crew Resource Management

CSRS – Clinical Safety Reporting System

ER/PR – Estrogen Receptor/Progesterone Receptor

HR – Human Resources

NL – Newfoundland and Labrador

POAE - Provincial Office of Adverse Events

PTSD - Post-Traumatic Stress Disorder

QRM – Quality and Risk Management Department

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CHAPTER 1

Locating the Health Care Provider within an Adverse Event

1.1 Introduction

The experience of being involved in an adverse event may leave the health care provider traumatized as a *second victim*. This study examines the second victim experience of health care providers from front-line staff to organizational leaders. The result is concrete direction about how a health care organization can better support health care providers to reduce the impact of *adverse events* on second victims and patients in the long term, and how to reform adverse event management. A critical ethnographic approach was used to examine adverse event experiences from the perspective of health care providers.

Adverse events are common in health care and can have a significant effect on health care providers. Health care providers frequently feel "personally responsible for the unexpected patient outcomes and feel as though they have failed their patients, second-guessing their clinical skills and knowledge base" (Scott et al., 2010, p. 233). After an adverse event, health care providers – and by that I am referring to *all* people involved in the provision of health care from front-line staff to organizational leaders -- are often left to find support through their own resources, leaving the health care provider unsupported. As this study will show, this may in turn change behaviour and pose risks for future patients. The experience of being involved in an adverse event has been relatively unexamined and remains poorly understood even by the health care providers who have had such experiences.

The scope of adverse event management is very broad, encompassing: the reporting system, the policies and guidelines that inform the activities, the investigative processes and the responses of individuals, colleagues and organizational leadership to the event. The last fifteen years have seen an exponential increase in research on and attention to medical error and patient[1] safety in health care (Conway & Weingart, 2009). The health care system has become increasingly cognisant of ethical practice and concerned for acknowledging the unnecessary suffering of patients and families. Far less progress has been made toward respect and compassion for the health care workers (Conway & Weingart, 2009). Studies examining the type and frequency of adverse events have not considered the experience from the health care providers' standpoint, nor how a health care provider is located within such an event and how adverse events are organized within a health care organization.

This study is important because it makes visible the adverse event experience, in particular revealing how it is understood by health care providers. When an adverse event happens, there are a number of processes that are activated, and those involved may or may not have had contact with or be known to one another. It is only by having an understanding of the experience of adverse events from the health care providers' standpoint that a health care organization can begin to put mechanisms in place to mitigate future effects on health care providers and the patients who receive care.

This study employed critical ethnography as the methodology. Critical ethnography helps to situate what is observed in the field in the larger context, to see the

[1] In this dissertation, the term *patient* is used to represent patients, clients and residents.

links “between everyday action or interaction and wider cultural formations” (Savage, 2006, p. 385). “Critical ethnography explicates a political agenda and is not simply a description of the insider’s perspective” (McCabe & Holmes, 2014, p. 79). It attempts to uncover the hidden or taken-for-granted structures and relationships of power and control (Bransford, 2006; Grbich, 1999). “Healthcare organizations, like all organizations, are politically and historically constructed,” (Batch & Windsor, 2015, p. 872) and Eastern Health, where this study is situated, is no exception. Undertaking ethnography with a critical lens ensured a focus on what was (or is) but also on what could be (Batch & Windsor, 2015). The orientation toward change in critical ethnography, according to Foley and Valenzuela (2008), spans a continuum from political activity at one end to enlightening policy direction at the other. This research assumed the latter position.

An adverse event can be a frightening experience for both the patient and the health care provider. For some health care providers, it can be an event that is never resolved. Some health care providers continue to feel punished by their colleagues and their employer long after the event. Before attempting to begin to examine the experiences of staff[2] involved in adverse events within Eastern Health it is important to describe what constitutes an adverse event for the purposes of this study and to define the level of harm in relation to victimization that is being considered in this study.

[2] For ease of reading the term ‘staff’ will be used at times in place of ‘staff members’, such that the term is used in a singular as well as plural sense throughout the dissertation. I am using staff and health care providers interchangeably and by health care providers I am referring to all people involved in health care delivery from front-line staff to organizational leaders.

1.2 The Definition of Adverse Event

Adverse events, including errors, have been acknowledged as a frequent occurrence in health care for at least the past decade (Levinson & Gallagher, 2007, p. 95), although occurrences have probably always existed. The Canadian Patient Safety Institute (CPSI) defines an adverse event as "an event that results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition" (2012b, p. 1). An adverse event may or may not be directly connected with an error. "An error is defined as the failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning)" (Institute of Medicine, 1999, p. 28). Therefore an adverse event that results from the failure of a planned action or the use of a wrong plan would be considered an adverse event caused by an error. An adverse event attributable to error is considered a preventable adverse event, whereas in a non-preventable adverse event, no error is identifiable.

It is important to acknowledge that an adverse event attributable to error is not necessarily attributable to a person, but may be the result of a system that created the opportunity for error, often referred to in this study as a systems issue or systemic problem. Systems issues and systemic problems will be discussed in more detail in Section 2.10 ("System and Human Factors"). It is important to begin the discussion of adverse events with a focus on the persons who are harmed by the adverse event and by defining the concept of victim and how *victim* is used within adverse event and patient safety management discourse.

1.3 Victims of an Adverse Event

There are three distinct levels of harm identified in relation to an adverse event (Leuven Institute for Healthcare Research, 2016). First, the event begins with the individual who is affected, the patient. There has been an increasing focus in recent years on patient safety and the effect of adverse events on the individual patient and family, who are often referred to as the *victim*. The effect of the adverse event extends outward, beyond the individual first victim, to include health care providers who are involved in the event in some capacity and are potentially affected by the event. Those individuals are referred to in the literature as the second victims. The experience of being a second victim will vary depending on how close or distant the health care provider is to the adverse event. The third level of contact is the effect of the adverse event on the corporate or organizational body, referred to as *the third victim.* Some people who are not considered to be *involved* in the event, perhaps seen as observers and not typically identified as possible victims, may also be affected by the event.

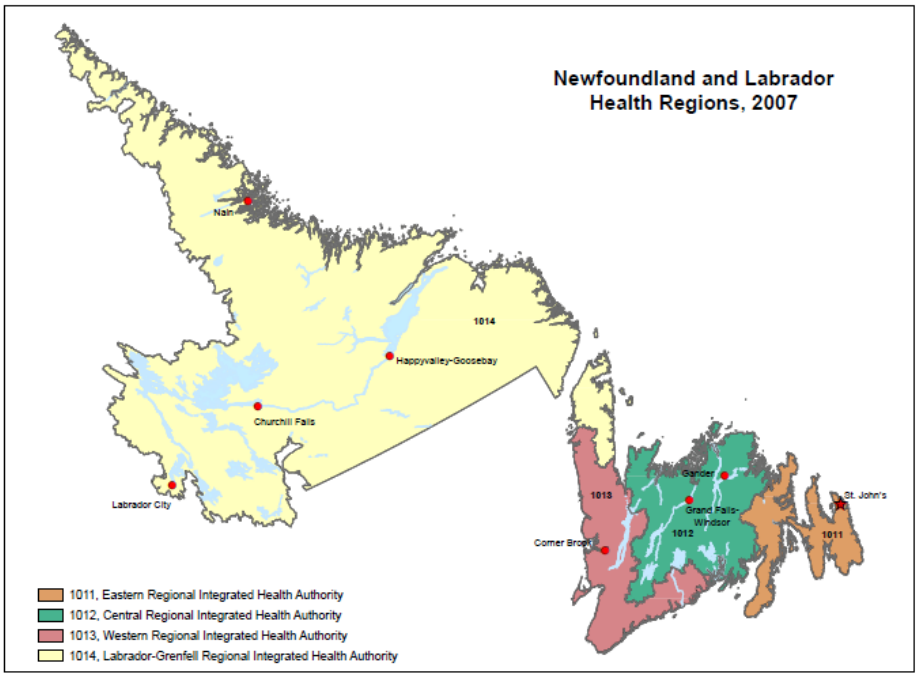
Adverse events share many of the same attributes as other forms of trauma, including the difficulty faced by the victims in sharing their stories since those stories bring the event back to conscious awareness (Wu & Steckelberg, 2012). As a result of this challenge, the force of an adverse event is often locked behind the silence and untold stories of its victims. This study examines the experiences of second victims. For the purposes of this inquiry, the category of second victims includes not only health care providers who have been directly involved in an adverse event, but those who have been negatively and seriously affected by an event because of indirect involvement or

involvement by association. The distinctions between direct, indirect and associated involvement will be described in more detail in Section 1.13 (“Research Questions”).

1.4 Study Site

The study was conducted within the Eastern Health region of Newfoundland and Labrador (NL). NL is the most easterly province of Canada, situated in the country’s Atlantic region. It incorporates the island of Newfoundland and mainland Labrador to the northwest, with a combined area of 405,212 square kilometres (Government of Newfoundland and Labrador, 2015). The province’s population in 2014 was estimated at 526,000 with approximately 92% of the population living on the island of Newfoundland (Government of Newfoundland and Labrador, 2015). Eastern Health is the largest integrated health authority in Newfoundland and Labrador.

Figure 1-1: Newfoundland and Labrador Health Regions, 2007. Source: Statistics Canada



At the time of this writing, Eastern Health had approximately 13,500 employees and was serving a regional population of approximately 290,000. It offers the full continuum of health and community services and is the only health authority within NL providing tertiary care.

The experience of the hugely significant adverse event known as ER/PR[3] inevitably shapes how Eastern Health staff experience adverse events in general. The purpose of the next section is to describe ER/PR.

1.5 ER/PR

At the entrance to the Health Science Centre in St. John's, Newfoundland (NL) sits a monument, placed to honour the victims of a tragedy. Those who pass by or come to visit the monument think about the victims -- the patients and families -- who were affected by that tragedy. However, some health care providers who were involved in this tragedy and who must pass by perceive the monument in a very different way. The tragedy is referred to by staff in Eastern Health as ER/PR. ER/PR is an acronym that refers to estrogen receptor and progesterone receptor testing for breast cancer; but when staff use the term ER/PR they are referring to a period in the organization's history, specifically the time from the identification of a problem with ER/PR testing in 2005 to the beginning of the Cameron Inquiry[4] in 2008.

ER/PR testing is performed by a process called immunohistochemistry (IHC), involving the application of labelled antibodies to a section of breast cancer tissue. The

[3] ER/PR - Estrogen Receptor Progesterone Receptor testing.
[4] The Cameron Inquiry was a Commission of Inquiry on Hormone Receptor Testing established in June 2007 with Justice Margaret Cameron appointed to lead it.

slides are subsequently examined under a microscope to assess whether there are hormone receptors which take up these antibodies (Rayson & Barnes, 2008). The determination of a potentially hormonally-sensitive tumour is based on the presence of one or both of these hormone receptors, referred to as markers. The evaluation of these ER/PR markers is critical for therapeutic decision-making and plays an essential role in determining whether a breast cancer patient would benefit from anti-hormonal therapy (Mathews, Newbury, & Housser, 2011; Rayson & Barnes, 2008). "Patients with clinically positive results may be offered Tamoxifen or an aromatase inhibitor" (Mathews et al., 2011, p. 175).

In the Spring of 2005, a breast cancer patient (PD) whose cancer had spread to her liver and spine, having exhausted all her treatment options, travelled with her husband to New York for a holiday. In the context of that trip, her husband, a physician himself, by happen-stance met a physician from Memorial Sloan-Kettering Cancer Center (MS-KCC), in an elevator (Cameron, 2009a). The physician from MS-KCC was attending a conference on cancer treatment in the same hotel. PD's husband enquired about the possibility of any new or experimental treatment that his wife might participate in and returned to St. John's with a plan to have his wife's oncologist contact MS-KCC to inquire about the possibilities (Cameron, 2009b). It was in the context of the contact made with a breast oncologist at MS-KCC, in April 2005, that PD's diagnosis in relation to her ER/PR results was described as "very rare" and a recommendation was made to repeat the ER/PR testing (Cameron, 2009b, p. 2). It was determined from retesting that both the estrogen and progesterone receptor status changed to positive, and anti-hormonal treatment that was originally rejected as a treatment option was now indicated, although

unfortunately PD's illness was too far advanced and she succumbed to her illness in the summer of 2005 (Cameron, 2009b).

As a result of the outcome of PD's sample retest, an informal internal investigation was conducted to retest a number of other patients' samples whose original results were also negative for ER/PR (Mathews et al., 2011). In May 2005, Eastern Health began a more formal internal investigation into ER/PR receptor tests after a number of breast cancer patients' test results changed from clinically negative to positive on retest (Cameron, 2009b). In the summer of 2005, a decision was made to retest all breast cancer samples for patients who were tested between 1997 and 2005 and whose initial ER/PR status was clinically negative (Mathews et al., 2011). Samples were sent for retesting to a reference laboratory in Toronto, although Eastern Health encountered difficulties identifying all the patients who should have been retested since "there was no single data source that captured this information" (Mathews et al., 2011, p. 175). The retesting of ER/PR samples occurred over the course of a year and resulted in a high rate of result changes from negative to positive. The new result meant that some women would have been offered different treatment options if the new result had been reported originally.

Patients who were initially retested as part of the internal investigation and whose results had changed were contacted and followed up by a physician, usually their oncologist (Cameron, 2009b). Eastern Health decided to wait to inform the patients in the larger group until their retest results were received, which resulted in a delay in informing some patients, since the retesting in some cases took several months (Mathews et al., 2011). There was also a decision made by Eastern Health against making a public

announcement about the concerns with the test (Mathews et al., 2011). A plan to communicate with patients had not yet been decided when a local newspaper broke the story in October 2005 (Cameron, 2009b). Eastern Health then began to contact patients in a more comprehensive fashion by using the staff resources of the Quality and Risk Management program.

The messaging by Eastern Health, related to the cause of the testing problems and the numbers of patients impacted, proved problematic for the organization. In October of 2005 and again in December of 2006 Eastern Health suggested that the cause of the problems was a change in equipment which increased the sensitivity of the test (Cameron, 2009b). However, both internal and external reviews found serious problems in the preparation and preservation of tissues, the preparation of slides, the staining of tissues, as well as a lack of quality control and quality assurance protocols (Mathews et al., 2011). In December of 2006, Eastern Health identified the number of patients whose treatment had changed as a result of the retesting, indicating an error rate of 12 percent. However, in May 2007, in the context of a class action lawsuit[5] (discussed in more detail in Chapter 4), a different report of the total number of patients whose results had changed suggested an error rate of 42 percent. This information led to questions about whether all patients had been contacted, with Eastern Health reporting that all patients had been contacted and media reports contradicting those assurances (Mathews et al., 2011). The provincial government began to question Eastern Health's handling of the ER/PR retesting and as a result established a Commission of Inquiry on Hormone Receptor

[5] Verna Doucette v. Eastern Regional Integrated Health Authority, 2010.

Testing[6], in June 2007, with Justice Margaret Cameron appointed to lead it. The period referred to as ER/PR is the period from the discovery of the changed results in 2005 to the beginning of the public hearings in the Commission of Inquiry on Hormone Receptor Testing (The Cameron Inquiry) in March 2008.

Although adverse events are an expected reality in health care organizations across the country, this event seemed different. It became the focus of local media attention for many months, even garnering the attention of national media.

1.6 Researcher within Eastern Health

It is important to note that I do not have any personal experience of ER/PR or the Cameron Inquiry. I joined the organization as an employee in 2009, a few months after the Cameron Inquiry report had been released. I joined the QRM program staff more than 2 years later, in 2011. During my first 2 years with Eastern Health I was only peripherally aware of the circumstances of ER/PR and the Cameron Inquiry, since the Public Health Program where I was employed as a manager had no direct connections with the ER/PR events. Staff in Public Health occasionally mentioned the Cameron Inquiry as an organizational point of interest, but I had not read the report and there were no specific changes in the program I was managing (Communicable Disease Control and Immunization) based on the recommendations of the Cameron Inquiry report. When I began my position as Quality Clinical Safety Leader, in QRM, in the Fall of 2011, I was working directly with people in a program that had been intimately involved in the events of ER/PR and the Cameron Inquiry, and directly affected by the development of new

[6] The Commission of Inquiry on Hormone Receptor Testing, known as *The Cameron Inquiry*.

policy that resulted from the Cameron Inquiry Report (see Section 4.7.3) and by the realignment of program functions based on the recommendations of the Cameron Inquiry Report and the Task Force on Adverse Health Events Report (see Section 4.3.2). I was also directly involved with the management of the Client Safety Reporting System (see Section 4.2.5), working with staff to provide orientation to the reporting system and encouraging reporting, completing Quality Case Reviews (see Section 4.2.7) and Root Cause Analysis Concise Investigations (see Section 4.2.6), and supporting program management in disclosure and adverse event management.

1.7 Examining the Experience of Adverse Events

This study aimed to examine the experiences of health care providers who were second victims of adverse events within Eastern Health, the largest regional health authority in Canada's most easterly province of Newfoundland and Labrador. That particular health region had experienced a significant adverse event (referred to as ER/PR and described in detail in Section 1.5) that involved many staff and patients and received nation-wide media attention. The event had resulted in an Inquiry and, subsequently, many policy and procedural changes within the organization, beginning about a decade prior to this research and ongoing at the time this research was initiated. This study begins with an examination of the experiences reported by staff in the context of ER/PR and continues with the experiences of adverse events in the years that followed. An examination or critique of the ER/PR event would make an interesting project but that was not the focus of this study. The intent of this study was not to analyse any particular event; instead, this study examines the system in which such events take place. The intent was to "unpack" and scrutinize the ways things are done, what things are said, who

interacts with whom, where power dynamics are, and how power is exercised, resisted, ignored, or dismissed by various players, with a focus on those health care providers – both staff and management -- who have been second victims of adverse events within Eastern Health.

This study is very complex from an organizational as well as emotional perspective. The experiences of participants and the stories that were shared within the context of this study were heartfelt and heart-breaking at times. This study was made even more complex by the reality that it was very difficult to accurately portray such sensitive and hurtful content. As well, it was made complex because the story continues -- these experiences are not in the past; the experiences are ongoing. Many who continue to work in Eastern Health suffer in very tangible ways from adverse events that happened in the past.

Prior to conducting this research, I had already been well aware of the pain of the second victims of adverse events, through my role as Quality Clinical Safety Leader in Quality and Risk Management (QRM) for Eastern Health (a role that concluded just as data collection was beginning). Subsequently, as I listened to and examined, over many months, the stories shared in this study, I was increasingly personally transformed by the pain of the second victims who shared their experiences with me. At the conclusion of this research, I now position myself as a second victim. This is in part by virtue of my previous work in the QRM program investigating adverse events and in part as a result of my experiences entering into participants' pain as a critical ethnographer.

In this dissertation, some events have been altered slightly and, at times, genders of participants have been changed to preserve the confidentiality of participants and to

make events less recognizable. I have tried to do this in a way that maintains the integrity of each participant's intent.

1.8 Variances in the Experiences of Adverse Events

Observations within my QRM role caused me to reflect on an earlier experience I had, working elsewhere, regarding a family's loss. That reflection led me to this research inquiry. While working in QRM and observing the experience of both front line staff and QRM staff trying to cope in the aftermath of adverse events, and observing the responses of patients and families, I began to reflect on a story that seemed to tell a different tale, for both staff and patients. In 1998 I relocated to the province of British Columbia. Shortly after arriving in BC I met a family who had recently lost a child, a daughter, as a result of a medical error. At that time I had not identified medical errors or circumstances of medical error to be a particular interest of mine, so I just listened to their story. As the story unfolded there were a number of details that were shared with me and have remained important to me within the context of my observations in QRM and subsequently during this research.

The daughter was 7 years old when she had an isolated relapse of lymphoblastic leukaemia of her bone marrow, approximately 2 years after her initial treatment for central nervous system-negative acute lymphoblastic leukaemia. The chemotherapy treatments for the relapse were provided at the BC Children's Hospital in a treatment room similar to an operating theatre, with the oncologist and nurses present while the parents waited in a waiting area. During the course of a chemotherapy treatment, the

oncologist, in error, gave an intrathecal[7] injection of Vincristine, a drug whose route of administration is intravenous, that resulted in the child's death. The error was recognized immediately and several medical interventions were attempted to prevent her impending demise, but unfortunately those efforts failed. As soon as this mistake occurred, the physician -- being aware of the fatal effect that the medication given by this delivery method would have -- approached the parents to explain what had happened. The mother explained to me, in 1998, that when the physician recognized his error he immediately came out to speak to her and her husband: he described his error, took responsibility for the error, expressed his remorse, and encouraged them to come into the treatment room and spend as much time as possible with their daughter before what, he believed, would be a rapid death. In fact the girl did not die immediately, but succumbed to death on day 13 following the incident. The family received a further official apology from the president of BC Children's Hospital immediately following the death, accepting responsibility for the error and the harm done (Ombudsman of British Columbia, 1997). The circumstances of this event were published, in the peer reviewed Journal of Paediatric Haematology/Oncology in 1998, due to a commitment by the physicians involved to prevent future errors of this type (Fernandez, Esua, Hamilton, Fitzsimmons & Pritchard, 1998).[8]

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[7] Intrathecal refers to an injection into the spinal canal, more specifically into the sub-arachnoid space so that it reaches the Cerebral Spinal Fluid rather than into the blood stream.

[8] An identical error that had not been shared with the wider health care community, 5 years earlier, had resulted in the death of a four-year-old girl. In April of 1992, in Halifax, Nova Scotia, Vincristine had been given intrathecally resulting in the child's death, the same error described at BC Children's Hospital. The 1997 death is

My reflections in relation to my study relate to the relationship between the BC parents and physician that resulted following the events of 1997, and how the physician was able to move forward in his professional life. The parents described the physician as someone they admired and respected for the way he responded and interacted with them on the day of the error. Years later, as I observed the experiences of staff, physicians, patients and families in the context of my QRM work in Eastern Health, I began to compare and contrast their experiences with the story I had heard years before. I wondered what it was about the events of the 1997 BC death that had allowed the parents to respond in a supportive way toward the physician. Their response was in contrast to the events I was observing, where the health care providers, patients and patients' families tended to appear adversarial and the health care providers appeared to be traumatized and fearful of acknowledging an adverse event -- whether or not there was error involved. Staff who were involved in adverse events within Eastern Health were being traumatized and there did not appear to be any opportunity for them to become champions for patient safety.

Fear of litigation seemed to play a part in the responses I was observing in Eastern Health. The parents in BC had described their feelings toward the physician involved in their daughter's care as being concerned about him and having no ill feelings. This response seemed to be related to the way he had taken responsibility for his role in their daughter's death. The mother verbalized that she and her husband had no desire to seek

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representative of the result when repeatable errors in health care are not shared openly (Baker & Norton, 2001). The importance of this observation to this study, is the potential for harm that is created when incidents occur and staff do not feel safe to share their experience.

financial compensation from the physician or the hospital. Their only interest was in contributing to an Inquiry that would ensure that no other person would have to die as a result of this same kind of error, a completely preventable adverse event. This case went to Inquiry and articles have been written that implore system change to prevent future errors of this type (Fernandez et al., 1998; Noble & Donaldson, 2010). The physician and this family have been proactive in efforts of patient-safety in relation to paediatric chemotherapy.

When patients and families are aware of an adverse event -- in particular a preventable adverse event -- they will commonly, from my observations in QRM, request information and perhaps an explanation or apology from the direct care decision-maker. In many cases, following the processing of their immediate grief response, they will express a desire to know what is being done to prevent this from happening to someone else. In most cases they are not interested in pursuing a legal process unless they begin to sense that their questions are not being answered or not being treated as important, or they encounter people who are trying to block their access to a reasonable process. My observations are supported by the literature (The American College of Obstetricians and Gynecologists, 2012; Tsimtsiou, Kirana, Hatzimouratidis, & Hatzichristou, 2014).

When Eastern Health organizes a meeting with patients and their families for the purpose of explaining what happened or answering the patient's or family's questions, the patient and the family will be attending to details about who is present and who is providing information. Are they hearing an explanation directly from the person who was making the decisions that resulted in the event? Are they hearing an apology, if that is

what they deem to be appropriate? Are they being told how the system failed or how the system is being changed to prevent this from happening to someone else?

In my observations of physicians, nurses, pharmacy and laboratory staff through my role in QRM, I had noticed that when significant events happened that negatively impacted a patient, staff did not immediately -- or perhaps ever -- freely talk to the patient or family about what had happened. When a formal apology was offered it tended to be delivered by a member of the organizational leadership team.

1.9 The Importance of the Study Emerges from a Disturbing Disjuncture

The two contrasting observations described above, combined with what I was hearing anecdotally from my co-workers about the ongoing experiences of trauma to health care providers from the ER/PR event,[9] laid the foundation for the study. While both ER/PR and Cameron had occurred before I began my employment at Eastern Health, I had also personally witnessed health care providers commenting on the trauma that they continued to experience. For example, I heard many staff, across various programs and disciplines, reporting discomfort with being identified as an Eastern Health employee at the time of the Cameron Inquiry and even subsequently.

Before beginning my employment in QRM I had worked as a nurse for over 30 years. I had observed many dynamics within the culture of medicine and the context of health service delivery related to communication, support, system functioning and management oversight. I had been aware of many adverse events; but my knowledge was

[9] The ER/PR event will be referred to again in the discussion of the Cameron Inquiry in Section 4.7.3. ER/PR and Cameron both occurred before I began my employment at Eastern Health.

never as poignant as when I began my employment in the Quality and Risk Management (QRM) department and began to function within the role of a Quality Clinical Safety Leader. The Quality Clinical Safety Leader role within the health authority is specifically identified as having responsibility to advocate for patient safety including, in part, to assess and investigate the circumstances and possible causes of adverse events or unexpected patient outcomes. Within the event investigation, the Quality Clinical Safety Leader is meant to function in a neutral role, simply examining the facts and identifying, with the patient, the patient's family, staff and program leadership, ways that the health care system may have allowed the opportunity for the event or outcome to occur.

My observations of the staff's non-use of the Client Safety Reporting System (CSRS) or, perhaps more accurately, the reluctance or fear of reporting that staff described -- seemed to be linked in some tangible way to the Cameron Inquiry and to an organizational culture that was increasingly being described by some staff as blaming or punitive. At the same time that the organization was continuing to enhance the resources of the QRM department, there was an increasing national movement toward patient safety and disclosure of adverse events. It became clear that to fully understand the experience of staff in adverse events and to begin to make a difference in that experience as a Quality Clinical Safety Leader, it would be necessary to examine not only their experience but also the texts, behaviors, and expectations of the work environment and organizational culture within which adverse events were occurring.

My interest in this study was solidified when I discovered a discrepancy between what I was being told was the organizational approach to adverse event management, and staff accounts and experiences of being involved in adverse events. I observed that some

employees who were involved directly, indirectly, or even at a distance in adverse events and outcomes were exhibiting significant traumatic responses. I also began to hear anecdotal reports that staff who had reported adverse events were being penalized or disciplined in some way. Staff who reported being indirectly involved or not involved but who had knowledge of events, described fear and anxiety related to future adverse events in terms of possible discipline. At the same time that I began noticing the lived experience of staff in adverse events, I was beginning to examine the policies in the context of my position in QRM, and I realized two important aspects of policies related to adverse events. First, the policy addressing adverse event management described an organization that intended to "support the spirit of a just culture" (Eastern Health, 2011a, p. 2). Second, the policies apparently did not attend to *staff* experiences of trauma relating to an adverse event.

I also observed angst among the QRM staff as it related to the treatment of staff at the time of adverse events and during quality case review processes. Quality Clinical Safety Leaders made ongoing attempts to advocate for staff and to create a non-punitive environment, including participation in policy development. There was a desire on the part of the QRM staff to create policy specifically related to a *just culture* (see Section 2.11) that was indicative of their desire to acknowledge the harm that was coming to staff involved in events often outside staff's control. In addition, QRM staff were concerned for the welfare of staff as a result of a health care culture that was perceived to be punitive. The observation of this disjuncture between the expected organizational approach to adverse event management as described in organizational policy (see Section

4.2.4) and the staff's experiences led me to recognize the importance of doing this research.

1.10 The Personification of the Organization

In many cases it was difficult for staff to describe their event without vilifying Eastern Health. The personification of Eastern Health as a villain runs deeply through participant accounts. As much as participants may refer to "Eastern Health" (the organization and organizational leadership) in negative terms, there is of course no one person named "Eastern Health" who is responsible for the pain experienced. Managers and directors[10] have also been identified as second victims as a result of being involved in managing or directing staff at the time of adverse events, and some of those managers and directors are key informants that I have interviewed within this study and who have contributed to the collective understanding of what it is to be a second victim. I wish to emphasise in this introductory chapter that it was a challenge in this writing to be true to participants' words while not inadvertently perpetuating the negative personification of Eastern Health. I hope that I achieved this objective.

1.11 Research Phases

This research involved five principal phases. First, a review of the literature was conducted to understand the history of the concept of the second victim (defined in Section 1.3), focusing on how the concept came to be recognized and understood and on the evolution of the discourse of risk management and patient safety. In addition, the

[10] The title of Director is used in Eastern Health for members of the management team who have managers reporting to them and who report at the Executive level to positions entitled "Vice President".

literature review examined forms of organizational support, the concept of organizational "culture" and health care culture in particular, and the key concepts of power and silence. Second, informant interviews were conducted with 35 health care providers representing a full spectrum of disciplinary perspective and varying years of work experience. Examination of the interview data constituted the third phase and was ongoing throughout the data collection period and into the analysis and writing phase. A fourth phase involved a further review of the literature to explore *system and human factors* (as opposed to an emphasis on individual responsibility) and the concept of just culture, specifically in relation to the context shaping the experiences of health care providers involved in adverse events. And finally, in the fifth phase, texts that informants had identified as framing their experience were examined.

1.12 Objectives

The objectives of this research were:

1) To examine the experiences of health care providers involved directly[11], indirectly[12] or by association[13] with an adverse event; specifically, how an adverse event is managed and understood, with attention to the mechanisms of power that shape individual experiences.

[11] By "directly involved" I mean health care providers who were responsible for the direct clinical and care decisions related to the patient's outcome.
[12] By "indirectly involved" I mean health care providers who were present at the time of the occurrence, aware of the clinical and care decisions, but not responsible for the clinical and care decisions related to the patient's outcome.
[13] By "involved by association" I mean health care providers who were not present at the time of the occurrence and not aware of the clinical and care decisions related to the patient's outcome. This included health care providers who were considered associated with the adverse event by someone else or who identified with the adverse event themselves.

2) To examine whether and how the organizational culture of the health care organization shapes the experiences of adverse events; and to identify how organizational strategies and supports figure in to the experience of adverse events by health care providers (HCPs).
3) To examine whether, from the perspective of HCPs, the way adverse events are managed affects the ability to fully provide effective health care in the wake of being involved in an adverse event; that is, to elicit HCP opinions about whether there are resultant concerns related to quality and safety of patient care when health care is provided by a HCP who has been involved directly, indirectly or by association with an adverse event.

1.13 Research Questions

The research questions for this study included:

What is the experience of HCPs who have been involved directly, indirectly or by association in an adverse event? How would a HCP describe their personal response in relation to the adverse event? What type of intervention, response or support by colleagues did the HCP experience in relation to the adverse event? What type of intervention/response by the health care organization did the HCP experience in relation to the adverse event?

Specific questions included:

What are the types of and pathways for communication between HCPs in the aftermath of an adverse event and implications for disclosure to patients and reports to the institution? What are the multiple ways that adverse event reporting and patient disclosure takes place or is silenced? Do HCPs believe that the quality

and safety of patient care is affected when care is provided by a HCP who has been involved in an adverse event? What type of intervention/response do HCPs believe would mitigate the effects of being involved in an adverse event?

1.14 Potential Contributions of the Study

This research provides knowledge about how health care providers experience adverse events. In addition, this study provides information about how the experience of adverse events is shaped by and (re)shapes the organizational culture of reporting and disclosure. Moreover, this study provides important insight into whether adverse events have an effect on the quality and safety of patient care in the wake of a health care provider's involvement in an adverse event. The outcome of these findings is the identification of effective strategies and supports to mitigate possible negative effects of adverse events on health care providers, on the organization itself, and on the patient population in general.

At a micro-level of inquiry, this is the first study to examine how responses to adverse events are experienced within a health care organization that has experienced a significant adverse event. While it is well known that there are adverse patient events of varying severity that occur within any health care setting, individual perspectives have, to now, only been anecdotally reported within Eastern Health and most other health care organizations. For Eastern Health, the Cameron Inquiry brought the reality of adverse patient events to the forefront for public examination, but the organization has not intentionally explored the experience of health care providers. The implications of the study may include new and challenging knowledge for the organization. The study will provide insight into the experience of health care employees, and has the potential to

contribute in very positive ways to organizational responses to adverse events that could clearly affect not only health care providers but the future quality of patient care.

More generally (that is, beyond Eastern Health), the findings of this study will inform individuals and health care organizations about the experience of health care providers who have been involved, directly, indirectly or by association, in an adverse patient event. The concept of second victim will be more fully understood and the role of organizational culture as it relates to the experience of second victims, as described here, will be available for consideration by health care organization leadership teams. The study will also inform the development of health care policy related to organizational response following adverse events.

For the purpose of this study it is important to make a distinction between disclosure of adverse events to a patient or family, reporting for the purpose of adverse event management and participation in quality assurance activities. *Disclosure* refers to the provision of information to a patient and their family at the time of an adverse event. It was clear to me during my role in QRM that staff know the right thing to do in terms of disclosure to patients and families; staff express concern when disclosure does not happen either in a timely manner or in a thorough and transparent manner. Therefore, research on disclosure did not seem to be a necessary focus for my research. *Reporting* for the purpose of adverse event management refers to reporting to the organization through mechanisms like the client safety reporting system for the purpose of counting and classifying level of harm in an adverse event. *Participation in quality assurance activities* refers to efforts made to examine policy and procedures for the express purpose of improving practice and care for the purposes of patient safety improvement. This is not

a study of the ethics of whether or when disclosure should happen. This is not a study which examines whether reporting has occurred in an appropriate manner. This is a study that focuses on the experience of staff in adverse events and how that experience shapes their behaviour of disclosure, reporting and participation in quality assurance activities.

1.15 The Chapters: An Overview

I began by contextualizing this research with the story of the ER/PR testing errors, a significant laboratory medicine event that marked a pivotal point in the history of Eastern Health adverse event management. My interest in this study emerges from the story of a small child whose avoidable death speaks volumes about the experience of adverse events. The child's family is introduced, and the struggle that health care providers have to overcome in the face of adverse events is described, a crucial observation in the decision to undertake this important study. This chapter has provided a description of the background and importance of this study. It provided definitions of key concepts which are foundational to understanding the adverse event experience and to positioning study participants within the experience. The disjuncture which disturbed the homeostasis of my understanding of the organization's behaviour was also provided; that disjuncture began my path toward identifying the importance of this study.

Chapter 2 provides a review of the literature which is key to laying a foundation to begin this exploration. Peer reviewed sources are used to explore key concepts that provide the background and context for this study.

Chapter 3 provides the context and method of the study. The researcher and the participants who work together to make the experience of adverse events visible are introduced. This chapter describes the Critical Ethnographic approach used. It attends to

the important details of the study methods, data collection and analysis procedures, rigor, ethics and human rights considerations and participant support.

Chapter 4 provides an examination of the evolution of the discourse of risk management and patient safety, a backdrop to the substantial changes that were expected as a result of the Inquiry and task force reports. The description of the evolution of text within Eastern Health gives a sense of the stresses and strains that the organization faced as organizational leaders attempted to respond through policy development to two significant reports – the Cameron Report with its 60 recommendations and the Adverse Events Task Force Report with another 9 recommendations and a list of proposed legislative and governance changes. At the same time, staff within the health authority were having to balance these demands for change with the direction of provincial legislation, new national guidelines, and the discipline specific text from various professional organizations who all had a stake in the policy decisions within the health authority. This chapter sets the stage for understanding the complexity of the adverse event experience in an organization trying to undergo systemic change.

Chapter 5 begins with the experiences of staff who were present during the time of ER/PR, and travels through the many months of the investigation and Inquiry with several key informants from the Immunohistochemistry Laboratory and the Quality and Risk Management Program. Woven within their accounts of the experience are vignettes from other participants who shared the same experience or helped to define some of the details of this important recollection. The intimate details of the feelings and struggles of the staff of Eastern Health during a time of pain and endurance are shared. A memorial

honouring the patients and families of ER/PR will be described from the staff's perspective.

Chapter 6 moves onward through the months and years after the Inquiry and examines the ongoing experience of working in a wounded organization. Several individuals from different programs describe how adverse events are organized, and how they have experienced adverse events. Although this chapter is not one continuous story but rather a collection of reflections from a variety of participants, collectively it provides a comprehensive view of the organization and how additional adverse events are experienced as a reflection of a significant organizational event.

Chapter 7 explores the key features of the adverse event experiences as described by the collective of second victims. Health care providers who have dropped out, survived and some who have thrived after an experience of harm provide insight into support and non-support, blame, powerlessness and a culture of silence.

And finally, Chapter 8 considers the major findings of the study and acknowledges the importance of key recommendations for education, practice, research and policy to alter the experience of other health care providers who will undoubtedly face adverse events. The experience of the second victim is honoured in the challenge to health care organizations to consider positive change in light of the findings of this important and illuminating study.

Health care is a complex environment with influences from many different stakeholders, from the patients who require care to the government that sets policy and requires accountability. This study brings forth the voices of health care providers – from front line staff to upper-level managers -- who have been harmed by adverse events. The

recommendations that emerge out of their stories will assist those with the power to change experiences of harm within health care to better support and respond to health care providers who are the second victims of adverse events.

CHAPTER 2

Review of the Literature

This literature review critically and thematically explores the concept of second victim as it relates to the experience of adverse events in health care. It begins with a review of the concept of adverse events and reporting of adverse events. It moves on to examine the concept of second victim, including its associated contextual features -- forms of support, organizational and health care culture, power, and voice and silence. Finally, it narrows in to examine health care culture in relation to the second victim including a discussion of system and human factors and just culture. These concepts are important when examining the experience of health care providers in adverse events, sometimes to understand the role of the concept in the experience and at other times to understand how the experience is described. For example, the role of voice and silence in the adverse event experience is instrumental in the experience of suffering described within the descriptions of ER/PR. Power and powerlessness within the health care environment is key to frame the experiences of health care providers who are grappling with the trauma of feeling blamed.

The search strategy was to capture a comprehensive, multi-disciplinary cross-section of research conducted on the adverse events in health care from 2009 - 2014. The search was limited to 5 years, as the intention was to describe the recent evolution of the discourse of risk management and patient safety rather than to conduct an exhaustive search. The search strategy utilized the following search variables: adverse event, adverse

patient event, medical error, adverse event outcomes, adverse events/errors and health care provider and second victim. In addition, a search was undertaken within Commissions of Inquiry[14] and Legal Case[15] directories to locate health care inquiries and legal landmark cases that set the context for the environment in which the study was being undertaken. Research on adverse events spans a number of disciplines, including medicine, nursing, psychology, business, and sociology. Therefore, it was important to include databases that would capture at least those disciplines. Sources that included international citations were also chosen, based on the knowledge that adverse events are a universal issue within healthcare and that the experiences of other countries would be informative. The databases chosen were: PubMed, Scopus, CINAHL and EMbase. A systematic review of the BMJ *Quality and Safety in Health Care Journal* was undertaken as many of the studies found through the search terms cited that particular journal. In addition, the Institute for Healthcare Improvement (2015) and CPSI (2014) websites were explored as they include specific patient safety components and adverse event information.

Review of the literature from the initial searches meant returning to the literature to obtain key studies that were frequently cited but fell outside the search criteria, primarily due to year of publication. It was noted that when "Canada" was added as a limit, the number of citations was very few. Studies included in this literature review

[14] Commission of Inquiry directories used for the search included the National Archives of Canada – Index to Federal Royal Commissions, Government of NL Health publications and Royal Commissions of Ontario.
[15] Legal Case directories used for the search included Dominion Law Reports, CanLII – the Canadian Legal Information Institute and Lexum – Supreme Court of Canada.

focused on perceptions of adverse events as they relate to the health care provider experience. In addition, studies which examined the perception of adverse events to justify the development of support programs within health care organizations were included.

The literature review is organized into five broad themes. First, I reviewed studies on adverse events, including frequency and reporting of adverse events in health care. Second, I examined research on the second victim concept and experience, including how the term was coined and forms of support for the second victim. Third, I turned to the medical sociology and anthropology literature to inform myself about the notion of *organizational culture*, and then focused on the culture of health care organizations more specifically. Fourth, I examined the concepts of power and voice and silence as key features of the experience of health care providers. Finally, the patient safety management literature was reviewed in order to more fully understand some recent and important facets of that discourse. In that review, I focused on system and human factors and the concept of just culture. Each of these literatures: adverse events, second victim, organizational culture, power, voice/silence together are a cluster of interrelated concepts that are central to informing an understanding of the second victim experience.

2.1 Adverse Events

The definition of an adverse event, according to Baker et al. (2004), is: an unintended injury or complication that is caused by health care management, rather than by the patient's underlying disease, and that leads to death, disability at the time of discharge, or a prolonged hospital stay. To understand the magnitude of the involvement of health care providers in adverse events and the breadth of the issue, particularly in the

Canadian context in which this study takes place, it was pertinent to appreciate the frequency of adverse events. Two important studies, one in the United States and one in Canada, provide some informative data in this regard. The Harvard Medical Practice Study examined more than 30,000 randomly selected discharges from 51 randomly selected hospitals in New York State in 1984 (Brennan et al., 1991; Leape et al., 1991). Based on that study, the Institute of Medicine reports that

> Adverse events, manifest by prolonged hospitalization or disability at the time of discharge or both, occurred in 3.7 percent of the hospitalizations. The proportion of adverse events attributable to errors (i.e. preventable adverse events) was 58 percent and the proportion of adverse events due to negligence was 27.6 percent (1999, p. 30).

Baker et al. (2004) examined adverse events in four Canadian hospitals in each of five provinces (British Columbia, Alberta, Ontario, Quebec and Nova Scotia). This was the first Canadian study to provide a national estimate of the incidence of adverse events across a range of hospitals (teaching, large community and small community). The adverse event rate was reported as 7.5% of hospital admissions. "Among the patients with adverse events, events judged to be preventable occurred in 36.9% and death in 20.8%" (Baker et al., 2004, p. 1678). The overall interpretation of the rate of adverse events translates into 185,000 adverse events associated with 2.5 million annual hospital admissions in Canada, with close to 70,000 of those events being potentially preventable (Baker et al., 2004, p. 1678).

The Canadian Paediatric Adverse Events Study (CPAES) was the first National study of the epidemiology of adverse events in hospitalized children designed to determine and compare the types and preventability of adverse events in paediatric centres and large community hospitals (Matlow et al., 2013). The CPAES included

twenty-two hospitals in 7 provinces and based on the results it was determined that 9.2% of children hospitalized in Canada experience adverse events (Matlow et al., 2013). The type of hospital was a determining factor in the likelihood of experiencing an adverse event, with children in paedatric centres having significantly more adverse events at a rate of 11.2%, whereas children in community hospitals experienced adverse events at a rate of 3.3% (Matlow et al., 2013).

In a prospective cohort study Barker, Flynn, Pepper, Bates, and Mikeal (2002) utilized a random sample of 36 institutions to identify the prevalence of medication errors. Based on that study, Barker et al. report that

> Medication errors were frequent, occurring at a rate of nearly 1 of every 5 doses in the typical hospital and skilled nursing facility. The percentage of errors rated potentially harmful was 7%, or more than 40 per day per 300 inpatients, on the average" (2002, p. 1903).

Based on these studies, it is clear that adverse event rates in Canada and the United States represent a significant issue in health care. It is reasonable to expect that for each adverse event there will be at least one, but presumably more, health care professionals involved to varying degrees.

2.2 Reporting of Adverse Events

Handler, Nace, Studenski, and Fridsma (2004) describe their findings of knowledge, attitudes and beliefs of medication error reporting in a single long-term care facility. Three methods were used to characterize the medication error reporting processes and perceptions about errors, including: observation and semi-structured interviews to identify basic reporting processes; review of medication error reports; and a survey of nursing facility staff about their knowledge, attitudes and beliefs concerning

medication errors. The authors used estimates provided by Barker et al. (2002), to determine a comparator to the data found in their study. Handler et al. (2004) reported that Barker et al. (2002) found that 20% of medications administered in long term care were associated with an error and that 7% were potentially harmful. Using these estimates, approximately 250 medication administration errors per day would be expected in the study facility, with approximately 18 being potentially harmful. The Handler et al. findings indicate a reporting rate of 0.16 medication errors per day, "a fraction of the errors that were likely to have occurred" (2004, p. 194). A summary of the findings indicate "a low frequency of formal reporting, a narrow perspective on sources of error, and concerns about disciplinary action" (Handler et al., 2004, p. 195).

A study by Mrayyan, Shishani, and Al-Faouri (2007) describes Jordanian nurses' perceptions about medication errors, including their opinions about reporting rates. The findings indicate that the nurses believed that medication errors are under-reported, and that punitive actions are prevalent. "Using incident reports, only 42.1% of medication errors were reported to nurse managers" (Mrayyan et al., p. 665). Results indicated that the nurses failed to report medication errors because they were afraid of disciplinary action or job loss.

Having considered adverse events and the reporting of adverse events, I will turn now to the concept of the second victim and to research on the experiences of second victims of adverse events.

2.3 Second Victim

A second victim is a health care provider who becomes victimized by experiencing trauma as a result of involvement in an unanticipated adverse patient event,

medical error and/or a patient-related injury (Scott et al., 2010). The term was first coined by Albert Wu in his original writing on the topic of medical error in 2000. The term has been used consistently since, to describe the concept of a health care provider involved in an adverse medical event. Several authors report that the effect of adverse events on the health care provider is not well recognized or acknowledged (Christensen, Levinson, & Dunn, 1992; Crigger & Meek, 2007; Edrees, Paine, Feroli, & Wu, 2011; Massachusetts Coalition for the Prevention of Medical Errors, 2006; Meurier, Vincent, & Parmar, 1997; Rassin, Kanti, & Silner, 2005; Scheirton, Mu, & Lohman, 2003; Smetzer, 2012; Waterman et al., 2007). Wu states that "virtually every practitioner" has this shared experience, the "sickening realization of making a bad mistake," whereas "sadly, the kind of unconditional sympathy and support that are really needed are rarely forthcoming" (2000, p. 358). And further "while there is a norm of not criticizing, reassurance from colleagues is often grudging or qualified" (Wu, 2000, pp. 358-359). Wu and Steckelberg describe the response of the second victim as signs and symptoms of a disorder "similar to those in acute stress disorder" (2012, p. 267). Their analysis is based on a limited number of anecdotes, from which they formulated a description of the process of experiencing an adverse event.

The impact of an adverse event on a second victim is often written about but less often studied. It is clear from the literature that many individuals and organizations within health care are recognizing the presence of a phenomenon which can have and reportedly does have significant impact on health care providers, and potentially on the recipients of health care (eg. Christensen, et al., 1992). Some writers contend that the adverse event is

well recognized within health care but the impact on the health care provider is not as well recognized or acknowledged (eg. Edrees et al., 2001).

The Harvard consensus statement of 2006, drawing on interviews with managers and clinicians, examined manager and clinician communication with patients about errors and adverse events. Their findings were not based on accounts of actual experiences of adverse events, as the study was about the experience of communicating with patients. Nonetheless the statement reports that health care providers are "unrecognized 'second victims' in these events, and receive little understanding or support" and "following a serious adverse event caregivers often feel isolated and experience profound shame and guilt" (Massachusetts Coalition for the Prevention of Medical Errors, 2006, p. 17). In addition, the Harvard consensus statement reports that the absence of a support system "can have a longstanding and detrimental impact on a clinician's ability to provide patient care following an adverse event" (Massachusetts Coalition for the Prevention of Medical Errors, 2006, p. 17). Similarly, Smetzer (2012) states

> The healthcare industry as a whole has not widely communicated or implemented effective support mechanisms to address the deeply personal, social, spiritual, and professional crisis often experienced by the "second victims" of fatal errors. Too often, we remain silent and abandon the second victims of errors – our wounded healers – in their time of greatest need. Second victims suffer a medical emergency equivalent to post-traumatic stress disorder (PTSD) (p. 55).

A small number of studies have directly examined the experiences of second victims. Christensen et al. (1992) reported that physicians experienced profound emotional distress that continued for prolonged periods following the occurrence of a mistake. Similarly, Newman (1996) reported on a study in which all study subjects who did not deny their mistakes also experienced some form of emotional distress. Waterman

et al. (2007) conducted a survey of 3,171 physicians that indicated physician distress was common, with physicians reporting increased anxiety about future errors, loss of confidence, sleeping difficulties, reduced job satisfaction and fear of harm to their reputation. Interestingly, one third of those physicians who were involved only in a "near miss" (Waterman et al., 2007, p. 472) also reported increased stress. Scott, describing a study of clinicians in the University of Missouri Health Care system, noted that many of their participants provided meticulously detailed accounts of events, including the exact date and event-specific details like the colour of clothing (Scott, 2011). She described one of the most striking findings being that "every second victim participating in the project described their respective unanticipated clinical event as a life-altering experience that left a lasting impression on them" (Scott, 2011, p. 2).

Experiences of nurses as second victims have also been studied, though to a lesser extent. Meurier et al. (1997) examined nursing practice and found that the majority of participants described having experienced emotional distress in response to their errors, including anger (at themselves or others), feelings of inadequacy, fear of repercussion and guilt feelings. Nurses also reported loss of confidence and increased anxiety in their work. Similarly, Rassin et al. in a qualitative study of medication errors in relation to stress and PTSD[16] symptoms among nurses, suggest that errors have "severe emotional effects: fear, guilt, shame, sometimes even mental pressure lasting for months, reminiscent of PTSD" (2005, p. 884).

[16] Post-traumatic stress disorder (PTSD) is a mental health condition that's triggered by a terrifying event — either experiencing it or witnessing it. Symptoms may include flashbacks, nightmares and severe anxiety, as well as uncontrollable thoughts about the event (Mayo Clinic, 2016).

Sirriyeh, Lawton, Gardner, and Armitage (2010) and Schwappach and Boluarte (2008) conducted systematic reviews to assess the effects of involvement in medical errors on healthcare professionals' psychological well-being. They found significant emotional distress (shame, guilt) immediately following an error, as well as psychological responses (self-doubt, perceptions of altered relationships) in all research they reviewed. They reported there was limited evidence related to how health professionals cope with having been involved in a medical error (Sirriyeh et al., 2010). The authors remark that it is not clear how responses to error vary across clinical settings and professional groups, although "nursing samples were consistent in … a feeling of personal responsibility for an error and the commitment to reporting such incidents regardless of an increase likelihood of being blamed" (Sirriyeh et al., 2010, p. 7). Schwappach and Boluarte report on intense emotional distress and increased risk of burn-out and depression associated with involvement in medical errors. In addition, the authors described the "reciprocal cycle of these symptoms and future suboptimal patient care and error" (Schwappach & Boluarte, 2008, p. 9). They report that there have been few studies that have examined physicians' needs and experiences in relation to errors, such as factors and conditions that may impede or contribute to a constructive approach (Schwappach & Boluarte, 2008).

It is evident from this literature that the experience of health care providers involved directly in adverse events is likely significant and yet remains relatively unexamined. The experiences of health care providers who are affected by adverse events *indirectly* or *by association*, for example by virtue of their employment, profession or, proximity to the location of the event, have not yet been examined. In addition, the

effects of adverse events on the organization itself are likely significant and have not been addressed.

Several authors have presented explanations of the second victim response, and two of these have proposed descriptions of the second victim response that may be considered models to explain the progression of response. The two models include: Crigger and Meek's four stages of self-reconciliation (2007) and Scott et al.'s natural history of recovery (2009). A model that specifically addresses recovery is Berlinger's forgiveness model (2011). Other authors equate the second victim response to the existing model of PTSD, including Edrees et al. (2011), Rassin et al. (2005), Smetzer (2012), and Wu and Steckelberg (2012).

2.4 Forms of Support for the Second Victim

Several studies examining adverse events and the experience of the second victim illuminate the importance of, and the forms of, support for the second victim. The general consensus throughout the literature, as Smetzer states, is that "the healthcare industry as a whole has not widely communicated or implemented effective support mechanisms" (2012, p. 55). The experience of health care providers is described in the literature as ranging from feeling supported to feeling abandoned. Silversides reported that one physician described that "support from patients and colleagues alleviated much of his stress," whereas another physician described the experience of feeling abandoned: "except for one or 2 friends, I felt abandoned by my peers, it was as if they thought what was happening to me might contaminate them" (2008, p. 309).

Some authors state the importance of support but do not specifically recommend or identify the forms of support, whereas other authors identify specific direct support

strategies or indirect strategies which may result in support. Included among those studies that cite the importance of support is that of Berlinger (2011), who advocates for better institutional support for caregivers involved in errors to help them focus their attention on the affected patient. Similarly, Waterman et al. (2007) explored support following errors and discussed the importance of support mechanisms. Reportedly, "ninety percent of physicians disagreed (37% strongly) that hospitals and health care organizations adequately support them in coping with stress associated with medical errors" (Waterman et al., 2007, p. 470). Denham, who studied the perspective of health care leaders in relation to second victims, reported that leaders identify a need to support second victims "as much as and as strongly as we support the patients and their families," noting that second victims "have the right to be treated with respect" (2007, p. 111).

Edrees et al., in a 2011 study, examined the importance of support structures for second victims and the findings confirmed for the investigators the need for second victim support strategies within health care organizations. As a result of the study, John Hopkins Hospital has established a peer-support program. Similarly, van Pelt (2008) described an adverse medical event and the ensuing apology and open communication between physician and patient that led to the development and implementation of a structured peer-based support service. The support service for care providers following adverse events is entitled "Medically Induced Trauma Support Services" (van Pelt, 2008, p. 250). The Harvard Consensus statement provides anecdotal evidence for the importance of a caregiver support program. "The absence of a structured support system can have a longstanding and detrimental impact on a clinician's ability to provide patient care following an adverse event" (Massachusetts Coalition for the Prevention of Medical

Errors, 2006, p. 17). This consensus statement resulted in a peer support system created within the Boston hospitals.

The types of indirect strategies identified which may result in support are found in several studies including Christensen et al. (1992), whose recommendations included bringing open discussion into mainstream medicine. Similarly, Engel, Rosenthal, and Sutcliffe (2006) concluded that physician training programs need to promote coping by providing emotional support and learning opportunities as a result of medical mishaps. Mechanisms which are increasingly being utilized within quality and risk initiatives, such as disclosure strategies, are also identified by authors as a component of support mechanisms to health care providers (Clancy, 2012). It is clear that there is a beginning recognition of the link between the experience of the second victim and support, but literature providing evidence of the success of support programs remains to be developed.

2.5 Organizational Culture

By definition culture is "the customary beliefs, social forms, and material traits of a racial, religious, or social group; the characteristic features of everyday existence shared by people in a place or time" (Merriam-Webster Dictionary, 2012). "Notions of 'culture' have deep roots in the anthropological literature going back many decades" (Davies, Nutley, & Mannion, 2000, p. 111). "Organizational culture is defined as the pattern of values, beliefs and expectation shared by the organization's members" (Wakefield, Wakefield, Uden-Holman, & Blegen, 1996, p. 196). Common norms of employee action are based on the values and beliefs of employees who interact with an organization's structure, control systems, and people (Wakefield et al., 1996).

Davies et al. provide a historical view of organizational culture, noting that the application of ideas about culture when applied "to organizations rather than indigenous people began in the United States in the immediate post war period but came to popular attention in the 1980s" (2000, p. 111). Organizational culture within health care is clearly demonstrated by Davies et al. in their description of several levels of culture within the National Health Service (NHS). First are "the underlying assumptions that represent the unconscious and 'taken for granted' beliefs that structure the thinking and behaviour of an individual" (Davies et al., 2000, p. 112) such as those ingrained in medical care "about measurability, aggregation and transferability of knowledge" (Davies et al., 2000, p. 114). The assumptions give rise to the second level of culture which is the organizational values "that operate at a more conscious level and represent the standards and goals to which individuals attribute intrinsic worth" (Davies et al., 2000, p. 112). "Values constitute the basic foundations for making judgements and distinguishing 'right' from 'wrong' behaviour" (Davies et al., 2000, p. 114), such as the Hippocratic[17] principle of medicine. And finally, "more visible still are those artefacts that represent the concrete manifestations of culture" such as ceremonies, traditions, and incentive structures (Davies et al., 2000, p. 112). In health care these may include dress codes, standard ways of running services, such as waiting lists, admissions, and methods of performance assessment, such as peer review. Davies et al. make an important observation that "the organizational culture cannot be tackled in isolation from such issues as the

[17] In the medical profession conduct has traditionally been based on the Hippocratic principle of placing the needs of individual patients above broader economic and corporate objectives (Davies et al., 2000, p. 114).

organizational structure, financial arrangements, lines of control and accountability, strategy formulation, or human resource management initiatives" (2000, p. 116).

Within the literature of organizational culture there is an additional concept that is important to acknowledge, namely organizational climate. Denison provides a comprehensive analysis of the difference between organizational culture and organizational climate in his 1996 review. He notes that the two literatures, those of organizational cultural and organizational climate, present contrasting perspectives with little overlap. "*Culture* refers to the deep structure of organizations, which is rooted in the values, beliefs, and assumptions held by organizational members. Meaning is established through socialization to a variety of identity groups that converge in the workplace" (Denison, 1996, p. 624). "*Climate*, in contrast, portrays organizational environments as being rooted in the organization's value system, but tends to present these social environments in relatively static terms, describing them in terms of a fixed set of dimensions" (Denison, 1996, p. 624). To simplify this perceived divergence, Denison notes "the culture and climate literatures actually address a common phenomenon: the creation and influence of social contexts in organizations" (1996, p. 646).

As noted above, Clancy (2012) discusses the systematic nature of patient safety events, and states that health care-associated injuries are events associated with the process or structure of care, rather than with a patient's condition. Included is helpful and interesting discussion about safety culture "that focuses on the role of systems and de-emphasizes blame" (Clancy, 2012, p. 2). In essence Clancy is describing organizational culture under the specific umbrella of safety culture since the focus of her commentary is patient safety events. All of these related concepts -- organizational culture, organization

climate and safety culture -- are provided to address the potential components of organizational culture within health care.

Cox and Howarth (1990) provided insight into the concept of organizational culture. In this 1990 commentary, the concept was reported to be relatively new. The authors make the point that "for human organizations there is the added complexity of existing at two different levels, the objective and the subjective" (Cox & Howarth, 1990, p. 107).

> At the objective level, an organization is defined by its written policies, rules of operation and procedures, its communication channels and its physical interchanges of materials and products within and between its different environments. At the subjective level, an organization is represented in people's understanding of it and attitudes towards it, both individual and collective (Cox & Howarth, 1990, p. 107).

Cox and Howarth argue that "a healthy organization requires its culture (subjective aspects) to be in some way consistent with its structure, policies and procedures (objective aspects)" (1990, p. 108).

The concept of an organizational culture is a critical concept in considering the experience of health care workers involved in adverse events. Wakefield et al. (1996) undertook a study of perceived barriers in reporting medication administration errors in 24 acute care hospitals with 1384 respondents. The findings revealed the importance of considering errors in relation to organizational culture, with implications for understanding the experience of adverse events. In addition to organizational culture, Wakefield et al. also drew attention to professional culture and work group culture as distinct entities. Professional culture is described as the socialization of both student physicians and nurses "to strive for error-free practice with an emphasis on perfection"

(Wakefield et al., 1996, p. 196). In professional culture, "corrective measures have traditionally been aimed at the person to ensure that the same error was not repeated, rather than focusing on the underlying cause of the error and thus reducing the risk of someone else repeating the same error" (Wakefield et al., 1996, p. 196). Work group culture is described as "perhaps the most salient culture for an employee" and Wakefield et al. give the example that within hospitals, the nurse's immediate work group usually exists on the individual patient care unit (1996, p. 197). Organizational, professional and work group culture are all important concepts for understanding the complexity of health care culture.

2.6 Healthcare Culture

Since at least the 1980s, social scientists have examined the nature of health care culture and how it shapes the experiences, values, beliefs and behaviors of health care providers (Armstrong, 1983; Ehrenreich & Ehrenreich, 1978; Frankenberg, 1986; Lock & Gordon, 1988; Wright & Treacher, 1982; Young, 1993). The fact that "culture and component subcultures exist in all organizations," with hospitals being no exception (Nordstrom & Allen, 1987, p. 43), is pivotal to this discussion. Health care culture is specific to the everyday experience shared by health care providers within the context of a health care organization or within the context of the health care provider role. Health care culture provides expectations, values and processes that can be considered the features, beliefs, social forms and traits of that existence. Health care culture is a complex conception as it integrates organizational culture, the professional culture of several distinct groups, as well as the work group culture of many units of function. One individual may cross several cultures simultaneously.

Health care culture is often referred to, directly or indirectly, in the literature that explores the experiences of second victims, and typically it is described in the context of providing an explanation for the second victim phenomenon. For example, the authors of the Harvard Consensus Statement, 2006, describe

> … a medical culture that expects physicians particularly to remain strong, objective, and emotionally detached from their patients afflicted by illness; a health care and legal system that blames the caregiver rather than the care process when an incident occurs; and internalization of the dictum to "first do no harm" that leads physicians to expect infallibility and that reinforces the adverse outcome as a taboo event (Massachusetts Coalition for the Prevention of Medical Errors, 2006, p. 17).

Some studies have explored health care culture in relation to a specific issue or concern. For example, Coffey and colleagues, conducting research on disclosure, emphasized the culture of the health care setting in their Toronto-based study (Coffey, Thomson, Tallett, and Matlow (2010)). A survey of 64 pediatric residents and three focus groups with 24 participants were used to gather data. The objectives of the study were to explore pediatric residents' knowledge, attitudes, and self-reported behaviors with respect to disclosure. The contextual themes identified within that study which would be considered facets of health care culture were: social boundaries[18], hierarchy[19], quality of relationships[20], and reputation risk. The results indicated that residents find it difficult to disclose errors. Contextual and social factors reportedly facilitate and inhibit

[18] Social boundaries are created by the service which the medical resident is associated with and encompasses medical service; for example a neurosurgeon would be outside the social boundary of a general surgery resident.
[19] Hierarchy in medicine refers to the ranking of staff in order of experience, such as junior resident, senior resident, fellow and medical staff person.
[20] Quality of relationships refers to the relationships within the medical service between the ranks of medical staff.

disclosure, depending on the circumstance. For example, hierarchy within medicine was described by some as facilitating disclosure and by others as inhibiting disclosure. Those who felt hierarchy facilitated disclosure viewed their position as a "junior" physician to be protective, whereas those who felt hierarchy inhibited disclosure were concerned for their reputation.

It is often documented that staff will only report accurately and consistently in organizations with a *positive safety culture*[21]. Hughes and Lapane (2006) examined patient safety culture in nursing homes. This study's objective was to evaluate whether perceptions of patient safety by employees varied by employment length, category of employee and shift assignment within a long term care home. The results provide some interesting findings in relation to health care culture. Hughes and Lapane described that the frequency of reporting of adverse events can be anticipated to be directly related to the staff's perception of the punitive outcome of adverse event reporting. The authors report that "regardless of staff type, one in five reported feeling punished and two in five reported that reporting of errors [by colleagues] was seen as a 'personal attack'" (Hughes & Lapane, 2006, p. 281). "Data from this study suggests that a 'blame and shame' culture predominates in the nursing home setting" (Hughes & Lapane, 2006, p. 283). The findings indicate that 60% of nursing assistants (n=636) and 80% of nurses (n=367) reported observing a safety problem at least once in the previous month, for a total of 676

[21] "A positive safety culture has three key elements: working practices and rules for effectively controlling hazards; a positive attitude towards risk management and compliance with the control processes; the capacity to learn from accidents, near misses and safety performance indicators and bring about continual improvement" (Institution for Occupational Safety and Health, 2015, p. 3).

adverse events in the previous month. The reporting of adverse events was anticipated by the authors to be a fraction of this number, although no report frequency was provided.

The writings of Edmondson (2002) on psychological safety in work teams is useful to consider in relation to health care culture. *Psychological safety* has begun appearing in patient safety literature in relation to the concepts of health care culture and just culture (Institute for Healthcare Improvement, 2015). Edmondson notes that "an extensive literature on organizational culture examines how norms, values and beliefs arise in organizations to reduce the anxiety people feel confronting ambiguity and uncertainty" (2002, p. 2). She explains that the construct of psychological safety has its roots in research on organizational change conducted in the mid-1960s by Schein and Bennis, who reportedly identified the need to create psychological safety for individuals to feel secure and capable of changing (Edmondson, 2002, p. 7; Schein & Bennis, 1965). "If relationships within a group are characterized by trust and respect, individuals are likely to believe they will be given the benefit of the doubt - a defining characteristic of psychological safety" (Edmondson, 2002, p. 10). Importantly for an understanding of the experiences of second victims, Edmondson noted that "psychological safety means no one will be punished or humiliated for errors, questions, or requests for help, in the service of reaching ambitious performance goals" (2002, p. 22).

Nordstrom and Allen (1987) explored how culture influences behaviour in a hospital in their study entitled *Cultural change versus behavioral change*. They report on a multi-hospital system's climate study conducted in three hospitals and three convalescent facilities in California. The authors state that "culture proves to be both beneficial and detrimental to groups" (Nordstrom & Allen, p. 43). An important point

made by the authors is that hospitals have a culture, "however, one should not assume that all health care institutions have the same culture. A given hospital will be drastically different from others" (Nordstrom & Allen, p. 44). They note that "the reasons for differences lie in variations in management, local economy, technology and specialization, and socialization needs" (Nordstrom & Allen, p. 44).

Speroff et al. (2010), in a cross-sectional analysis of surveys in 64 Intensive Care Units in 40 hospitals in the U. S., which included 1406 participants from nursing, ancillary staff, allied staff and physicians, examined cultural variation across hospitals to determine if an organizational group culture shows better alignment with patient safety climate. The term *group culture* was used to denote a culture which is indicative of teamwork as distinguished from a bureaucratic organizational culture. The authors report that the findings of the study support their premise "that hospitals vary in organizational culture and that the type of culture within the hospital would relate to perceived safety climate" (Speroff et al., p. 594). In addition, "organizations characterized as having group culture are more effective, and hospitals with hierarchical culture are less effective at implementing quality improvement" (Speroff et al., p. 594). The authors conclude that "the current study's findings in combination with prior research suggest that a healthcare organization's culture is a pivotal force to contend with in the implementation of quality improvement and the development of a patient safety climate" (Speroff et al., p. 595).

Health care culture is not a static or consistent entity across health care settings. As there are some specificities in the culture of all health care institutions, as Nordstrom and Allen and Speroff, et al. assert, the organizational culture varies depending on different institutional aspects. It is reasonable to expect that, given the diverse natures of

organizational cultures, the experiences of second victims across health care cultures will also be variable. As noted by Lock, "culture is a necessary concept for most research projects, especially when culture is explicitly made to do work by the particular people or institutions that one is studying" (2001, p. 488).

2.7 Power

Power is important to this study on a number of fronts including: where power is identified, and how power is exercised, resisted, ignored, or dismissed by various players, with a focus on those health care providers – both staff and management. In particular, how an adverse event is managed and understood, with attention to the mechanisms of power that shape individual experiences. There are different types of power, and these can be categorized according to the resources employed to exercise the power – for example, coercive power from force, power from wealth, and persuasive power based on knowledge, information or authority (van Dijk, 1993). van Dijk (1993) notes that power is seldom absolute, that groups may control other groups in specific situations or social domains, and that dominated groups may more or less resist, accept, comply or legitimate such power. "Power involves control, namely by (members of) one group over (those of) other groups" (van Dijk, 1993, p. 254). "Dominance may be enacted and reproduced by subtle, routine, everyday forms of text and talk that appear 'natural' and quite 'acceptable'" (van Dijk, 1993, p. 254).

Scholars advancing the social studies of medicine, drawing on the examination of power offered by theorists such as Foucault (1980) and Bourdieu (1977), have demonstrated that the culture of medicine is inevitably shaped by power (Gordon, 1988; Lock & Gordon, 1988; Lupton, 1995; Young, 1993). They argue that the culture of

medicine constitutes not only systems of beliefs and values, but also ideologies or statements about what ought to be. According to Lupton, "Foucauldian approaches stress that power in the context of the medical encounter is not a unitary entity, but a strategic relation which is diffuse and invisible" (2003, p. 120). Power, used in this context, is not necessarily a controlling force aimed at domination, but is closer to a form of social organization by which social order and conformity are maintained (Lupton, 2003). Therefore, power is not only a repressive force but also a productive force, "producing knowledge and subjectivity" (Lupton, 2003, p. 120). Foucault (1982) described power as a relation and, as such, certain people in relations will find themselves in different positions of power or domination. "Those who are marginalized or dominated will struggle to have their voices heard with the dialogue and may well find an alternate voice imposed on them" (Burkitt, 1999, p. 77).

When adverse events happen, it may be that the clinical judgement or expertise of the professional is called into question and the professional is then placed in a vulnerable position. In 1992, Christensen, Levinson and Dunn reported on a qualitative study comprised of in-depth interviews with eleven physicians in which each physician discussed a previous mistake and its impact on his or her life. Beliefs about control were key for shaping the degree of distress experienced following a mistake. Those physicians who focused, following a mistake, on the uncertainty of their own knowledge and simultaneously on the certainty that disease could be potentially controlled tended to attribute the mistake to themselves; those who believed that medicine actually controls very little, by contrast, did not attribute a mistake to themselves and therefore experienced less distress.

In order to understand relations of power within an organization, it is important to examine the power differences between employees and their managers. Managers may wield coercive power and thus have the capacity to influence the lives of their subordinates (Milliken & Lam, 2009). The possession of power, for example, has been found to affect how people perceive and interpret events as well as the emotional reactions they have to these events (Milliken & Lam, 2009). Power may also operate in other more subtle ways to affect the flow of information in organizations, including the use of voice and silence, concepts examined in detail in the next section.

2.8 Voice and Silence

Voice is defined by Brinsfield, Edwards, and Greenberg (2009, p. 4) "as the expression of ideas, information, opinions, or concerns and *silence* as withholding them." The concepts of voice and silence have been explored from a number of perspectives including: voice or silence as a form of control, power or self-protection (eg. Ellis & Van Dyne, 2009); "being silenced" by an individual or an organization (eg. Morrison & Rothman, 2009); and the prevention of communication by silence (eg. Tangirala & Ramanujam, 2009). All of these forms of voice or silence seem to have important implications in the experience of health care providers involved in adverse events.

Ellis and Van Dyne (2009) used the concept of "defensive voice" to explain how employees respond when they experience mistreatment in the workplace. They describe defensive voice as a self-protective strategy used to reduce personal threats. They note that although defensive voice may involve complaints and rude or negative comments, it is primarily self-focused and is not intended to harm others or the organization. Although defensive voice may have a negative effect on peers, supervisors, and others in the

organization, it is "motivated by a sense of injustice and attempts to regain a sense of personal control" (Ellis & Van Dyne, 2009, p. 44). In the context of an adverse event, defensive voice may be used when an employee feels that an injustice is being done, to express frustration or in an attempt to regain their sense of control over the situation and protect themselves from criticism or discipline.

Morrison and Rothman (2009) offered a comprehensive analysis of how power is implicated in the decision to remain silent, discussing the psychological mechanisms underlying the power-silence relationship. Morrison and Rothman (2009) present evidence about the lack of willingness of employees to share their concerns with authority figures, preferring to remain silent. "Employee silence refers to the conscious withholding of information, opinions, suggestions, or concerns about potentially important organizational issues" (Morrison & Rothman, 2009, p. 112) from organizational leaders who may be able to address the issues. Morrison and Rothman report that power is one of the most important variables in silence, noting that fundamentally "employee silence is a reluctance to convey information to a person or persons with power" (2009, p. 112). The employee is in a position of relatively low power and the manager is in a position of relatively high power, and Morrison and Rothman contend that "the power imbalance inherent in organizational roles is perhaps *the* most important factor that makes employee silence a common experience" (2009, p. 112). Morrison and Rothman (2009) highlight what they believe are two key judgements at the root of employee silence: that speaking up is futile and that speaking up is dangerous. They reason that managers behave in ways consistent with elevated power and staff understand those behaviours through a lens of low power, "hence, both parties

contribute to the silencing process, although often unaware that they are doing so" (Morrison & Rothman, 2009, p. 128).

Lind and Kulik (2009) reviewed how voice influences employees' perceptions of fairness in the workplace. The authors contend that voice matters, definitely, "but it does not always matter to the same degree" (Lind & Kulik, 2009, p. 147). Lind and Kulik report that the perception of the need for voice opportunities depend on the outcome of a decision, relationship and confidence. "Voice matters -- but it seems to matter especially when people are likely to receive negative outcomes, when people are engaged in a strong relationship with the organization making the decision, or when people are feeling uncertain" (Lind & Kulik, 2009, p. 148). Lind and Van den Bos (2002) contend that having voice makes the uncertainty of being subject to other people's decisions feel a lot more manageable psychologically. They suggest that managers be particularly focused on providing voice to employees in personal crises, when uncertainty is especially high and the positive consequences of giving voice or the negative consequences of denying voice will be especially powerful. Lind and Kulik (2009) note, too, that it is very important that organizational decision makers provide voice during periods of high organizational uncertainty. They conclude that "voice enhances feelings of fair treatment (Lind & Kulik, 2009, p. 147).

Ashford, Sutcliffe, and Christianson (2009) analysed how leaders influence the use of voice by their subordinates and the factors that affect how leaders listen and respond to subordinates' expressions of voice. Their findings show that employees take both the direct and indirect cost of voice into account (image, retaliation and a wounded psyche) and are reluctant to share information with those who might be threatening, such

as people above them in the organization (Ashford et al., 2009). Ashford et al. (2009) explain that leaders influence voice by virtue of their leadership style, for example, leaders who exhibit a supportive style and open-mindedness motivate employees to speak up due to a perceived opportunity for voice. "Such leadership behaviours may be particularly important if only to offset the dampening effects of formal organizational structures on voice" (Ashford et al., 2009, p. 181).

Tangirala and Ramanujam (2009) considered why loyal employees often feel compelled to remain silent about organizational problems and concerns, suggesting that individual factors and work contexts help explain the loyalty-silence relationship. The authors report inconsistent findings in the literature regarding the relationship between organizational loyalty and voice. They report that some studies indicate that employees who are strongly invested in their workplaces are inclined to speak up about their work-related concerns when dissatisfied, while other studies reach the opposite conclusion that loyal employees suffer in silence in order to minimize the potential disruption of bringing their concerns forward. The opportunity for voice in relation to loyalty is reported as a key feature motivating employees to speak up. "In general, in workplaces in which the social contexts for speaking up are favourable, a positive relationship between employee loyalty and voice is expected to be found" (Tangirala & Ramanujam, 2009, p. 207). "By contrast, in workplaces in which the social contexts for speaking up are unfavourable, employees with high professional or organizational loyalty are likely to refrain from speaking up" (Tangirala & Ramanujam, 2009, p. 207). Tangirala and Ramanujam identify three contextual moderators that create a positive relationship between voice and

loyalty: "(1) provide employees' *perceived opportunities for voice*, (2) reduce their *fear of reprisals*, and (3) increase the *perceived utility of voice*" (2009, p. 207).

Milliken and Lam (2009) considered the implications of silence for organizational learning. Although the authors recognize that this connection between silence and organizational learning is not new, they contribute to the literature by examining some of specific ways in which decisions about speaking up affect an organization's capacity to learn, change and innovate. Milliken and Lam argue that "employees are much more likely to be silent about information that signals the potential existence of a problem than they are to be silent about information that they think will be interpreted as positive by management" (2009, p. 228). Even new ideas or suggestions may fall into the category of information that is difficult to share because ideas suggest a need for change to the status quo (Milliken & Lam, 2009). This skewed transfer of information leads the manager to have a distorted picture of how their organization is functioning, and the quality of decision-making decreases with organizational learning being compromised, change being jeopardized, and innovation lagging behind (Milliken & Lam, 2009). "An organization with a climate of silence is expected to be ill-equipped to deal with a changing environment" (Milliken & Lam, 2009, p. 240).

2.9 Healthcare Culture and the Second Victim

While the concepts of health care culture and the second victim have been explored, as described above,[22] there is a scarcity of literature that links the two concepts and examines the impact of health care culture *on* a second victim. Nelson and Beyea

[22] The literature in section 2.6 discussed health care culture and second victims but didn't explicitly discuss how the culture shapes the experience of being a second victim.

(2009) provide a commentary on the role of an *ethical* health care culture for the prevention and recovery of second victims. There are two important linked concepts that are brought forward in this commentary, the role of ethics in achieving a positive health care culture and moral distress[23]. Nelson and Beyea note that in the study by Scott et al., "the clinician's experiences reflect the overall culture of their healthcare organization and its programs for safety and quality" (2009, p. 323). One of the main points made is that health care organizations have a moral imperative to provide quality care, by establishing an ethics-grounded organizational culture – "one in which ethical uncertainty and questions can be openly acknowledged and systematically addressed" (Nelson & Beyea, 2009, p. 324).

In a descriptive article, Goldberg, Kuhn, Andrew and Thomas, who are emergency physicians, discuss the culture of medicine and its impact on the experience of physician error, arguing that "for a variety of reasons, disclosure of mistakes is not encouraged" (2002, p. 290). The authors note that there is a need for a shift in culture within the medical training curricula from blame to continuous improvement.

An early commentary by Hilfiker (1984) is widely cited in the literature. It describes mistakes from a physician's perspective based on his own personal experience, modeling the type of sharing and transparency that, he argues, will move medicine into a culture of learning from mistakes rather than judging and blaming. "The cumulative impact of such mistakes (and the ever-present potential for many others) has had a devastating effect on my own emotional health, as it does, I believe, for most physicians"

[23] Moral distress was first noted by Jameton (1984) in the nursing ethics literature.

(Hilfiker, 1984, p. 120). “Even the word ‘malpractice’ carries the implication that one has done something more than make a natural mistake, it connotes guilt and sinfulness” (Hilfiker, 1984, p. 121). Hilfiker encourages other physicians to become transparent about medical errors:

> At some point we must bring our mistakes out of the closet. We need to give ourselves permission to recognize our errors and their consequences. We need to find healthy ways to deal with our emotional responses to those errors. Our profession is difficult enough without our having to wear the yoke of perfection (Hilfiker, 1984, p. 122).

The concept of *moral distress* has been used in the context of disclosure, particularly in relation to how the culture of medicine may shape the distress that a health care provider experiences after a medical error.

> Moral distress occurs when a healthcare professional, in a given situation, knows or believes she knows what the ethical appropriate action is but is unable or feels constrained from acting because of obstacles, such as lack of supervisory support and/or organizational constraints” (Nelson & Beyea, 2009, p. 323).

The result of lack of action “can increase staff stress, decrease morale, foster job turnover and diminish the organization’s culture” (Nelson & Beyea, 2009, p. 323). Moral distress may be experienced by the clinician but the clinician “does not feel comfortable speaking up about problems because of fears of retaliation or loss of one’s employment” (Nelson & Beyea, 2009, p. 323). The fear of speaking up about problems is compounded by fears of making an error or harming a patient.

In the case of errors, “another ethical issue exists when a clinician believes it is morally appropriate to disclose information about an error to the patient or family members; however, the supervisor or attending physician may direct the clinician not to talk about the case. This type of conflict serves as a clear trigger leading to moral

distress" (Nelson & Beyea, 2009, p. 323). Nelson and Beyea contend that to create a culture of quality and safety, an organization must critically examine whether it fosters an environment that supports clinicians when errors occur. "Additional research is needed to identify and understand the full complement of victims of medical errors" (Nelson & Beyea, 2009, p. 324) but it is a reasonable expectation that ethical quandaries and moral distress experienced following an adverse event will have an impact on the experience of the second victim.

Wakefield, McLaws, Whitby, and Patton (2010) conducted the first study to develop predictive models for patient safety behaviours in health care workers, using a cross-sectional survey of 5294 clinical and managerial staff in one health care region of Australia. "This study clearly demonstrated that two key factors influence the safety behaviours of all health care workers: observed behaviour of professional peers (Professional Peer Behaviour) and a genuine belief in the safety outcomes of the behaviours (Preventive Action Beliefs)" (Wakefield et al., 2010, p. 589). The authors note that "existing medical culture is characterized by individual concepts of clinical work, clinical purism and opaque accountability" and "junior doctors are quickly socialized to these values and behaviours" (Wakefield et al., 2010, p. 589). When comparing junior doctors with other respondents involved in adverse events, "they are more likely to perceive blame as a result of an incident, and less likely to report positively about management, or speak up when an error is made" (Wakefield et al., 2010, p. 589) indicating both a negative impact on the junior doctor and on current and future patients. The terms *safety climate* and *safety culture* are distinguished, with safety climate referring to an individuals' attitudes towards safety and safety culture denoting the shared

beliefs and convictions underpinning individuals' attitudes, the prevailing values of the social group. The authors note "the overall trend appears to be in favour of the term safety culture" (Wakefield et al., 2010, p. 585) which may be an unnecessary debate since the evidence seems to indicate that individual attitude is a minor contributing factor in the face of the prevailing values of the group.

In response to one health insurer decision to discontinue payment for eleven preventable errors such as wrong-site surgery, wrong-patient surgery, wrong type of surgery on correct patient, and objects left in the body post-surgery, Briefings in Patient Safety (2008) provided the reflections of three physician leaders on the toll errors can take on clinicians. The physician leaders reported that errors are distressing for health care workers but at the same time there is "not a lot of conversation about providing support" (Briefings in Patient Safety, 2008, p. 2). The promotion of a non-punitive culture was believed to be a strategy to facilitate discussions about errors and "give [staff members] permission to talk about their experiences," allowing clinicians to learn from a process that is "nonthreatening and as supportive as possible" (Briefings in Patient Safety, 2008, p. 3). In addition, these physicians reported that "to be a safe and effective clinician you needed to be supported after an error" (Briefings in Patient Safety, 2008, p. 3). They note "it's much easier to go forward and change your practice, admit you made a mistake, and not do it again if you're not constantly defensive about it and feeling guilty" (Briefings in Patient Safety, 2008, p. 3).

Two concepts which are relatively new within the discourse of patient safety and adverse event management are *system and human factors* (Reason, 2000) and *just culture* (Marx, 2001). These concepts figure prominently in the experience of second victims and

are considered here in order to set the context for how second victims within this study experience the behaviour, policies and practices of the organization.

2.10 System and Human Factors

It is very common for adverse events to be examined based on human error, with the broader context being de-emphasized in the analysis. Reason notes that "human error can be viewed in two ways: the person approach and the system approach" (2000, p. 768). Reason believes that the *person approach* is a longstanding and widespread tradition that remains the dominant tradition in medicine, that focuses on unsafe acts such as errors and procedural violations by people in direct contact with the patient or "at the sharp end" (2000, p. 768). The "sharp" end, in the context of health care and patient safety, refers to the work of people in direct contact with the patient, in contrast to the "blunt" end, referring to the work of healthcare management and other organizational staff (Carayon & Wood, 2010). Unsafe acts are believed to arise from aberrant human processes such as forgetfulness and inattention, and the associated *person approach* countermeasures are directed at reducing variability in human behaviour (Reason, 2000). Those countermeasures or interventions include writing another procedure, disciplinary measures, retraining, threat of litigation or loss of employment, naming, blaming and shaming (Reason, 2000). In the person approach, errors are treated as moral issues (Reason, 2000). Reason argues that "a serious weakness of the person approach is that by focusing on the individual origins of error it isolates unsafe acts from their system context (2000, p. 769).

The *system approach*, on the other hand, holds the basic premise that humans are fallible and that errors are expected. "Errors are seen as consequences rather than causes,

having their origins not so much in the perversity of human nature as in ‘upstream’ systemic factors” (Reason, 2000, p. 768). The system approach focuses on the conditions under which individuals are required to work and tries to create defences to avoid errors and mitigate their effects (Reason, 2000). The system approach uses the central idea of creating countermeasures or system defences, based on the assumption that it is difficult to change the human condition, but it is possible to change the conditions under which people work (Reason, 2000).

Where Reason (2000) describes the person approach as distinct from the system approach, examining adverse events through a patient safety lens requires consideration of whether the healthcare professionals had the right tools and environment to perform their tasks in a safe and effective manner (Carayon & Wood, 2010). The United States Joint Commission on Patient Safety ascribes to a human factors analysis or engineering approach to patient safety (2015). “Human factors is a human-centered science using tools and methods to enhance the understanding around human behaviour, cognition, and physical capabilities and limitations, and applying this knowledge to designing systems in support of these capabilities and limitations” (The Joint Commission, 2015, p. 7). According to The Joint Commission, “systems thinking is part and parcel to human factors engineering, … we consider each layer of a system and its interconnected components in terms of how to design in support of human strengths and compensate for limitations” (2015, p. 8).

Carlton and Blegen (2006) conducted a literature review which provides an overview of the incidence of adverse drug events and the antecedents for these errors to occur. Carlton and Blegen note the differences in research findings reflecting perceptions

of individual responsibility and system responsibility as a paradigm shift. Early research (through to the mid-1990s) focused on individual responsibility for error with little system factor consideration. During the past decade, research has shifted the emphasis toward identification of inherent system problems which contribute to error occurrence (Carlton & Blegen, 2006, p. 30). Across the studies examined, the paradigm shift toward system responsibility was noted, and the most frequently cited causes of adverse drug events reflect this change. Causes cited included: interruptions and distractions, nurse fatigue and exhaustion, RN forgetfulness and business, high acuity and heavy workloads, inadequate staffing, confusion and chaos, medications arriving late from pharmacy, and illegible physicians orders (Carlton & Blegen, 2006, p. 33).

"There is now broad awareness among clinicians and managers about the challenge of patient safety, as well as a greater understanding that problems in patients safety reflect systems rather than individuals alone" (Wu, 2011, p. xi). "Capturing information about these problems depends on reliable reporting systems" (Wu, 2011, p. xi) and staff who trust the organizations they work for enough to participate in those reporting systems.

2.11 Just Culture

First used by D. Marx (2001), a just culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control. A just culture also recognizes that many individual errors represent predictable interactions between human operators and the systems in which they work, but does not tolerate conscious disregard of clear risk or gross misconduct (Marx, 2001). In a just culture, open reporting and participation in prevention and improvement is encouraged.

In a just culture, a focus on understanding the root of the problem allows for learning, process improvement, and changes to design strategies and systems to promote prevention.

Just culture, as noted by Edmondson (2002), is a relatively recent concept in the literature on health care organizational culture. Earlier attempts to reform what was recognized to be a punitive culture had used the concept of *no-blame culture*, a concept that flourished in the 1990s and still endures today. Leaders in human error management, such as Marx (2001), chose to not refer to a no-blame culture, promoting instead the concept of a just culture. The development of no-blame culture acknowledged that a large proportion of unsafe acts were "honest errors" (the kinds of slips, lapses and mistakes that even the best people can make) and were not truly blameworthy, and acknowledged that there was not much in the way of remedial or preventative benefit to be had by punishing perpetrators (Marx, 2001). But this viewpoint had two serious weaknesses: 1) It ignored or, at least failed to confront, those individuals who willfully (and often repeatedly) engaged in dangerous behaviors that most observers would recognize as being likely to increase the risk of a bad outcome; 2) It did not properly address the crucial business of distinguishing between culpable and non-culpable unsafe acts (Marx, 2001). The development of just culture takes into consideration the reality that not all behaviours can be no-blame and yet promotes an organizational climate of safety and reporting of unsafe or risky situations or processes without fear of reprisal (Marx, 2001).

Denham (2007) described a number of interviews with leaders in health care, such as Presidents, CEOs, and Medical Directors, with the purpose of identifying the rights of the second victim. The interviews explore concepts of safety, performance, introduction

of new technology, just culture and second victim. According to Denham "a Just Culture is one that differentiates between error and unjustifiable risk taking" (2007, p. 109). Denham describes some core concepts purveyed in the interviews, including just culture, system fault[24], sharp end blunt end model[25], trust, grief, the second victim, the second victim medical emergency[26], and five rights for the second victim. The acronym, 'TRUST' is used for the five rights of the second victim, which include: Treatment that is Just, Respect, Understanding and Compassion, Supportive Care, and Transparency. Several key themes were identified by Denham, including: clinicians have good will and good intent; there is a responsibility to support clinicians who have a right to be treated with respect; and employees are the most precious resources. Denham summarizes the finding of the study by stating:

> Your employees are going to make mistakes because they're human, and they're operating in imperfect systems. Mistakes are going to be made, and it's our moral obligation to support our employees and support our team members when mistakes are made (2007, p. 111).

This study is unique by virtue of naming and clearly defining the rights of the second victim, and identifying the responsibility or obligation of the organization.

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[24] System Fault may be defined as the totality of active and latent errors within a system. Active errors occur at the point of contact. Latent errors refer to organization or design failures.

[25] The sharp end blunt end model is a conceptual framework to examine predisposing factors to harmful events that occur at the point of care. The "sharp end" is the part of the health care system in direct contact with patients, for example, personnel and equipment. The "blunt end" is the many layers of the health care system not in direct contact with patients but which influence the personnel and equipment.

[26] When caregivers are involved in an adverse event, it can become a medical emergency for them, equivalent to post traumatic stress disorder.

To summarize, a just culture is one in which staff are treated with respect. In a just culture, there is a recognition that mistakes will be made, but in most cases by people working in imperfect systems who are trying to do the right thing. A just culture recognizes the importance of examining systems as well as human factors when adverse events happen. A just culture is one in which the organization supports staff at the time of mistakes without blaming or taking a punitive stance.

2.12 Supported by the Literature

Adverse events are known to be a reality of health care provision and the involvement of health care providers in adverse events has been described in a number of studies. It is clear from the literature that individuals and organizations within health care recognize the importance of the second victim phenomenon, but the experience of health care providers is largely unknown. There is no research that has examined the experience described by a second victim of providing patient care in the long-term, or the experience of colleagues working alongside someone who has been involved in an adverse event.

As noted by Nelson and Beyea, "additional research is needed to identify and understand the full complement of victims of medical errors" (2009, p. 324). Second victims who were directly involved in an adverse event have been identified, but there are also second victims who have not been addressed in the literature, such as those health care providers who assisted but were not the primary care provider or health care providers who observe from the sidelines.

It is clear that there is a beginning recognition of the link between education, health care culture, the experience of the health care provider and support for the health care provider. It is only in understanding how adverse events are experienced by health

care providers that health care organizations can move toward a positive and responsive environment for health care providers involved in adverse events. Further exploration of how health care culture shapes the experience of health care providers is a critical facet of this study.

> If we truly are 'caregivers,' then we are long overdue to *move beyond the finger pointing* and inappropriate punishment of these 'second victims' and treat them with the support and respect they deserve, in an environment of compassion and transparency (Paparella, 2011, pp. 264-265).

This chapter critically and thematically explored the literature on adverse events and the second victim experience. It is evident from this literature that the experience of health care providers involved directly in adverse events is likely significant and yet remains relatively unexamined. The experiences of health care providers who are affected by adverse events indirectly or by association, for example by virtue of their employment, profession or, proximity to the location of the event, have not yet been examined. In addition, the effects of adverse events on the organization itself are likely significant and have not been addressed.

While the concepts of health care culture and the second victim have been explored, there is a scarcity of literature that links the two concepts and examines the impact of health care culture *on* a second victim. It is evident from this literature review that this research study will contribute to a body of knowledge which is incomplete. This study examines the experiences of health care providers involved directly, indirectly or by association with an adverse event, specifically, how an adverse event is managed and understood. As well, this study examines whether and how the organizational culture of the health care organization shapes the experiences of adverse events; and it identifies

how organizational strategies and supports figure in to the experience of adverse events by health care providers.

CHAPTER 3

The Study: Context and Method

3.1 Critical Ethnography

A Critical Ethnographic inquiry was well positioned to address the questions posed by this study. Historically, ethnography evolved in cultural anthropology, typically focused on small societies (Boyle, 1994). Boyle (1994) notes that ethnography is always reflexive, with the researcher open to and part of the process and is presented from the emic (insider) perspective. A critical ethnography "does not necessarily stand in opposition to conventional ethnography … rather, it offers a more reflective style of thinking about the relationship between knowledge, society and freedom from unnecessary forms of social domination" (Thomas, 2004, p. 1). The 'critical' of critical ethnography refers not to complaint, in order to connote dissatisfaction, but 'critique.' Critique, in contrast to critical, "assesses 'how things are' with an added premise that 'things could be better' if we examine the underlying sources of conditions" (Thomas, 2004, p. 1).

Critical ethnography, rather than being a theory that generates a set of testable propositions, is a perspective about our social world that provides images, metaphors, and understandings, and provides value premises to ask questions and suggest ways to change (Thomas, 2004). It is a methodology that "strives to unmask hegemony and address oppressive forces" (Crotty, 1998, p. 12). The concept of "hegemony" makes explicit the connections between culture and power. Hegemony is political, economic, ideological or cultural power exerted by a dominant group over other groups, and can be understood as

that part of a dominant worldview which is "naturalized" and thus does not appear as ideology (Scott, 2008). Hidden in the habits of everyday life and regenerated through repetitive, everyday acts, this type of power lies in the realm of the taken-for-granted or the commonsensical and may not be experienced as the implementation of power at all (Comaroff & Comaroff, 1991; Scott, 2008).

The theoretical stance for this study is a critical interpretive approach, influenced by the work of Foucault (1977) and Geertz (1973), as applied by Lock and Gordon (1988). Culture in its relation to power is an important focus of this approach. Power, used in this context is not necessarily a controlling force aimed at domination, but is closer to a form of social organization by which social order and conformity are maintained (Lupton, 2003).

Critical ethnographers begin from a view of "what is out there to know," or an *ontology,* that furnishes a set of images or metaphors in which various forms of social oppression constitute what is to be known (Thomas, 1993, p. 34). Van Maanen argues that most ethnography proceeds from a "realist narrative" entailing an "author-proclaimed description and something of an explanation" (1988, p. 45) for the cultural practices observed. Relying on the participant's point of view as filtered through the data collector's interpretative framework, a realist ontology provides a detailed, "thick" description that lets the participants "do the talking" (Geertz, 1973, p. 7). Critical ethnography enabled me to use my existing knowledge as an insider to health care culture to explore the embodied and everyday experiences of health care providers involved in adverse events.

Having provided a description of the background and importance of the study as well as the method of inquiry, I will turn now to an explanation of the specific context in which this research took place, and the particular methods employed. I begin with the geopolitical context of the organization, followed by comprehensive descriptions of study methods, data collection and analysis, rigor, ethics and human rights considerations and finally the measures taken to support research participants as they related their experiences of living through the aftermath of adverse events.

3.2 Geopolitical Context

To understand Eastern Health as an organization, it is important to understand the political governance structures that create its accountability. Over the last four decades, there has been increasing amalgamation of what was once a number of separate organizations and facilities providing health care in Newfoundland and Labrador. The first wave of regionalization occurred in the mid-1980s, when financial pressures saw the reduction of over seventy independent health boards to fifty-four. A second wave of regionalization, in the mid-1990s, was due to a reduction in federal transfer payments to the provinces and resulted in the fifty-four health boards being combined into fourteen. The largest of these was the Health Care Corporation of St. John's (HCCSJ). It and the other regional health care boards came into effect April 1, 1995. The overall organization of the HCCSJ was a pyramid structure with the Board of Trustees at its peak. The Chief Executive Officer (CEO) reported to the Board, and the executive positions below the CEO were primarily Vice-President positions that varied in title and composition over the years that followed. The HCCSJ adopted a program management model as its organizational structure, a model that continued into the time of the study.

The Eastern Regional Health Authority (Eastern Health) came into being on April 1, 2005 when further provincial amalgamation of health boards and community agencies resulted in the creation of four provincial health authorities, as seen in Figure 1 (p. 15). Eastern Health was comprised of seven organizations. The amalgamation nearly doubled the number of employees over that of the former HCCSJ, and diversified the kind of services being offered because of the addition of community-based services. The final step in the amalgamation efforts within the Eastern health care region was the move of the previously independent Newfoundland Cancer Treatment and Research Foundation (NCTRF) into Eastern Health in 2008. The addition of NCTRF meant that the provincial Cancer Care program was now administered by Eastern Health.

For the majority of the time under review in the Cameron Inquiry, the Anatomic Pathology Division of Eastern Health was in fact a Division of the Laboratory Medicine program of the former HCCSJ. When the problem with ER/PR was discovered, in May 2005, it was just two short months after Eastern Health had been created as a new organization. The ER/PR testing in question and under review had occurred while the HCCSJ was responsible for the testing and the testing policies. Although there had been direction given to begin developing new policies that would replace the former HCCSJ policies, that process was only beginning when the crisis was identified.

3.3 Funding for this study

In 2011, Eastern Health established two annual Quality Healthcare Scholarships to promote the study of key themes identified during the Commission of Inquiry on Hormone Receptor Testing. The scholarships were introduced as part of the settlement agreement of the class action suit on estrogen and progesterone receptor (ER/PR) testing

and implemented in consultation with class action members. The first scholarships were awarded in 2012 and I was one of two first recipients. The scholarship was presented to me by the CEO.

3.4 Study Methods

In outlining the study methods used within this critical ethnography, it is important to position myself as the researcher in terms of my insider role with the QRM department, within Eastern Health and in terms of potential conflict of interest.

3.4.1 Researcher's Insider Role and Conflict of Interest

At the beginning of the study, I held a management position within the QRM department with Eastern Health, as a Quality and Clinical Safety Leader. The insider role is addressed in the Tri-Council Policy Statement under "Conflicts of Interest" specifically related to *Dual Roles* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 2014, Chapter 7, Article 7.4). "Dual roles of researchers and their associated obligations" -- in my case acting both as a researcher and a quality clinical safety leader -- had the potential to "create conflicts, undue influences, power imbalances or coercion" affecting relationships and the consent process (Canadian Institutes of Health Research et al., 2014, p. 95).

By virtue of my position as a Quality and Clinical Safety Leader I was party to knowledge about adverse events that had happened within Eastern Health. It was therefore considered within normal practice to discuss adverse events and patient outcomes in the context of adverse event reviews. This experience and therefore comfort with the occurrence of adverse events provided an advantage in terms of having an in-

depth and expected skill for listening to descriptions of adverse event experiences in an objective and open manner. That is, on one hand, participants did not experience barriers about discussing adverse events, since they were aware of my insider knowledge base and in some cases had had previous conversations with me about adverse events. On the other hand, participants may have been reluctant to discuss adverse events that had not been appropriately reported through official channels.

My professional involvement as a Quality Clinical Safety Leader within the QRM department may have created participant concern about potential influence over the outcome of investigations of adverse events within Eastern Health as a result of participation or non-participation in this study. More importantly, if a serious adverse event were to have been disclosed to me in the context of research (for example, if a participant revealed that they have observed multiple patient deaths due to negligence by a particular physician), even where I did not have a *legal* duty to report the event since I was not operating at that time within my management role, I may have found myself having a *moral* obligation to breach researcher-participant confidentiality.

To separate these roles to the greatest extent possible, I explained the distinction between my two roles to the participants during recruitment, during the consent process, and during the study when required. I explained that it was not my role, in the context of research, to disclose information about any adverse event discussed, and that I would maintain confidentiality to the best of my ability. However, I could not guarantee confidentiality because I might find myself in a moral conflict whereby my role as manager might trump my desire to protect the participants' interest. I encouraged participants to avoid disclosing serious adverse events that were not widely known or had

not been reported through the appropriate process. This insider role conflict was resolved early in the study when I accepted another position within the organization and was no longer working in the QRM department. Prior to that change in employment, I did not experience any moral obligation to report adverse events shared by participants.

3.4.2 Participants

The study included participants who were health care providers involved in an institutional health care adverse patient event either directly, indirectly or by association (see Table 3.2). Health care providers directly involved in an adverse event were defined as those who were responsible for the direct clinical and care decisions related to the patient's outcome. Health care providers indirectly involved were defined as those who were present at the time of the occurrence, aware of the clinical and care decisions, but not responsible for the clinical and care decisions related to the patient's outcome. Health care providers involved by association were defined as those who were not present at the time of the occurrence and not aware or responsible for the clinical and care decisions related to the patient's outcome. This included health care providers who were considered associated with the adverse event by someone else or who identified with the adverse event themselves but were not actually involved or present at the time of the event. Interviews were also conducted with Regional Health Authority staff who were able to inform the study about policy development and organizational processes that related to how the adverse event management and disclosure processes were structured and enacted.

3.4.3 Participant Groups

Health care providers from a variety of health care worker groups, including management, nurses, physicians, pharmacy and diagnostic staff with varying years of work experience were invited to participate in the study.

Table 3-1: Participants by Discipline

Discipline	***Number of Participants***
Management Staff	6
Management/Nurse	2
Nurse	15
Physician	7
Pharmacy Staff	1
Diagnostic Staff	4

Several attempts were made to recruit within the medical student/resident group to no avail. The participation of medical students was not considered critical since physicians were very open about their medical school experiences and their observations of medical students/residents support-seeking behaviours.

3.4.4 Target Groups

Interviews were to be conducted with three target groups, based on inclusion criteria and discipline, as outlined in Table 3-2 below.

Table 3-2: Interview Target Groups

Target Group	*Inclusion Criteria*	*Discipline*
Persons who were directly involved in an adverse event	Health care providers who were responsible for the direct clinical and care decisions related to the patient's outcome	Nurses Pharmacy Staff Laboratory Staff Physicians
Persons indirectly involved in an adverse event	Health care providers who were present at the time of the occurrence, aware of the clinical and care decisions, but not responsible for the clinical and care decisions related to the patient's outcome	
Persons who experienced the adverse event by association	Health care providers who were not present at the time of the occurrence and not aware or responsible for the clinical and care decisions related to the patient's outcome	

However, very few persons were identified in only one target group, as many people described multiple experiences of adverse events. The target groups, based on inclusion criteria, were well represented within the participant group.

3.4.5 Participant Recruitment

As noted earlier, since the target groups over-lapped, most participants represented more than one group and the number of informants required resulted in interviews with thirty-five informants.

Participants were recruited in four distinct ways including targeted presentations to professionals and medical students, posters, letters of invitation and personal invitations to known contacts within the system. The targeted presentations to professionals included a two minute presentation of the proposed research (see Appendix

C) that was conducted both for physician and nursing professional groups in the context of professional forums to stimulate interest in the study for the purposes of recruitment. Specific forums that were addressed included: i) nursing grand rounds; ii) medical grand rounds; iii) residents' orientation; iv) residents' ethics sessions. In addition, opportunities for recruitment were provided by clinical program managers in the context of nursing professional development and quality rounds. Targeted presentations to medical students included a two minute presentation of the proposed research (see Appendix D) that was conducted at the beginning of one class with first and second year medical students, and during the fourth year medicine "Back to Basics" course that brings all 4th year clerks together. Ethics professors provided time and opportunity for these presentations.

A poster was provided at the forums and posted on clinical bulletin boards in acute care facilities, long term care facilities, and in multi-staff community health sites (see Appendix B). The poster was also used for recruitment via social media and email. A letter of invitation to describe the study was provided at the professional forums to supplement the presentations. In addition, the letters of invitation were distributed to targeted Eastern Health employee groups through staff meetings via program managers for nursing, pharmacy and laboratory medicine (see Appendix A). Program managers at the Health Sciences Centre site, the Janeway Children's Health and Rehabilitation Centre site and St. Clare's Mercy Hospital site were approached about the study, including an explanation and opportunity to ask questions. In addition, each manager was provided with a package including letters of invitation and posters to be distributed at staff gatherings (meetings or informal gatherings). Following the initial recruitment period, each participant was invited to mention the study to colleagues and to provide colleagues

with researcher contact information and a letter of invitation if the participant was agreeable.

In addition to invitations issued within group settings, social media was used in a number of recruitment strategies. The Association of Registered Nurses of Newfoundland and Labrador (ARNNL) was approached to provide contact information for registered nurses who had indicated a willingness to receive information in relation to participation in research projects at the time of their annual registration renewal. A list was provided by ARNNL to me and a number of nurses were randomly selected by me. An email was sent by ARNNL with the letter of invitation and poster attached, inviting them to contact the researcher directly if interested in participation. The College of Licensed Practical Nurses of Newfoundland and Labrador was approached to send an email to all their members with the letter of invitation and poster attached. The College agreed and an all-member email was sent. The Newfoundland and Labrador Nurses Union posted the letter of invitation and the poster on their Facebook[27] page inviting interested parties to contact the researcher.

My intention was to examine the experience of health care providers involved in adverse events who experienced trauma. This study does not capture the voices of those who were not traumatized by second victim experiences. The focus of the study was the experiences of second victims of adverse events; the recruitment process necessarily excluded those who did not feel trauma as a result of their experience (just as it excludes some of those who remain so extremely traumatized that they declined to talk about the

[27] Facebook is an online social networking service.

experience for fear of re-living their experiences). Participants in this study are those who continue to feel affected by their experiences in a negative way, to a greater or lesser extent (that is, those who are "second victims"). By contrast, those who experienced an adverse event but did not come forward to participate in this study may not have felt traumatized.

The recruitment strategies included a reassurance that willingness or not to participate would not affect their relationship with Eastern Health or specifically the QRM department. As described in the earlier section of this chapter on *Researcher's Insider Role and Conflict of Interest*, I described my role and answered any questions that an informant had based on their own perception of my role, during recruitment. For any informants with whom I had previous relationships in other roles, I undertook specific conversation to clarify the distinction of those roles. No informant expressed any concern about the distinction between my role as a Quality Clinical Safety Leader and as the principal investigator in this study.

3.4.6 Inclusion/Exclusion Criteria

Considering the number of health care providers involved directly and indirectly with any one patient, the effect of a single event could reach a large number of health care providers. Understanding the scope of the effect was important to fully understand who would best inform this study. Careful attention was paid to the nature of the adverse event itself to ensure that a range of types of adverse events were available for capture in my analysis. It was possible that the experience was dependent on the type of event, so it was important to include a range of events.

I only included individuals who were involved in health care provision either directly or through clinical support roles. Persons working within the health care setting but not considered health care professionals such as dietary, laundry, housekeeping, infrastructure support, security, administrative support and allied health staff were excluded. The exclusion was based on their involvement in non-clinical support roles, and therefore not care decision-makers and not based on a determination that they would not experience an adverse event. The decision to focus on persons in clinical support roles was a strategy to capture a thorough description of the experience in as close proximity to the event as possible, in terms of care decision-making.

This research project was inclusive of gender, age and a range of years of experience within the health care provider demographic.

3.5 Data Collection and Analysis Procedures

3.5.1 Data collection

The primary method of data collection was semi-structured interviews, contextualized by my experience as a former "insider" in QRM. Interviews captured the experientially based knowledge of health care providers about adverse events, organizational response and forms of support. The interviews were conducted by me and were digitally audio-recorded to allow me to attend closely to the interview process and to ensure accurate capture of participant data.

Prior to the beginning of the interview, consent was obtained through an informed consent process (described below in detail, in relation to ethical considerations for the study) and the signing of a consent form (Appendix E). I aimed to create a welcoming, nonthreatening environment to maximize the willingness of participants to share their

experiences and beliefs. Establishing an atmosphere of "power equality" as described by Karnieli-Miller, Strier, and Pessach (2009) was particularly important given my role as Management within Eastern Health (see *Researcher's Insider Role and Conflict of Interest*).

The key informant interviews were flexible in nature. "Critical ethnography is especially susceptible to the need for flexibility, because the questions that are most interesting may not be revealed until considerable background data emerges" (Thomas, 1993, p. 35). Questions were focused on the informant's experience and understanding of the event and were designed to elicit the informant's description of the processes surrounding adverse events including perceived affect, responses and support. If I noted emotional responses that would not be captured within the verbal response, I commonly asked for clarification about the emotional response to give voice to the non-verbal components of the interview. For example, if an informant began to cry I would ask them to talk about the emotion they were feeling at that time and the source of the emotion, if it wasn't obvious from the verbal description.

The location of informant interviews were organized at off-site locations, as it related to their workplace or former workplace. Some participants requested to meet at their own home and without exception all non-management participants expressed a desire not to meet in proximity to their workplace. Some participants explained their reasoning for the requested interview location as not wanting to be seen by their co-workers or manager in relation to the study and others, who had changed jobs, expressed wanting to avoid feeling upset by seeing their former workplace. For example, one participant who had moved work locations due to an adverse event expressed a desire to

avoid seeing the *Cameron Memorial* that was located at the entrance to the former work location (further discussion in Chapter 5). Some of the interviews with management staff were arranged off-site for convenience of meeting time but others were requested in the informants' offices. None of the management staff expressed concern about location based on association with the study or feeling upset.

All informants were asked to share their experience of having been involved in a direct, indirect or by-association adverse event, or having knowledge of an adverse event. In addition, physicians were encouraged to describe their experience of adverse events while in the role of medical student/resident, their mentorship of students and residents in relation to adverse events, and how they perceive support is sought by medical students/residents. Management staff were additionally invited to share their perceptions of: disclosure and adverse event management within Eastern Health, providing support or receiving support in the context of adverse events or disclosure, and what type of support is available to staff and utilized by staff.

3.5.2 Data Analysis

Data analysis began during the participant-researcher conversation. To retain an accurate account of the conversation, the interview narratives were audio-taped and then transcribed verbatim. Once the interview was transcribed, I reviewed the audio-tape to ensure accuracy. It is suggested that special attention be paid during transcription and subsequent audio checks to pauses, humour and emotional responses (DeVault, 1990), and in this study changes in volume also became important. For example, during particularly difficult descriptions it was not uncommon for an informant to whisper.

In addition to interview transcripts, data sources included reflexive interview notes, text (policies and legislation), blank text documents (reporting forms) and artistic representations. Data from all sources was subjected to content analysis. The analysis of the transcribed data and the interview notes occurred concurrently with the interviews. The transcribed data was uploaded to a qualitative software program (MAXQDA11©) that provided a means for the data to be organized and retrievable.

The organization of data represented descriptions or ideas that were being provided by participants and seemed to share or relate to a common thread in the experience of adverse events. As data was analyzed, the descriptions that began to emerge were clarified and further explored with subsequent participants. In some cases clarification was sought by speaking to informants more than once. This confirmed the accuracy of my understanding of the experience. The spacing between interviews was balanced in such a way as to ensure that the process of analysis was thorough and not rushed, at the same time not asking participants to wait for extended periods to have an interview completed. Avoiding extended waits acknowledged the anxiety that some participants may experience waiting to revisit a particularly difficult adverse event.

A critical interpretive approach was used to analyse the accounts of adverse event experiences provided by the participants. In keeping with a critical interpretative approach to ethnography, the primary focus was on what people said and did as well as the meanings they ascribed to what they said and did. Attention was also paid to moments of resistance to the normative assumptions within the work environment of the health care providers. The analysis considered points of convergence and divergence between and within the accounts of staff members, management and organizational leaders. The

analysis considered the experiences of participants specifically in relation to the concepts of just culture and power.

The goal was to secure interviews with participants from all participant groups in addition to as comprehensive as possible representation of levels of involvement in adverse events (direct, indirect and by association). Once those groups and levels were represented in the data I continued to collect data across various roles such as staff, management and organizational leadership. The types of adverse events in terms of severity were varied within the existing data and so further recruitment to achieve varying levels of severity within the interviews was not required.

3.6 Rigour

Steps were taken to address the credibility and transferability of the research and, as in all ethnographic research, the need for reflexivity in order to ensure trustworthiness. According to Lincoln and Guba (1985) credibility is one of the most important factors in establishing trustworthiness. Credibility was embedded in the commitment to report the perspectives of the informants as clearly as possible, strengthened by the opportunity to build trust, learn about the culture and test for misinformation (Lincoln & Guba, 1985). Shenton (2004) describes a number of provisions that can be made by researchers to ensure accuracy in the description of the phenomena under scrutiny, for example: adoption of well-established research methods, familiarity with the culture, random sampling, iterative questioning and frequent debriefing sessions with my supervisor. These method provisions were used in this study and are evident in the description of the study methods (data collection and analysis procedures) described in Sections 3.4 and 3.5. In addition, it is important to note that I had regular debriefing sessions (minimum

monthly) with my principle supervisor throughout the data collection and analysis period to discuss alternative perceptions and to help me recognize any biases in my analysis.

On transferability, Morse and Field (1995) suggest that providing a "thick description" (Geertz, 1973) of research allows for external parties to decide if a transfer of knowledge can be contemplated. It was reasonable to expect that the description captured in the data from persons involved directly, indirectly and by association with adverse events would inform a comprehensive understanding of the experience of adverse events by health care providers. In addition, sufficient contextual information about the site of the study has been provided to enable other individuals to determine whether the findings are applicable in their own settings (Shenton, 2004). Inclusion of verbatim interview segments and evidence of clear links between data and researcher interpretations also contributes to research trustworthiness.

The principle of reflexivity is that researchers should subject their own research practice to the same critical analysis that they deploy when studying their topic (Green & Thorogood, 2009). The interpretive process was underpinned by reflexivity as a method to ensure openness to possibilities in the analysis, while being aware of the influence of the setting and associated values and interests on my perspective. Reflexive practice was accomplished through the use of a reflexive journal, which enhanced understanding of my perspective and situated me in the interpretive process. I acknowledge that my position at the management level 'produced' thick descriptions from management and organizational leadership employees, who trusted me and were very forthcoming about their experiences because of our pre-existing relationship. I also recognized that my position at the management level required particular attention when building trust with

staff, in order to generate data that was accurate and comprehensive in reflecting their experiences. On that point, I believe that my personality style that connotes humility and nurturing and is transparently non-judgemental enabled me to build rapport and a relationship of trust despite the hierarchical nature of my role compared to theirs within Eastern Health.

3.7 Ethics and Human Rights Considerations

Ethics approval was sought and received from the Newfoundland and Labrador Health Research Ethics Board (see Appendix F) and from the Research Proposals Approval Committee (RPAC) of Eastern Health (see Appendix G). While there was no explicit discussion, in the ethics applications, that Eastern Health and the Cameron Inquiry would be identified, RPAC and all participants knew that the Cameron Inquiry was part of the study and therefore by implication Eastern Health would be identifiable.

3.7.1 Informed Consent

Informed consent was ensured by providing full disclosure of all information necessary for the participants to make an informed decision to participate in this research project. Full disclosure included, but was not limited to, details such as a description of the research project, the purpose described in plain language, my identity, duration and nature of participation, research procedures, participant responsibilities, and foreseeable risks and potential benefits of participating. The foreseeable risks included experiencing stress or anxiety about discussing a painful event or experiencing vulnerability in relation to sharing with a stranger. The potential benefits for informants were the opportunities: to explore their experience of an adverse event; to critically examine their perspective by describing various aspects of the experience or experiences; to deconstruct the adverse

event/s for closure and even healing; to reflect on the organization's response and the supports experienced; and to contribute to the formation of a support response model.

My conflict of interest in relation to my management role within Eastern Health was emphasized in the consent process (when applicable), as otherwise it would have jeopardized the integrity of the research and the protection of participants. As mentioned, I explained to participants that if, in the context of the interview, they divulged an event that I had a moral duty to report in the context of my employment, and that had not been previously reported, I would be obligated to do so.

Potential participants were informed that they were free to withdraw at any time and they were given details about what information would be collected and for what purpose, and the contact information of my research supervisor who could explain the scientific and scholarly aspects of the research. The key to voluntary consent is that consent is ongoing and informed until the project is complete. Ongoing consent was maintained throughout the research project by providing participants with information relevant to their decision to continue to participate, if the participant contacted the researcher. There were no changes during the research process that needed to be communicated for the purpose of ongoing consent.

3.7.2 Confidentiality

Privacy and confidentiality were of paramount importance in this research project. All participants had an opportunity to exercise control over their personal information by consenting to or withholding consent for the collection, use and/or disclosure of information (Canadian Institutes of Health Research et al., 2014), that was discussed in the consent process, and emphasized in relation to disclosure of my role as management

within Eastern Health. In addition, as a researcher I treated personal information in a confidential manner and ensured that data was protected from breaches of confidentiality by safeguarding participant data by ensuring security and protecting identity. Security measures that were used to protect information obtained in the study included physical safeguards (locked filing cabinet in my home office), administrative safeguards (only I and a transcriptionist had access to participant data) and technical safeguards (data files are password protected and stored on an encrypted USB key).

The information that was shared in the context of research findings was assessed for identifying information that had the potential to breach privacy and confidentiality such as direct identifiers (name) or indirect identifiers (unique personal characteristics). Information was de-identified (direct identifiers removed) to decrease the ethical concerns regarding privacy as it would reduce the possibility of identifying an individual. I employed a transcriptionist for this research; she signed an oath of confidentiality.

Caution was exercised since the relatively small population in this study made individuals potentially identifiable. The staff population of Eastern Health (13,500) is primarily comprised of individuals who have lived and worked for the organization or one of the legacy organizations, prior to the formation of Eastern Health, their entire adult working life. As a result of this dynamic and the non-transient nature of the population, many of the informants would work in close and daily proximity with one another. In this written dissertation and in subsequent publications, I use aggregated stories or other means to ensure that no particular individual could be identified in relation to a particular adverse event. However, given the relatively small population of those affected by publically known adverse events, there was one individual who could be identifiable by

insiders to the organization. In that particular instance, a frank discussion was held, at the time of writing, with that individual who consented with no hesitation to having the story kept intact despite the potential that insiders could identify the source.

3.8 Participant Support

Research of this nature could have created heightened anxiety in some participants, in particular if the participant had not resolved work or personal conflicts related to the adverse event. I anticipated this potential participant response and had a plan in place to meet the need for support or guidance. Specifically, I had copies of the employee and family assistance program counselling contact information that I was prepared to provide to participants regardless of whether they identified the need for counselling.

Having outlined the study methods and data collection and analysis procedures, I now turn my attention to the official (text-based) discourse of risk management and patient safety, which will set the context to consider the experiences of the health care providers. The experiences of health care providers occur within a complex environment with several layers of policy, procedures and governance. The risk management and patient safety discourse provides the backdrop against which to explore the experiences of health care providers including the perspectives of managers and organizational leadership.

CHAPTER 4

Policies and Procedures of Risk Management and Patient Safety: Evolution and Action

The formal texts and discourse of risk management and patient safety are a core feature of the field I entered as critical ethnographer. Examining the official, text-based descriptions of risk management and patient safety – which contain both definitions and policies for management – is key to understanding the experience of adverse events, because the texts constitute *orthodoxies* which shape behaviour and are also resisted, challenged and perhaps even purposefully ignored. Bourdieu distinguishes between overt power, in the form of written laws or *orthodoxy*, and power which is hidden in the forms of everyday life -- what he calls *doxa* (1977). Hegemonic reproduction is the key characteristic of doxa. It is within orthodoxy (which can be roughly glossed as official discourse) and heterodoxy (resistance to the official discourse) that ideologies are made apparent, challenged, defended, altered and changed.

Therefore, before beginning my examination of the experiences of adverse events, I must first examine the orthodoxy (that is, examine the official, text based discourse) that shapes, and is in turn (re)shaped by, the lived experiences of adverse events. In this chapter I begin by examining the evolution of the official (text-based) discourse of risk management and patient safety. Then I examine the official (text-based) discourse on risk management and patient safety specifically within Eastern Health, in Newfoundland and Labrador and in Canada including text from national professional organizations. Finally, I

examine a number of public judicial inquiries into adverse events that have each played a major role in the culture of Canadian health care.

4.1 Evolution of the Official (Text-Based) Discourse of Risk Management and Patient Safety

In the mid-1970s, as accountability for patient outcomes moved to the forefront of public attention, the frequency of malpractice claims and the size of financial awards and settlements increased substantially (Abbott, Weber, & Kelley, 2005). By the late 1970s and early 1980s "offering malpractice coverage became less profitable for the commercial carriers, and many exited the market" (Abbott et al., 2005, p. 1106). Commercially available professional liability insurance became prohibitively costly or difficult to obtain. As a result, in the 1980s, "new malpractice liability companies were founded by physicians" at about "the same time tort reform legislation was enacted in some states to limit awards for 'pain and suffering' " (Abbott et al., 2005, p. 1106).

The 1980s became a critical period when the importance of patient safety was recognized and strategies began to be developed to address patient safety. The medical sub-speciality of anaesthesia began to pay particular attention to patient safety in 1982 when, in the U.S., the ABC television program *20/20* aired a documentary entitled *The Deep Sleep* that presented accounts of anaesthetic accidents (Pierce, 2007). In 1983, the British Royal Society of Medicine and the Harvard Medical School jointly sponsored a symposium on anaesthesia deaths and injuries, resulting in an agreement to share statistics and to conduct studies. In 1985 the American Society of Anaesthesiologists established the Anaesthesia Patient Safety Foundation (Anesthesia Patient Safety Foundation, 2015). The Anaesthesia Patient Safety Foundation marked the first use of the

term *patient safety* in the name of a professional reviewing organization, and anaesthesiology became the leading medical specialty addressing issues of patient safety. In 1989, the Australian Patient Safety Foundation was founded for anaesthesia error monitoring (Australian Patient Safety Foundation, 2015). By the late 1980s, work began on a National Demonstration Project on Quality Improvement in Health Care in the United States, as part of an effort to redesign the U.S. health care system into a system without errors. As a result, the U.S. Institute for Healthcare Improvement was officially founded in 1991 (Institute for Healthcare Improvement, 2015).

At the same time as medicine was being challenged to examine patient safety in the U.S., the pharmaceutical industry was facing its own challenges. The 1982 poisoning of Tylenol capsules with cyanide in a suburb outside of Chicago is generally acknowledged as the beginning of the modern field of crisis management in health care. The fact that Johnson & Johnson, the makers of Tylenol, responded quickly by pulling all bottles of the medication off the shelves nationwide -- thus signalling that it was putting the safety of consumers ahead of profits -- served to make Johnson &Johnson an early role model for effective crisis management (Conway, Federico, Stewart, & Campbell, 2011).

The 1990s continued the pioneering efforts in patient safety and crisis management in the U.S. health care system when, in 1993, the Anaesthesia Adverse Event Protocol was introduced by Cooper and colleagues (Cooper, Cullen, Eichhorn, Philip, & Holzman, 1993). In the mid-1990s *clinical risk management* -- an approach to improving quality in healthcare that places special emphasis on identifying circumstances that put patients at risk of harm, and then acting to prevent or control those risks -- was

introduced (Reed, 1997). And finally the "To Err is Human" report (Institute of Medicine, 1999) that claimed that at least 44,000 and possibly as many as 98,000 Americans die each year as a result of medical errors, is in large part credited with prompting the patient safety movement (McCaffrey, 2010). The data presented in "To Err is Human" arose from the Harvard Medical Practice Study of 1984, and Colorado and Utah data were used to repeat the study in 1992 (Brennan et al., 1991; Leape et al., 1991; Thomas et al., 2000). When the "To Err is Human" report was released, there was a transition from the use of the terms *quality improvement* and *quality assurance* to *patient safety*. The use of patient safety terminology was believed to make the issues more understandable and person-based or personal.

The beginning of the 21st century in the U.S. saw the move for health care to incorporate or adopt strategies from other industries, such as aviation. Crew resource management (CRM) was recommended to be incorporated into collaborative techniques for improving health care (Kosnik, 2002). CRM is a communication methodology developed by the aviation industry, based on team-centred decision making systems. CRM as distinguished from other traditional continuous quality improvement and quality assurance initiatives stood as a new approach to assess and manage risk in health care domains.

While the patient safety movement may have been driven by the U.S., Canada's health care system followed a parallel evolution. Health Canada officially created and announced funding for the Canadian Patient Safety Institute (CPSI) in December of 2003 (Canadian Patient Safety Institute, 2014). The Canadian Adverse Events study was released in 2004 (Baker et al., 2004) and the Canadian Root Cause Analysis Framework

was developed and released in 2006 (Canadian Patient Safety Institute, 2006). In 2008, Accreditation Canada provided influential leadership for organizational practice changes in regard to disclosure through a Required Organizational Practice, supported by the Canadian Disclosure Guidelines (Canadian Patient Safety Institute, 2008). Also in 2008 the development of apology legislation began across Canada, with the strong support of CPSI and health-care organizations, providing additional incentive for open disclosure. And in 2012 the Canadian Root Cause Analysis Framework was re-released with the title "Canadian Incident Analysis Framework" acknowledging the key advancement of discontinuing the use of the term *root cause analysis* (Canadian Patient Safety Institute, 2011b, 2012a). It was recognized that rarely is there only one *root cause* to a patient safety incident and rarely is *causation* correctly attributable to a system that is ill designed to mitigate or prevent errors from occurring.

An important event, in 2013, was the release by CPSI of the Canadian Paediatric Adverse Events study (Matlow et al., 2012). The Canadian Paediatric Adverse Events Study is the first national study of the epidemiology of adverse events in hospitalized children. In addition to determining the incidence of adverse events in children hospitalized in Canada, the study was designed to determine and compare the types and preventability of adverse events in Academic Paediatric Centres and Large Community Hospitals.

While many health care providers are employed by health care organizations that began setting policy in response to the above named national guidelines, in fact many health care providers are also being guided by their professional associations. In 2009, the Canadian Medical Protective Association (CMPA) addressed the members of the

Canadian Medical Association regarding restrictions on disclosure and the medical liability issues associated with the reporting of and response to adverse events, in two position papers (Canadian Medical Protective Association, 2009a, 2009b). The first position paper states that "while it may be reasonable to share any actual improvements that were made arising out of a quality improvement review, it would be inappropriate to reveal information that can easily be tied back to a particular event" (Canadian Medical Protective Association, 2009a, p. 12). The second position paper recommends that "once the immediate clinical needs of the patient have been addressed, the first response is to disclose the adverse event to the patient" (Canadian Medical Protective Association, 2009b, p. 3).

Having considered the evolution of discourse related to risk management and patient safety, I will turn now to consider written policies and procedures related to risk management and patient safety specifically within Eastern Health. There are a number of texts which I identified as important for informing the adverse event experience and which assisted in my analysis of participant descriptions. The next section provides an explanation and then examination of each identified text as it relates to the adverse event experience.

4.2 Official (Text-Based) Discourse on Risk Management and Patient Safety within Eastern Health

There are a number of official texts that factor into the experience of participants of this study, including but not limited to: Clinical Safety Reporting System form;

Eastern Health Disclosure Policy[28]; Eastern Health Occurrence Reporting and Management Policy[29]; Apology Act[30]; Access to Information and Protection of Privacy Act[31]; and the Evidence Act[32]. There are two levels of text which are considered: text within the health authority, referred to as organizational policy; and text that originates within government, referred to as governing policies and legislation. How these texts are taken up and used (or ignored or dismissed) by informants in the study and how these texts factor into the experience of participants will be discussed in the analysis. Here, however, I turn already to the words of participants in this study to explain how and why these official texts emerged as they did within Eastern Health.

4.2.1 Evolution of dominant discourses on risk management and patient safety within Eastern Health

Eastern Health was the subject of the Cameron Inquiry in 2008/2009, occurring at the same time that CPSI was creating new guidelines for disclosure. Although Eastern Health had a disclosure policy, one of the recommendations from Cameron, according to a manager involved in policy development, included the directive "*to do a little bit more and really firm up our disclosure policy*." According to that policy leader, "*really, the impetus back in 2009… is that we needed to strengthen the policy*." Further, the policy leader explained that Eastern Health was directed to examine what CPSI was putting

[28] Office of Administrative Responsibility – Eastern Health - Quality, Patient Safety and Risk Management
[29] Office of Administrative Responsibility – Eastern Health - Quality, Patient Safety and Risk Management
[30] Government of Newfoundland and Labrador, SNL2009 Chapter A-10.1
[31] Government of Newfoundland and Labrador, SNL2002 Chapter A-1.1
[32] Government of Newfoundland and Labrador, RSNL1990 Chapter E-16

forward in their guidelines to strengthen the policy. Additionally, the participant reported that Eastern Health was expected, in conjunction with the policy development, to create or find an evidence-based education program to provide to the organizational leaders. The purpose of the education program was to integrate the strengthened policy with skill development, for organizational leaders, in the management of disclosure. "*So the basic concepts were the policy development piece and then the skill development of how to move forward*."

The impetus for the evolution of policies and procedures for risk management and patient safety within Eastern Health was multi-faceted. The Cameron Inquiry was also underway at the same time as the Adverse Events Task Force (AETF) was appointed by the provincial government, led by Robert Thompson.[33] The impression of a leader within the Quality and Risk Management (QRM) was that "*government was trying to get ahead…there's going to be recommendations, and how can we kind of step up and try to get some of this moving."* According to a manager involved in policy development, the AETF was conducting "*all kinds of consultations*." The task force conducted stakeholder consultations to identify what processes the health authorities believed were required for occurrence reporting and disclosure. In addition, the task force sought to identify common language for occurrence reporting across health authorities. As stated by a manager within QRM "*they [AETF] were kind of the impetus in [the] creation of going forward*." The AETF was described as being:

[33] Robert Thompson had managed the NL government's participation in the Commission of Inquiry on Hormone Receptor Testing and held positions of Secretary to Cabinet (Health Issues) and Clerk of the Executive Council.

> Tasked by the Department of Health to take this on, knowing the Inquiry was happening, knowing that we had to do a better job around the management of adverse events, and then what do the regional health authorities need in order to do that.

Eastern Health was required by the AETF to provide feedback on what Eastern Health as an organization felt they could do to improve the management of adverse events. According to a QRM staff member, the result was the creation of a consultation paper with input from physicians, organizational leaders, directors and others. According to the QRM staff member, that paper identified the need for increased resources within the organization to provide skills development and management of adverse events, in addition to an electronic reporting system to streamline and increase accountability for the reporting of adverse events. It was described as a cascade effect by the same staff member who was working in Eastern Health QRM. At the same time as tasks were being assigned to the organization, the QRM had gotten an increased number of positions for quality clinical safety leaders. During the same time period as the Cameron Inquiry was in process, the AETF report resulted in the development of the Provincial Office of Adverse Events (POAE). At that point there were no official texts to support the work of the QRM or the POAE.

The necessity to create clearer processes within Eastern Health for adverse event management and disclosure of adverse events, identified both by the Cameron Inquiry recommendations and by the AETF, resulted in the creation of several policies and guidance documents, as well as an electronic reporting system and the instituting of a disclosure training program. The texts applicable to this study include those as well as texts of the provincial government, such as *The Evidence Act*, that directly and indirectly

dictate the activities of staff of Eastern Health. As well, specific disciplines such as medicine or nursing provide guidelines that act in tandem with the organizational policies in guiding staff behaviour. My discussion of official text or orthodoxy governing risk management and patient safety begins with an examination of Eastern Health's disclosure policy.

4.2.2 Disclosure Policy

The revision of the disclosure policy that existed prior to the Cameron Inquiry was a task assigned to the QRM as a result of the recommendations of the Cameron Inquiry and the AETF Report (Cameron, 2009b, 2009c; Thompson, 2008). The disclosure policy was originally approved in 2007, with a revision as a result of the Inquiry in 2009. Further revisions occurred in 2013 with the release of the new Canadian Disclosure Guidelines in 2011 (Canadian Patient Safety Institute, 2011a; Eastern Health, 2013a). The disclosure policy provides a step-by-step procedure of disclosure from the observation or discovery of an occurrence to the determination of whether the disclosure is individual, multi-patient or multi-jurisdictional. The procedure includes who should disclose, when disclosure should occur, elements to be included in the disclosure meeting and what should be documented. The description of time expectations include "immediately" to "within one to two days" (Eastern Health, 2013a, p. 3). The severity rating of occurrences from non-patient related to serious/severe harm is included for the purpose of identifying which Eastern Health leadership members are to be notified and how quickly.

The overview of the disclosure policy states that:

> Eastern Health is committed to client safety and facilitating a culture that is just and fair, where health care providers understand, and can act upon, their individual, ethical and professional responsibility in disclosing occurrences. Disclosure is grounded in the spirit of a just and safe culture and allows the client to continue to make informed health care decisions. *Disclosure is the right thing to do* (Eastern Health, 2013a, p. 1).

These statements in the disclosure policy infer that the common usage of the term just culture is a commitment of Eastern Health. Just culture refers to the promotion of a non-punitive culture that promotes patient safety, where open reporting and participation in prevention and improvement is encouraged, with a focus on understanding the root of a problem to promote prevention of negative outcomes for patients (Connor et al., 2007; Marx, 2001).

All three versions of the disclosure policy (2007, 2009 and 2013) included statements that acknowledged the emotional needs of patients and family members:

> Practical and emotional support may be required for the client, substitute decision-maker, and/or family member. Resources required for support are provided by and/or arranged through Eastern Health (Eastern Health, 2013a, p. 3).

The 2007 and 2009 versions of the disclosure policy did not include a procedural statement that acknowledged the emotional or support needs of the health care provider. In the process of interacting with various members of the QRM program for the purposes of this study, the absence of an acknowledgement of the need for support for staff following an adverse event within the disclosure policy became evident. The result was the addition to the policy, at the time of the 2013 revision, of the following statement:

> The appropriate manager informs the care provider(s), and/or team involved of debriefing and counseling supports available (arranged through Employee Assistance Program), and/or Pastoral Care and Ethics supports (arranged through Pastoral Services).

It should be noted that informing the care provider of supports available or stating that they "may contact their professional bodies/associations" (Eastern Health, 2013a, p. 3) is not an equivalent level of support described in the policy as being provided or arranged for the patient, substitute decision-maker and/or family member.

Appended to the disclosure policy is a disclosure toolkit that was developed based on the Canadian Disclosure Guidelines (Canadian Patient Safety Institute, 2011a). The toolkit outlines the importance of disclosure, the professional and ethical responsibilities for physicians and nurses, a disclosure flowchart and a planning checklist that itemizes the process. The disclosure flowchart is a pictorial representation of the required notifications from the time an occurrence is identified through to documentation. In essence, the disclosure policy provides a description, a pictorial representation, and a checklist, all designed to inform the health care provider of the expectations of the organization in relation to an occurrence.

4.2.3 Disclosure Training

In 2009, an exploration of models for skill development in disclosure began, in conjunction with the revision of the disclosure policy, partially as a result of the AETF report that recommended "targeted disclosure training" (Thompson, 2008, p. 139). Ultimately, a disclosure program entitled "Disclosing Unanticipated Medical Outcomes" from the Institute of Healthcare Communication, located in the province of Alberta, was selected and a train-the-trainer model was initiated, with a staff member from the QRM initially sent for training (Canadian Patient Safety Institute, 2015; Institute for Healthcare Communication, 2016)). The Institute of Healthcare Communication training was

sponsored in Canada by the College of Family Physicians of Canada for nine years from 2006 to 2014. Within Eastern Health, several faculty were trained by the Institute of Healthcare Communication and many *learners* (executive members, management and physicians) received training from 2010 to 2014. Specifically the training was for those individuals who were directly involved in informal or formal disclosure activities. Several of the participants in this study participated in the Eastern Health disclosure training and a small number had been trained as faculty by the Institute of Healthcare Communication.

4.2.4 Occurrence Reporting and Management Policy

The occurrence reporting and management policy was originally approved in 2007 and, similarly to the disclosure policy, was revised in 2011 to reflect the recommendations of both the Cameron Inquiry and the AETF Report. The overview in the policy states that "Eastern Health is committed to a reporting and learning environment where occurrences and close calls are openly identified, reported, and managed in an efficient and comprehensive manner" (Eastern Health, 2011a, p. 1). In addition, the overview includes a number of statements that reportedly reflect Eastern Health's support for occurrence reporting and management, such as the following: "Effective management of occurrences supports the spirit of a just culture, complements a culture of safety, and strengthens the organization's integrity" (Eastern Health, 2011a, p. 2). Correspondingly to the disclosure policy, the occurrence reporting and management policy highlights the concept of a just culture.

The policy names the Client Safety Reporting System (CSRS) as the mechanism to be used for occurrence reporting and management within Eastern Health. In addition,

the policy outlines the responsibilities for reporting and managing the reported occurrence by role, including reporter, manager and Quality Clinical Safety Leader. Among the policy statements are the following:

> An occurrence report must be completed for all occurrences, including Close Calls[34];
>
> The employee or agent[35] must immediately communicate the occurrence to the most appropriate care provider;
>
> The health care provider must also document on the health record that an Occurrence Report form has been completed (Eastern Health, 2011a, p. 2).

According to the scope of the policy this "applies to all employees and agents of Eastern Health" (Eastern Health, 2011a, p. 3). The responsibilities as outlined in the procedure include an expectation that the reporter "record only factual information about the occurrence" and "not express personal opinion, attribute fault or lay blame," another indication of the intention to apply just and non-punitive attributes to the policy (Eastern Health, 2011a, p. 3). The policy includes a list of the definitions for the severity rating scale for occurrences from Close Calls (Level 0) to Severe (Level 6)[36].

The original intention of the policy was to capture the activities of managing occurrences as part of a quality assurance process that enabled the organization to learn from the occurrences and evaluate "systemic factors that may have contributed to the event" to prevent future recurrences (Eastern Health, 2011a, p. 2). Following the release

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[34] A *Close Call* is defined as "a potential adverse event that did not actually occur due to chance, corrective actions, and/or timely intervention" (Eastern Health, 2011a, p. 6).
[35] An agent is defined as "a person, other than an employee, authorized by Eastern Health to act on its behalf, and includes physicians, volunteers, and pastoral care workers as well as staff of contractors (Eastern Health, 2011a, p. 5).
[36] An event occurred that resulted in patient/resident/client death (Eastern Health, 2011a, p. 4)

of the AETF report and the Cameron Inquiry report, one of the most significant policy revisions was the addition of a statement that allows the occurrence report to be provided outside the organization and outside the intention of systems learning. Specifically the policy statement states that "the patient/resident/client can request a copy of the Occurrence Report through the Quality and Risk Management Department" (Eastern Health, 2011a, p. 2). As described by a policy leader within the organization:

> So in kind of the spirit of openness and . . . it was a section added . . . if the client is involved in an event and there is an occurrence report, they have an opportunity to request that . . . it was a different way of looking at it, which historically is a bit of a change because if you look at it in the true sense of the literature, occurrence reports were considered solely a quality assurance activity, and then occurrence reports back in the day were kept for systems learning. . . . Here it is [now], I'm sending it out to the world.

This shift in policy changed the perception among staff who now felt that occurrence reports were potentially harmful or punitive and increased the sense of personal and organizational vulnerability that in the view of staff in QRM may have impacted the confidence staff felt in reporting. One participant reported that prior to this change

> the occurrence report . . . would be considered protected under the Evidence Act in any type of proceeding at all, . . . our own legal counsel representing us would not even have access to occurrence reports, so it was really treated as a quality assurance activity, which was most [common] across the country . . . it's a quality assurance activity.

The second significant policy revision was the addition of a statement requiring the health care provider to document in the patient's record the fact that an occurrence report had been completed. The documentation tied the occurrence report directly to the patient's record so that, in the event that the patient was requesting their health record, the occurrence report was now inherently part of the patient's record.

4.2.5 Client Safety Reporting System

The client safety reporting system (CSRS) is an electronic tool used to manage occurrences from a reporting and documentation perspective. The use of CSRS for reporting and managing occurrences "is considered a quality assurance activity" (Eastern Health, 2011a, p. 1). The development of an electronic reporting system for Eastern Health was tasked to the QRM as a result of the AETF report. As stated in the AETF report:

> While the establishment of an electronic occurrence reporting system may be seen, at first, to be just another IT project, it is actually the opportunity for communication, cultural change, and a new beginning. It is the most important recommendation of the Task Force (Thompson, 2008, p. 138).

CSRS was implemented in 2009 using a phased-in approach in all managerial units within the Health Authority, with the implementation completed in 2011. CSRS replaced a paper-based reporting system. CSRS is a web-based application with the operating system and data housed on the Eastern Health server that allows for report generation and ensures data security. CSRS was purchased from Datix®, a company based in the United Kingdom, with the Eastern Health application developed through a collaboration with the QRM. Orientation to CSRS is the responsibility of Quality Clinical Safety Leaders from the QRM, both for users and managers. The orientation includes discussion about how the purpose and intention of CSRS is to be a quality improvement tool and not a system for staff performance review or punitive action.

The occurrence reporting and management policy directs the reporter to complete the report "within 24 hours after the occurrence, where possible" (Eastern Health, 2011a, p. 3). CSRS is accessed on the Eastern Health website homepage, with the reporter using

the link entitled “Report Occurrences and Close Calls”. The link directs the reporter to the report form that is to be completed by the person who identified the occurrence or close call. The report form has a number of mandatory fields and drop-down menus to assist the reporter in completing the form. As stated above, the report is intended to include only factual information about the occurrence.

The report form begins with details about the reporter, other persons involved and the date and time of the occurrence. When CSRS was introduced, users were instructed that reporting could be done anonymously, but as the QRM has continued to manage the reporting system, there is recognition that anonymous reporting does not allow the managers to effectively analyse the occurrence, and therefore anonymous reporting is now discouraged. The main body of the report directs the reporter to provide details about the type of occurrence and the severity of the occurrence, and to complete text fields providing a description of the facts and contributory factors. With the revision of the disclosure policy, as discussed earlier, questions about disclosure and documentation, have been added to CSRS as additional fields, acting as reminders to complete these tasks. The final reporter function is submission of the completed report.

The submission of a completed CSRS report causes a number of automated processes to occur, including: an email to the reporter with the occurrence number to verify the completed report, an email notification to the manager for the clinical/service area, and the electronic filing of the report in a Datix® folder that can be reviewed by the manager and Quality Clinical Safety Leader. For any occurrence that is reported as serious or severe (Level 5 or 6), an automated email notification is also sent to the Program Director, the Director of QRM, the VPs of the program and quality portfolios,

the Program Clinical Chief and the CEO of Eastern Health, and the occurrence is available for review by anyone responsible for the clinical/service area. The manager of the clinical/service area is responsible for the initial management of the occurrence, with support provided by the Quality Clinical Safety Leader from the QRM. The occurrence is reviewed and investigated by the manager and the documentation of the findings is recorded in the occurrence report. The occurrence is moved through a series of electronic folders within the reporting system based on who is responsible for the follow-up. Initially the manager is responsible for the occurrence and once the manager has completed their follow-up, the occurrence is moved to a folder that creates a notification for the Quality Clinical Safety Leader that the occurrence is ready for QRM review and documentation. The final process of review is done by QRM where the occurrence is categorized based on type, the severity is finalized, and the occurrence is closed.

As noted above, the CSRS report requires the health care providers involved in the event to be identified and the reporter is asked to identify any system related issues that may have contributed, but the report does not require any information about support, if any, being provided to the health care provider. There are a variety of documentation processes in addition to CSRS outlined below.

4.2.6 Root Cause Analysis Concise Investigation

The investigation of an occurrence that results in the determination of a severity of Level 4, that is, moderate and defined as "an event occurred that resulted in initial or prolonged hospitalization, and/or caused temporary (physical and/or psychological) patient/resident/client harm" (Eastern Health, 2011a, p. 4), is documented by the Quality Clinical Safety Leader on a *Root Cause Analysis Concise Investigation Form*, referred to

within QRM as a *Concise Investigation*. The purpose of the form is to provide a format to document the examination of the occurrence beyond simply severity and type. The required documentation includes a description of the scope of the investigation, a detailed chronology of events including date and time, a description of the detection of the occurrence, identification of care and service delivery issues, contributory factors, root causes, lessons learned, recommendations and arrangements for sharing and learning. The form also requires documentation of the involvement, disclosure and support of the patient and family. Similarly to the CSRS report, the Root Cause Analysis Concise Investigation does not include any information about support, if any, being provided to the health care provider.

Completion of the Concise Investigation Form is the responsibility of the Quality Clinical Safety Leader who seeks assistance from the program/service manager for details not outlined in CSRS, such as ongoing patient outcome, specific staff involvement, manager-identified care and service delivery issues, contributory factors and root causes. In addition, the Quality Clinical Safety Leader uses reference documents such as the patient's chart, laboratory results, diagnostic imaging reports, organizational policies and procedures and best practice literature. The Quality Clinical Safety Leader may meet with staff involved in the occurrence to seek clarification for aspects of the occurrence that are not well understood. The reporter of the occurrence who was the individual who identified the occurrence may not be aware of the contributory factors and root causes of the occurrence. Although the form requires documentation of the involvement, disclosure and support provided to the family at the time of the occurrence, this level of occurrence does not normally involve formal disclosure to the family. In most cases either the health

care provider at the time of the identification of the occurrence or the program/service manager shortly thereafter will discuss the incident with the patient and their family.

4.2.7 Quality Case Review

The quality case review document was finalized in 2011 in response to the recommendations of the Cameron Inquiry and the AETF report. "The purpose of the quality case review is to review, assess and evaluate the provision of health care" (Eastern Health, 2011b, p. 6) and is considered a quality assurance activity. There is an extensive list provided of guiding principles for a Quality Case Review such as:

> The review is the responsibility of the Program in which the occurrence occurred.
>
> The role of the Quality and Risk Management Department will be to help facilitate the process.
>
> The review will be an objective, factual gathering of information.
>
> The review will be conducted in a spirit of openness and transparency.
>
> The review will seek input from client/families, employees, and agents (including physicians) of Eastern Health (2011b, p. 6).

All Level 5 and 6 category occurrences (serious and severe) are assessed by the program's leadership in collaboration with the Quality Clinical Safety Leader to determine whether a Quality Case Review should be initiated, and this assessment is documented on the Quality Case Review Checklist and Preliminary Investigation Template. There are five key directives or criteria provided for determining whether a Quality Case Review is required. First, a Quality Case Review is not recommended if the occurrence involves an event that requires human resources (HR), professional practice or another administrative body to intervene such as in a criminal act or a purposefully unsafe act. Second, there are a number of mandatory reasons for a Quality Case Review,

categorized under five headings: surgical events, products or device events, patient protection events, care management events and environmental events. An example of a surgical event requiring a Quality Case Review would be a "surgery performed on a wrong body part" or "retention of a foreign object in a patient after surgery or other procedure" (Eastern Health, 2011b, p. 16). An example of a care management event requiring a Quality Case Review would be a "patient death or serious disability associated with a medication or fluid error including, but not limited to, errors involving the wrong drug" (Eastern Health, 2011b, p. 17). Third, when there are key areas where learnings may warrant a Quality Case Review, such as "issues related to patient assessment believed to be a factor" (Eastern Health, 2011b, p. 7). Fourth, an executive team member may require a Quality Case Review when it is believed that important organizational learning could occur that would help promote safety. And finally, a Quality Case Review can be initiated by QRM through the Vice President responsible for QRM or a Quality Case Review can be initiated by the CEO of Eastern Health.

In the context of the Quality Case Review, the program leadership are required to create a Quality Case Review committee that consists of the program leadership including director, medical director, possibly manager/s, a Quality Clinical Safety Leader from QRM and possibly the QRM risk manager. The committee is tasked with reviewing the details of the case and determining questions that need to be asked, answers that need to be sought, and persons who need to be questioned. This review of the incident may or may not involve meeting with the patient and their family to seek their input. It is, however, prescribed that, in the context of this process, the patient and their family will

be invited to provide questions to the committee that would be incorporated into the review process.

The Quality Case Review is expected to be completed within 28 working days, and at that point the committee is expected to meet with the patient and their family and provide details of the review and recommendations that have been determined by the committee. In reality, very few of the Quality Case Reviews were occurring within the specified time period at the time of this study; a fact that was of concern to Eastern Health executive and had been the subject of a review in 2013. From my observation, the delays in completing reviews in the specified time related to the resistance of staff to participate in the review process. The resistance may be related to several complex relations including discomfort with disclosure, concern about liability or lack of clarity about a particular person's involvement in the event. In addition, delays may occur when there is confusion created because an incident involves more than one program and therefore where responsibility lies for the investigation comes into question. Delays may also occur when there is a perception that there is criticism of the organization in relation to the event, sometimes via sources external to the organization, such as news and social media. Disclosure and Quality Case Review are intrinsically related by virtue of the disclosure components that result from a Quality Case Review.

The stated intention of the Quality Case Review is a quality assurance process[37] but, in reality, the context that Eastern Health finds itself in makes that perspective unrealistic. The expectation that staff will be required to inform the Quality Case Review

[37] Quality assurance processes are generally understood to be internal to an organization for the purpose of system evaluation and improvement.

process without protection from public enquiry may be intimidating, such as the medical review component in which one physician reviews the actions of another. And perhaps the most complex issue is that of the legal context. There are a number of statements used in the guideline to describe the current legal context in Eastern Health:

> A review of the Quality Assurance Committee or a Peer Review Committee is protected under Section 8.1 of the Evidence Act from being disclosed in a legal proceeding.
>
> In section 5(f) of the Access to Information and the Protection of Privacy Act (ATIPPA) regulations, section 8.1 of the Evidence Act is stated to prevail over other provisions of ATIPPA in the context of a legal proceeding.
>
> The Public Inquiries Act, 2006 at section 9, 12, 13 apply to the power to compel the production of documents in the context of a public Inquiry. Section 12 (3) states that a person cannot refuse to disclose information to the Commission of Inquiry on the grounds that the discussion is prohibited or restricted by another Act or regulations.
>
> The production of documentation can be challenged through a court application under section 13 of the Public Inquires Act (Eastern Health, 2011b, p. 22).

At the time of this writing, no court challenge has occurred to test the protection by the Evidence Act of the Quality Case Review process or its documents. However, this may perhaps be a moot point, since retaining the concept that Quality Case Review is primarily a quality assurance process is difficult given the recommendations of the Cameron Inquiry to make the documents available outside the organization. In particular, recommendation 35 states that "disclosure should also involve providing the patient with a copy of any peer review or quality assurance report respecting the adverse event" (Cameron, 2009b, p. 470). This recommendation resulted in a revision to the guideline that states that "the patient or family will be offered a copy of the review" (Eastern Health, 2011b, p. 13). The question, then, is how can you expect to protect the documents

of a quality assurance review in a court proceeding when the organization itself has provided the document to the patient and their family? This is a point not lost on staff, and may add to the reluctance of staff to report occurrences or participate in quality assurance reviews.

4.2.8 Quality Case Review Checklist and Preliminary Investigation

The preliminary investigation process in which determination of whether a Quality Case Review will be undertaken in relation to a specific occurrence is documented on the Quality Case Review checklist. Similarly to the concise investigation form, the Quality Case Review checklist provides documentation of the severity and summary of the occurrence, the effect on the patient, and involvement, disclosure and support of the patient and their family. The checklist also provides documentation of the rationale for determining whether a Quality Case Review is indicated. The Quality Clinical Safety Leader collaborates with the program director and clinical chief to assess the criteria for Quality Case Review and to identify the members of the Quality Case Review committee if indicated.

4.2.9 Quality Case Review Report

When a Quality Case Review is undertaken, the components of the investigation and findings are documented on the Quality Case Review report. The report is a very comprehensive review, evaluation and summary of the findings of the Quality Case Review committee. The final section contains recommendations that the report should: target the elimination of the root causes; offer a long-term solution to the problem; have a greater positive impact on other processes, resources and schedules; be objective and measurable and be achievable and reasonable (Eastern Health, 2011b, p. 27).

This consideration of the official discourse provided in texts within Eastern Health provides an important backdrop to examine the experiences of staff; but official texts from outside the immediate environment are also an important consideration for understanding the experiences of staff in Eastern Health. Written policies and procedures from outside the organization play a key role in organizing the activities and work practices of Eastern Health staff, although the texts themselves are often not visible or known to the staff. I will turn now to consider these external texts. These texts are separated into 3 sections based on their source -- either provincial, federal or discipline specific (that is, those that give guidance to individual staff based on their professional designation). I begin with those from provincial sources, which include: The Evidence Act, Task Force on Adverse Health Events Report, Access to Information and Protection of Privacy Act and The Apology Act. The Cameron Inquiry Report would also be considered a provincial text, but it will be discussed within the examination of the Cameron Inquiry later in this chapter.

4.3 Text in Newfoundland and Labrador

4.3.1 The Evidence Act

As described in the AETF Report, all jurisdictions in Canada have legislation that protects individuals from being compelled "to testify in a legal proceeding about their participation in a peer review or quality assurance activity" (Thompson, 2008, p. 18). This protection is regarded as essential to creating an open environment in which health care providers are able to share opinions and make recommendations (Thompson, 2008). Thompson notes that in Newfoundland and Labrador "this protection in respect of quality assurance committees and peer review committees" is provided in the Evidence Act

(2008, p. 18). Interestingly, Cameron in Recommendation 33, discussed in more detail in Section 4.7.3, directs the Government of Newfoundland and Labrador to consider "whether section 8.1 of the *Evidence Act*[38] remains relevant" (2009b, p. 469).

The Evidence Act was originally tabled as statute in 1990, with amendments made as recently as 2012. It includes a section on Inadmissible Evidence, commonly referred to as section 8.1 in Eastern Health documents. This section of the Act applies to certain committees within the health authority including "(b) a quality assurance committee … as defined under the *Hospital and Nursing Home Association Act*[39], and (c) a peer review committee … as defined under the *Hospital and Nursing Home Association Act*" (Government of Newfoundland and Labrador, 2014a, 8.1(2)). Reports are also specifically addressed in this section:

> No report, statement, evaluation, recommendation, memorandum, document or information, of, or made by, for or to, a committee to which this section applies shall be disclosed in or in connection with a legal proceeding (Government of Newfoundland and Labrador, 2014a, 8.1(3)).

Furthermore the expectations of an individual as witness are also addressed:

> where a person appears as a witness in a legal proceeding, that person shall not be asked and shall not (a) answer a question in connection with proceedings of a committee set out in subsection (2); or (b) produce a report, evaluation, recommendation, memorandum, document or information, of, or made by, for or to, a committee to which this section applies (Government of Newfoundland and Labrador, 2014a, 8.1(4)).

The recommendations of the Cameron Inquiry as will be discussed in Section 4.7.3 do not align with the Evidence Act in terms of the protection of quality assurance activities. Therefore the clarity that Eastern Health was directed to provide as a result of the

[38] RSNL1990, c. E-16
[39] RSNL 1990, c. H-8

Cameron Inquiry within both its disclosure policy and its occurrence reporting and management policy have resulted in revisions that now make *inadmissible evidence* public knowledge by providing copies of committee reports and evaluation documents to patients and their families.[40]

4.3.2 Task Force on Adverse Health Events Report

The AETF report also provided recommendations that addressed the processes of quality assurance and protection of regional health authority documents and review processes. As introduced earlier, the AETF was appointed in May 2007 with a specific scope and mandate in part:

> to examine and evaluate how the health system identifies, evaluates, responds and communicates in regard to adverse events within the health system; to examine relevant best practices in other jurisdictions; . . . and to make such recommendations as may be appropriate (Thompson, 2008, p. ix).

The process the AETF undertook was one of consultation. The consultations involved a number of key informants including health authority leadership, committee of health authority safety and quality officials, the public, relevant stakeholders using a variety of methods ranging from regular dialogue, written submissions and a symposium. "The Task Force was not established to look at specific adverse events, but rather to determine if the Newfoundland and Labrador health and community services system responds appropriately to adverse events when they happen" (Thompson, 2008, p. ix).

[40] Whether or not the Quality Review documents that are provided to families are or are not admissible in court and whether the evidence act extends to families who are in possession of quality reports is not a consideration of this study. The fact that families are in possession of quality review documents figures into the experience of health care providers and that experience is a consideration of this study.

The report provides a lengthy discussion acknowledging the emotional and physical effects that the health care professional may experience in the context of an adverse event:

> Care for the caregivers is a significant aspect of adverse event management. When an event occurs, and the possibility for stress and anxiety on the part of the provider is identified, it is important to provide them with information on informal and formal support mechanisms available to them (e.g., debriefing by other health care professionals, Employee Assistance Programs, psychological counselling). This support needs to be made available in a timely and appropriate manner. Providers should also be aware that they will not be exposed to any recrimination simply based on their involvement in an adverse event. Nonetheless, they should also be counselled to consider, where appropriate, obtaining advice from their professional association or legal counsel. They should be given appropriate access to leave time or alternative clinical responsibilities (Thompson, 2008, p. 90).

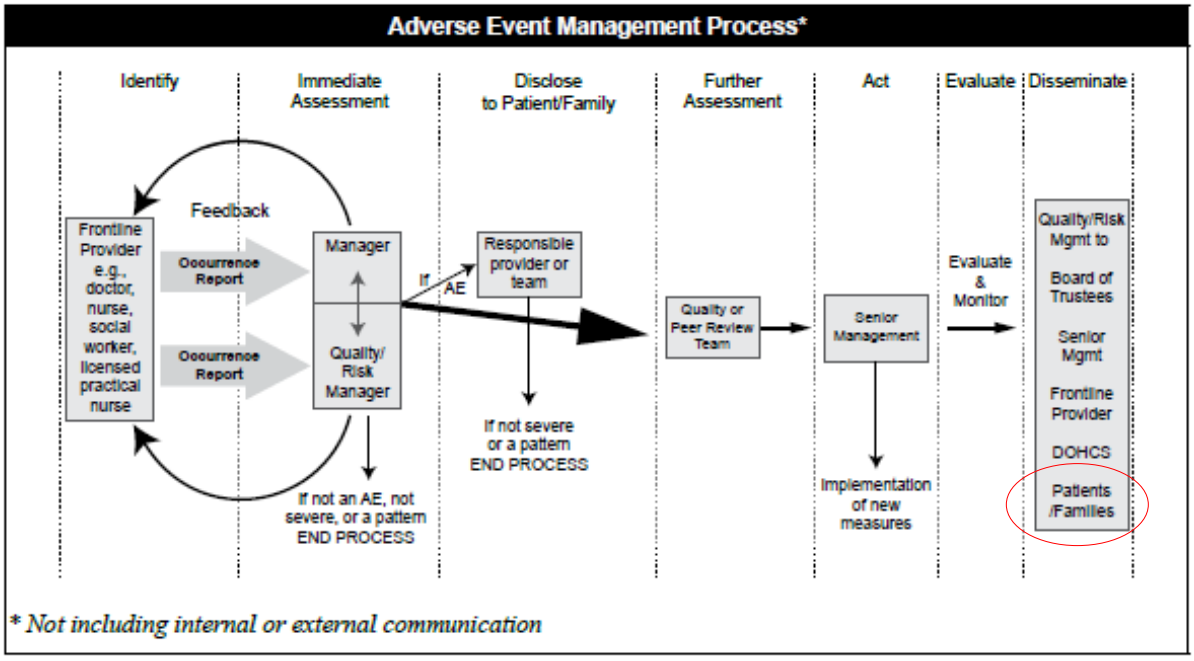
The resultant recommendations include two that specifically acknowledge concern about the legal protection and emotional needs of staff. Recommendation 3 states that "legal protection be provided for employees to ensure there are no negative repercussions or reprisals against them for participating in occurrence reporting according to established policies" (Thompson, 2008, p. xii). There is no evidence in the Eastern Health occurrence reporting and management policy that acknowledges this recommendation or suggests whether Eastern Health intends to provide such protection. Recommendation 15 directs the Regional Health Authority to "develop policies and procedures for responding to the emotional and psychological needs of care providers who are affected by adverse events" (Thompson, 2008, p. xvi). As discussed, the Eastern Health disclosure policy includes a statement about how a health care provider may access support, but there are no procedures in place to respond to the emotional and psychological needs of health care providers. In Eastern Health accessing support is left to the individual to organize either

through employee and family assistance program, their professional organization or through personal resources.

The AETF report[41] also makes recommendations similar to the Cameron Inquiry recommendations discussed in Section 4.7.3 that create the expectation of an open process of quality review, including the provision that "factual information in peer reviews and quality reviews be disclosed to patients" and that "when a request is made by the Minister, Regional Health Authorities will provide copies of peer reviews and quality assurance reviews" (Thompson, 2008, p. xv). An adverse event management process was recommended in the report (see Figure 4-1) that shows disclosure to the patient and their family at the time of the event. In addition, following the quality or peer review team assessment there is dissemination of the findings that also includes patients and their families, thereby altering the process from internal quality assurance to a public process.

[41] The AETF report was released in December of 2008 followed very soon afterward by the Cameron Inquiry Report in March of 2009.

Figure 4-1: Adverse Event Management Process (Thompson, 2008, p. xi)



4.3.3 Access to Information and Protection of Privacy Act

The *Access to Information and Protection of Privacy Act*[42] (ATIPPA) was brought into force in 2002 with several amendments made since that time. The purpose of the Act was to make public bodies "more accountable to the public and to protect personal privacy by

(a) giving the public a right of access to records;

(b) giving individuals a right of access to, and a right to request correction of, personal information about themselves (Government of Newfoundland and Labrador, 2014b, p. 3.(1)).

As a result of the attachment of occurrence reports to the patient record, the occurrence becomes part of the patient's record and therefore is subject to an ATIPPA request.

[42] SNL2002, c. A-1.1

4.3.4 Apology Act

Both the Cameron Inquiry and AETF findings recommended the introduction in Newfoundland and Labrador (NL) of an Act respecting Apology. The resulting *Apology Act*[43] provides the opportunity to express sympathy or regret without affecting liability. In other words, an apology made in connection with an event does not constitute an express or implied admission of fault or liability and is not admissible in a court as evidence of fault or liability (Government of Newfoundland and Labrador, 2009).

I turn next to consider official texts from federal sources. In this category there is one text which is especially applicable to the discussion of staff experiences, the Canadian Disclosure Guidelines. The importance of this particular text is that it guides health authority policy and practice.

4.4 Official Federal Discourse on Risk Management and Patient Safety

4.4.1 Canadian Disclosure Guidelines

The first Canadian Disclosure Guidelines were published in 2008 at a time when many health care organizations in Canada were just beginning to grapple with the development of policies that addressed disclosure of adverse events in a very tangible way. At the same time, organizations such as Eastern Health were experiencing events in which disclosure was coming under scrutiny. The guidelines emphasized "the importance of a clear and consistent approach to disclosure regardless of the variance in definitions across Canada related to harm and adverse events; patients have a right to be informed about all aspects of their care" (Canadian Patient Safety Institute, 2008, p. 8). While the

[43] SNL2009, c. A-10.1

guidelines focused "on the disclosure of adverse events, they emphasize that all harm must be communicated to patients, irrespective of the reason for the harm" (Canadian Patient Safety Institute, 2008, p. 8).

The 2008 version of the guidelines provided six guiding principles: patient-centred healthcare, patient autonomy, healthcare that is safe, leadership support, disclosure is the right thing to do and honesty and transparency (Canadian Patient Safety Institute, 2008). In addition, the guideline provided a list of recommended elements to be included in a disclosure policy, an indication of CPSI's commitment to assisting organizations to develop policy in the area of disclosure (Canadian Patient Safety Institute, 2008, p. 31).

The revision of the Canadian Disclosure Guidelines, entitled *Canadian Disclosure Guidelines: Being Open with Patients and Families*, published in 2011, followed closely a new strategic plan in 2010 for CPSI. A successful organization is defined according to five key achievements:

> Embrace prevention of all avoidable harm to patients as a core objective.
>
> Support all healthcare providers to make safety a top priority in their work.
>
> Nurture and support a commitment to improvement at all levels of the organization.
>
> Achieve long period of incident-free care without becoming complacent or overconfident.
>
> Adopt leading methods to measure, monitor and report on performance (Canadian Patient Safety Institute, 2011a, p. 6)

The guidelines aimed "to help organizations achieve this success by being open and honest with patients and families about patient safety incidents" (Canadian Patient Safety Institute, 2011a, p. 6), a concept highlighted in the document title.

This version of the guidelines proposed to harmonize the language of patient safety in Canada with that of the International Classification for Patient Safety being developed by the World Health Organization. For this reason, the following terms using the associated definitions, provided below, were integrated into the 2011 document:

> *Patient safety incident* – An event or circumstance which could have resulted, in unnecessary harm to a patient.
>
> *Harmful incident* – A patient safety incident that resulted in harm to the patient. Replaces "adverse event" and "sentinel event."
>
> *No harm incident* – A patient safety incident which reached a patient but no discernible harm resulted.
>
> *Near miss* – A patient safety incident that did not reach the patient. Replaces "close call" (Canadian Patient Safety Institute, 2011a, p. 11).

The final category of text to be considered is discipline specific text which factors into the experience of staff by virtue of their individual responsibility to their professional associations who have text that addresses specific components of adverse event management.

4.5 Discipline Specific Official Discourse on Risk Management and Patient Safety

Within any health care organization there are a number of licensed professionals that practice their discipline according to guidelines provided by their professional association including, for example, physicians, nurses, pharmacists and laboratory technologists. In addition, licenced professionals are also subject to the policies of the employing organization. Physicians in particular have been provided with various official texts by their professional association to guide their practice regarding adverse events and disclosure.

4.5.1 Canadian Medical Protective Association

The Canadian Medical Protective Association (CMPA) published three documents in 2008/09 addressing the topic of adverse events. The first document, *Communicating with your patient about harm: Disclosure of adverse events* (Canadian Medical Protective Association, 2008), provides a disclosure roadmap that describes the disclosure process from the initial clinical care to post-analysis disclosure of actions taken. The document provides a step by step outline of how to approach and accomplish disclosure, including answers to frequently asked questions such as: "What are my obligations to disclose?" "If I say 'I'm sorry' will I get sued?" and "I am aware of a possible adverse event that occurred under the care of another physician or health care provider. Should I provide disclosure to the patient directly?" (Canadian Medical Protective Association, 2008, pp. 32-33) In essence the document encourages physicians to disclose adverse events and provides a clear process to accomplish the task.

The second document, *Learning from adverse events: Fostering a just culture of safety in Canadian hospitals and health care institutions* (Canadian Medical Protective Association, 2009a), "describes the requirements and processes for reporting adverse events and close calls," (p. 4) and the best approach for individuals and organizations to review these events. As well, it contains an explanation of "how CMPA members and other health care providers can foster a just culture of safety within a hospital/institution" (Canadian Medical Protective Association, 2009a, p. 4). There are a number of statements made within the document that declare the position of CMPA, encouraging members in relation to adverse events:

> CMPA supports the development of policies and procedures regarding adverse event and close call reporting (Canadian Medical Protective Association, 2009a, p. 5).
>
> Even if participating is not mandatory, CMPA members are encouraged to participate in properly structured quality improvement reviews in the interest of improving patient safety (Canadian Medical Protective Association, 2009a, p. 9).

There are also a number of statements that are read as cautionary to CMPA members in relation to adverse events and review processes:

> These systems should focus on capturing only factual information, recognizing that speculations or opinions might lead to misunderstandings and inaccurate conclusions (Canadian Medical Protective Association, 2009a, p. 6).
>
> It is important to note that incident/occurrence reports may not benefit from the legislation that generally protects quality improvement information from being used in subsequent legal, regulatory or other proceedings (Canadian Medical Protective Association, 2009a, p. 6).[44]

The role of the physician in Eastern Health is to heed the advice and cautions of the CMPA while weighing that against the policies and procedures of the organization, policies that include specific expectations regarding staff-response at the time of adverse events.

The third document, *Reporting and responding to adverse events: A medical liability perspective* (Canadian Medical Protective Association, 2009b), described as a companion to the *Learning from adverse events* document addresses "the medical liability issues associated with the reporting of and response to adverse events" (p. 2). The document outlines a balanced approach to protect the nature of the learning environment that includes the quality improvement aspects and the public's right to be

[44] Incident/occurrence reports in this CMPA note refers to participation in an adverse management reporting system and should be distinguished from disclosure of the incident to the patient which is addressed above in an earlier statement.

provided explanations to understand how safety in health care can be improved. There is a depiction of an information firewall between the health care provider accountability to report and disclose that leads to explanations to patients and the quality improvement processes, called the protected discussion, that leads to improved health care (Canadian Medical Protective Association, 2009b, p. 4). The document provides recommendations for what policy makers, health care authorities, institutions, physicians and other health care providers should do to improve systems of care; but more importantly the document provides some important conclusions, including the following statements:

> The CMPA believes that the Canadian health care system has reached an important juncture in the area of improvements to quality of care. The path that would result in the widespread disclosure of quality improvement information threatens to undermine decades of efforts to improve care. The other path seeks to achieve an appropriate balance between the patient safety and the accountability responses, recognizes the need for both types of responses, and enables each type to contribute to a more effective and safer health care system (Canadian Medical Protective Association, 2009b, p. 13).

The direction and support given to physicians and health care organizations in these three principle CMPA documents laid the ground work for more comprehensive disclosure processes within Eastern Health.

4.5.2 Canadian Medical Association

The Canadian Medical Association Code of Ethics, in Section 14, states the following: "Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient" (Canadian Medical Association, 2004, p. 2). Although the Newfoundland and Labrador Medical Association does not provide a defined policy document regarding adverse events, "all of the medical regulatory licensing authorities (Colleges) in Canada would view the disclosure of adverse events to patients as an ethical

and professional obligation" (Canadian Medical Protective Association, 2008, p. 32). "Furthermore, although specific legislation mandating disclosure may not exist in a particular province or territory, disclosure will likely be seen as a legal professional obligation in all of the jurisdictions" (Canadian Medical Protective Association, 2008, p. 32).

4.5.3 Canadian Nurses Association

The Canadian Nurses Association (CNA) provides a Code of Ethics (2008) that includes a brief statement about adverse events. "Nurses admit mistakes and take all necessary actions to prevent or minimize harm arising from an adverse event. They work with others to reduce the potential for future risks and preventable harms" (Canadian Nurses Association, 2008, p. 9). The CNA Code of Ethics also notes that provincial and territorial legislation and nursing practice standards may include further direction regarding requirements for disclosure and reporting. The Registered Nurses Act of Newfoundland and Labrador does not provide any direction regarding requirements for disclosure and reporting as it relates to adverse events in patient care in Eastern Health (Government of Newfoundland and Labrador, 2008). The Association of Registered Nurses of Newfoundland and Labrador (2013) competencies document referring to the Registered Nurse states "protects clients through recognizing and reporting near misses and errors (the RN's own and others) and takes action to stop and minimize harm arising from adverse events" (p. 7) and "integrates quality improvement principles and activities into nursing practice" (p. 8). However, there is no statement of expectation regarding disclosure or involvement in quality reviews when adverse events occur within the context of the registered nurses' practice.

4.6 Orthodoxy at Work

This chapter has provided an examination of the official text-based discourses of Eastern Health, the government of NL and Canada, as well as those of the various professional organizations, that provide guidance to Eastern Health staff in the event of an adverse event. The Cameron Inquiry and the AETF both resulted in reports with recommendations that have been integrated into the policies and procedures of Eastern Health. In particular, the fact that the documents that result from the Quality Case Review process and all quality and peer review processes are now shared outside the organization with patients and families automatically[45], and shared with others through ATIPPA requests, has been demonstrated. The original intention of the Evidence Act was to provide legislative protection for quality assurance activities and specifically the protection of documents used in quality review and peer review processes. The recommendations of the Cameron Inquiry and AETF report have resulted in sharing of documents that would not have been shared, in the past, based on common understanding of the Evidence Act.[46]

This examination of official texts sets the groundwork for examining whether and how the changes to policies and procedures may make it difficult for staff to confidently participate in quality assurance activities, since these activities are no longer internal with

[45] In the Quality Case Review procedure documents it is clear that the Quality Case Review documents are automatically shared with patients and families, and this fact was confirmed by QRM staff.

[46] I note that some people believe that occurrence reports would have historically been part of the patient's chart and therefore available as part of ATIPPA requests. This is not in fact the case. Prior to the integration of the Cameron Report recommendations into Eastern Health practice, occurrence reports were not associated with the patient's chart. Moreover, historically the option existed to have the reports completed anonymously.

the assurance of protection from public review. At the same time that the assurance of protection of privacy has lessened, professional bodies have outlined clear expectations that members must participate in disclosure and quality review processes.

The final section of this chapter examining the orthodoxy of risk management and patient safety considers three judicial inquiries. These judicial inquiries are key sources of orthodoxy in relation to the management of adverse events (in particular, the Cameron Inquiry Report) and thus are important to consider in the context of this study.

4.7 Examination of Inquiries

There have been a number of public judicial inquiries[47] into adverse events that have played a major role in the evolution of the culture of Canadian health care. Three of these are particularly important in the context of this study: the Grange Inquiry (1984), the Krever Commission (1997) and the Cameron Inquiry (2009b).

4.7.1 The Grange Inquiry

The Grange Inquiry refers to the *Royal Commission of Inquiry into Certain Deaths at the Hospital for Sick Children*, headed by Mr. Justice Samuel Grange with his appointment on April 21, 1983. Prior to the Commission of Inquiry, from June 30, 1980 through to March 22, 1981, thirty-three babies and three older children (ranging in age from 9 days to 19 years) died on cardiac wards at Toronto's Hospital for Sick Children. This period of time is referred to as the "epidemic period", representing a 625% increase over previous nine month periods (Grange, 1984, p. 7). In late March of 1981, Nurse

[47] I recognize there are many important inquiries, in addition to the ones examined, such as the Manitoba Pediatric Cardiac Surgery Inquest, however the intent was not to be exhaustive but to provide examples.

Susan Nelles was charged in the death of four babies, and in January 1982, a Preliminary Inquiry into the charges began. The Preliminary Inquiry lasted 45 days and ended with the discharge of Nelles, with the finding that there was not sufficient evidence at the time of her arrest or sufficient evidence found during the Inquiry to justify her committal to trial (Grange, 1984). Justice Grange concluded that "in a perfect world, she would not have been arrested, charged or prosecuted" (Grange, 1984, p. 221). In his final report, Justice Grange categorized the deaths as: "deaths by digoxin toxicity" [8], including the four that Nelles was charged with; deaths either "suspicious of" or "highly suspicious of" digoxin toxicity [15]; and "deaths from natural causes" or cause "undesignated" [13] (Grange, 1984, pp. 170-171). "In the end, this litigation - much like the medical mysteries that gave rise to it – would produce more drama than meaningful resolution" (Bowal & Horvat, 2011, p. 56).

The Nelles Preliminary Inquiry and the resultant Grange Inquiry substantially changed the public's view of nursing. Although Nelles was exonerated, her name remains familiar to many nurses and others in health care, and in part the Inquiry transformed the impression by the public of nurses, from healers/carers to possible harmers and "potential purveyors of evil acts" (Buckley Day, 1987, p. 29). In addition to the Grange Inquiry, there were three additional reviews that were undertaken to attempt to resolve the questions at the Hospital for Sick Children. The Ontario government appointed a review committee chaired by Mr. Justice Charles Dubin to examine the procedures and practices at the Hospital for Sick Children. The review resulted in the Dubin Report that provided ninety-eight recommendations (Buckley Day, 1987). Simultaneously, the Hospital for Sick Children undertook its own study into the cause of deaths during the epidemic

period, completed by Dr. Harry Bain, former Chief of Paediatrics. Dr. Bain concluded that 34 of 36 deaths were from natural causes with two exceptions (SIDS[48] and transient renal insufficiency[49]) (Buckley Day, 1987). Following the Dubin Report and the Bain Study, a request was made by several Hospital for Sick Children physicians, including Bain, for the Centre for Disease Control[50] to undertake another investigation. The CDC investigation resulted in the Haynes Report. Despite multiple strategies to determine the cause of the deaths at Hospital for Sick Children, no report concluded the causes of death or could "say with certainty whether any crimes were ever committed on the paediatric cardiac ward" (Bowal & Horvat, 2011, p. 60).

Dr. Albert Burton[51] demonstrated using Statistics Canada data that most provinces across Canada displayed a paediatric cardiac death pattern that mirrored that of Hospital for Sick Children during the epidemic period, causing him to conclude that what happened at Hospital for Sick Children was the same as what was happening nationwide (Hamilton, 1993). Inquiry conclusions that were based on the best evidence at the time were refuted in subsequent years. For example, Hamilton (1993) later described the inaccuracy of the radioimmunoassay (RIA) test used to measure the digoxin levels of the Hospital for Sick Children samples and the role of 2-mercaptobenxothiazole (MBT) used in syringe rubber plungers now known to contaminate medications or be confused with digoxin, a finding that refutes the conclusions of the Grange Inquiry.

[48] SIDS is an acronym for Sudden Infant Death Syndrome
[49] Transient renal insufficiency is a form of kidney failure
[50] Centre for Disease Control in Atlanta, Georgia, USA
[51] Retired Professor of Biochemistry, University of British Columbia

Buckley Day (1987) described the Grange Inquiry as a witch hunt and nurses as scapegoats. Further, she notes that "during the Grange Inquiry the knowledge possessed by nurses was discounted, deemed irrelevant, or simply ignored" and "one of the basic reasons for the differential treatment that women received throughout Commission proceedings is their lack of social recognition as 'rightful knowers'" (Buckley Day, 1987, p. 31). The importance of this observation of *the lack of social recognition as rightful knowers*, as was observed in the Grange Inquiry, will become clear in later discussion of the experience of Eastern Health staff during ER/PR and in the Cameron Inquiry.

4.7.2 The Krever Commission

The Krever Commission refers to the *Report of the Commission of Inquiry on the Blood System in Canada*, a Royal commission headed by Mr. Justice Horace Krever, established by the Canadian Government in October 1993 with a report tabled in the House of Commons in November 1997 (Krever, 1997). It was established to investigate allegations that government, private and non-governmental organizations that were responsible for Canada's blood supply system had allowed contaminated blood to be used. The findings of the report described the scope of the problem as a "nationwide public health calamity" (Krever, 1997, p. 3) in which the national blood supply became contaminated with two infectious viruses, one causing a newly emerging disease (Human Immunodeficiency Virus) and the other causing a disease that had existed for many years but had not been previously identified precisely (Hepatitis C Virus). The Krever Commission's fifty recommendations changed the landscape of Canadian health care by bringing accountability for safety in health care practice and obligation for disclosure of health care risks to the forefront. The recommendations had significant implications for

the Canadian Blood Services[52], hospitals and health care providers. For example, obligations were stated about (1) obtaining patient's informed consent, (2) informing recipients immediately upon learning of potential risks to the safety of blood components or products, and (3) fully disclosing risks inherent in blood products (Spencer, 1998/1999).

Wilson (2007) states that, in retrospect, "the findings of the Krever Commission could perhaps be considered the most influential report on public health in Canadian history" (p. 1387). A major theme emerging from the Krever report was the importance of our public health system's role in protecting the health of Canadians (Wilson, 2007), a role that had become eroded by a reduction in resources. "Many of the recommendations from the report to ensure blood safety transcend the blood system and have influenced many other areas" (Wilson, 2007, p. 1387), for example, the call for precautionary measures in managing the risk of Sudden Acute Respiratory Syndrome (SARS), Creutzfeldt-Jakob Disease and West Nile Virus. The concept of *precautionary measures* resulted from the finding that while Canada waited for scientific certainty before taking essential preventive measures, a national public health disaster occurred (Wilson, 2007). A second major contribution of the Krever commission was its identification of the vital role of governance in ensuring safety in public health (Wilson, 2007, p. 1388). Two significant problems were identified in relation to governance, the first was that the system was organized with cost-consideration affecting decisions related to safety and the second was the ambiguity about roles and responsibilities that created risk (Wilson,

[52] The Canadian Blood Services assumed responsibility for the operation of Canada's blood supply system in September 1998.

2007). The importance of clear roles and responsibilities was demonstrated again by the Ontario experience of SARS, with recommendations made regarding the independence and leadership of the Chief Medical Officer of Health and local public health governance (Campbell, 2006).

4.7.3 The Cameron Inquiry

The Cameron Inquiry refers to *The Commission of Inquiry on Hormone Receptor Testing* established by the Government of Newfoundland and Labrador in July 2007. The Honourable Justice Margaret A. Cameron was appointed Commissioner and the report was released in March 2009. The Commission was divided into two parts. Part I involved an "inquiry into and report on problems with estrogen and progesterone hormone receptor tests conducted between 1997 and 2005 in the Newfoundland and Labrador health care system" (Cameron, 2009a, p. 2; 2009b). The specific mandate of the Inquiry into the testing was to examine what happened to cause or contribute to the problems with testing, to determine when the problems came to light and whether earlier detection was possible (Cameron, 2009a). The public hearings were conducted from March to October of 2008, with a total of 131 days of sitting, ninety-three witnesses, 3,609 public exhibits and 309 *in camera* exhibits (Cameron, 2009a). Part II of the Inquiry had a policy focus, that took a variety of forms (Cameron, 2009a, 2009c). First, "to canvass the duties, if any, of responsible authorities to patients, other parties within the health care system, and the public respecting differences in test results on re-testing" (Cameron, 2009a, p. 2). Second, to examine the testing and quality assurance systems in relation to best practice

(Cameron, 2009a). Third, the commission engaged with several experts[53] who were asked to prepare papers on certain aspects regarding disclosure obligations and present at a symposium, held in April 2008, with a view to "assist in the development of recommendations for policy reforms" (Cameron, 2009c, p. 1). The symposium provided the opportunity for the experts to make presentations and respond to questions from *parties with standing*[54] and the general public (Cameron, 2009a). The final phase of Part II was the receipt of written submissions and several replies to submissions from all parties with standing (Cameron, 2009a).

Webcasts on the commission's website, daily broadcasts on cable television and transcripts of the proceedings were provided for public perusal (Cameron, 2009a). As well, the local television and print media provided daily interpretations of the commission's proceedings. The media were perceived by staff as providing an incomplete and less than accurate portrayal of the events of ER/PR, as one laboratory staff member described:

> I think the media's portrayal was one of my biggest disappointments.… You didn't feel things were portrayed properly in the media.… It wasn't clear that

[53] Professor Timothy Caulfield (University of Alberta), Dr. Peter Norton (University of Calgary), Dr. Edward Etchells (Sunnybrook Health Sciences Centre), Professor Gerald Robertson (University of Alberta), Professor Bernard Dickens (University of Toronto), Professor Joan Gilmour (Osgoode Hall Law School), Dr. Thomas Gallagher (University of Washington), Dr. Philip Hébert (Joint Centre for Bioethics, University of Toronto), Dr. Sherry Espin (Ryerson University) and Dr. Stephen Ward (University of British Columbia).

[54] Parties with standing for parts I and II: Her Majesty in right of Newfoundland and Labrador, Eastern Regional Integrated Health Authority, Dr. Kara Laing et al., Central Regional Integrated Health Authority, Western Regional Integrated Health Authority, Labrador-Grenfell Regional Integrated Health Authority, Canadian Cancer Society – Newfoundland and Labrador Division, Members of the Breast Cancer Testing Class Action; Parties with standing for part II: Newfoundland and Labrador Medical Association, Healthcare Insurance Reciprocal of Canada.

> people weren't misdiagnosed. It seemed like, [we] told people they didn't have breast cancer when they did which is not at all what happened.

The significance of the media's treatment of the commission proceedings will be addressed later in the context of staff experiences. In addition, simultaneous commentary on the Inquiry was being written in other venues, such as scientific journals. For example Hede (2008), in the Journal of the National Cancer Institute, made comments such as "botched estrogen receptor tests has shaken public confidence in cancer care" and "even the affected patients were not told the retest results" (p. 836).

The commissioner provided a number of observations in her final report. First, she reported that "the primary causes of the changes in testing results were poor fixation and tissue processing, the absence of optimization of processes, the failure to follow proper procedures in ER/PR testing, and inadequate and/or improper antigen retrieval" (Cameron, 2009b, p. 451). She further noted that there were a number of contributing factors for each primary cause (Cameron, 2009b). Secondly, in terms of timeliness of reporting she noted that in her opinion, "had proper quality assurance and quality control policies been in place and had they been followed, the problem with ER/PR testing would certainly have been discovered much earlier" (Cameron, 2009b, p. 452). Further, the timeliness of reporting to patients was also noted as a significant issue due to decisions made about informing patients at their next scheduled appointment, that "could easily have resulted in delays of six months to a year" (Cameron, 2009b, p. 454). Thirdly, she reported that "the procedures and protocols within Eastern Health for ER/PR testing during the period from 1997 to 2005 were so deficient as to be practically non-existent" (Cameron, 2009b, p. 453).

There were sixty recommendations set out in the Inquiry report under the headings of best practices for hormone receptor testing by immunohistochemistry; quality assurance and accountability; laboratory technologists (training and continuing education); physicians (recruitment, retention, sub-specialization, continuing education and supervision); crisis management; legislation; information management; further investigation; disclosure and communications; and implementation and review of the recommendations (Cameron, 2009b). In relation to this study, there are a number of recommendations that are relevant. Recommendation 3 recognizes the "critical importance of quality" and directs each regional health authority to have a separate quality portfolio and a separate position of Vice-President Quality that "must be created to manage this portfolio" (Cameron, 2009b, p. 460). Recommendation 12 is the need to ensure that the electronic occurrence reporting system is "utilized to its full potential" and to "prevent the repeating of similar adverse events" (Cameron, 2009b, p. 463). Recommendation 33 directs the Government of Newfoundland and Labrador to consider "whether section 8.1 of the *Evidence Act*[55] remains relevant" (Cameron, 2009b, p. 469). Recommendation 34 proposes that "any conflict between section 8.1 of the *Evidence Act* and section 12 of the *Public Inquiries Act*, 2006[56] be resolved in favour of permitting Commissions of Inquiry to have access to peer review and quality assurance reports" (Cameron, 2009b, p. 469). Recommendation 35 addresses disclosure, recommending that "adverse event disclosure to patients include an explanation of why the adverse event occurred and what is being done to ensure that a similar event does not occur in the

[55] RSNL1990, c. E-16
[56] SNL2006, c. P-38.1

future" (Cameron, 2009b, p. 470). In addition, recommendation 35 states that "disclosure should also involve providing the patient with a copy of any peer review or quality assurance report respecting the adverse event" (Cameron, 2009b, p. 470). Recommendation 36 guides the adoption of apology legislation by the Government of Newfoundland and Labrador (Cameron, 2009b), noting the importance of apologies to both the care provider and the patient. Of the sixty recommendations, this is the only recommendation that includes concern for the care provider. Recommendation 51 states that all regional health authorities should have a "disclosure of adverse events" policy with the provision of ten elements from the facts to offers of support, although who is receiving support is not prescribed (Cameron, 2009b, p. 474). It is possible that the intention was to include support for care providers. The provision for health care provider support in the Eastern Health disclosure policy was discussed earlier in this Chapter.

Following the Cameron Inquiry, the 2010 Breast Cancer Testing class-action suit was brought against Eastern Regional Integrated Health Authority (*Doucette v. Eastern Regional Integrated Health Authority*) for a number of grievances including delays in and inaccurate communication of Estrogen Receptor/Progesterone Receptor (ER/PR) retesting results and therapeutic options with possible recurrence of breast cancer. This class-action suit was settled in favour of the plaintiff[57] with the disclosure communication of the organization found deficient.

The inquiries provide a number of important conceptions that are useful within the upcoming discussion of the experience of staff within the Cameron Inquiry as well as

[57] The plaintiff is the person who brings the suit, in this case, the members of the Breast Cancer Testing class-action suit.

the experience of staff within adverse events in general. The Grange Royal Commission demonstrated the potential for irreversible damage created by public perception of evidence within the judicial inquiry environment. The treatment of health care professionals and nurses in particular and the lack of social recognition as *rightful knowers* will be useful when examining the experience of various disciplines within Eastern Health. The Krever Commission demonstrated that ambiguity about roles and responsibility created significant risk, and that the delay in informing the public about that risk eroded public confidence in a system intended to protect the public. The Cameron Inquiry occurred within the local context of this study and the findings and recommendations are pivotal to understand the experience of staff in Eastern Health. The purpose of this chapter was to provide context for the adverse event experiences of staff in Eastern Health rather than to critique or analyse ER/PR and the Cameron Inquiry.

This chapter and the preceding three chapters have provided the background and significance of this study, the method of inquiry, the study methods and procedures and an examination of the dominant official discourses on risk management and patient safety. The three chapters that follow will examine the experience of study participants within adverse events in Eastern Health. Chapters 5 and 6 are organized chronologically in relation to ER/PR, with Chapter 5 describing experiences through the period of ER/PR and the Cameron Inquiry and Chapters 6 and 7 describing experiences in the years after the Cameron Inquiry Report was released.

CHAPTER 5

In the Eye of the Storm: ER/PR

For me, the *eye of the storm*[58] is a perfect metaphor to describe the place in which staff find themselves when an adverse event has occurred, the patient has been affected, the event has been reported, and staff members suddenly find that they are in the midst of a raging storm -- alone, afraid, and with little control over the series of coordinated activities that are unfolding. It is a strangely quiet place for the staff member because the flurry of activity is beyond them, outside their immediate environment. Not far away, the management and other staff are struggling with the fury of the storm, perhaps a very ill patient, an unhappy family or the media. The second victim feels the powerlessness of being in this isolated, deceptively calm place where they cannot in any way change the storm that rages all around them. Because the focus is on the raging storm, the second victim who is in the eye of the storm, is often forgotten. In this chapter I examine the experiences of staff and management in the storm known as *ER/PR.*

Not unlike the hours before a storm, in the months before ER/PR became a public event, certain events had begun to unfold that alerted some staff of Eastern Health of the impending storm. The description of ER/PR within this chapter begins in those months before ER/PR was made public. The ER/PR testing, which was the focal point of the Cameron Inquiry, was conducted within the Immunohistochemistry division of the

[58] The "eye of the storm" was not a metaphor offered by participants, it is a metaphor that helps me to think through the adverse event experience.

pathology department of laboratory medicine. I begin by explaining the hierarchy that exists within laboratory medicine followed, by an examination of the experiences of staff in the Immunohistochemistry Laboratory.

5.1 Hierarchy within Laboratory Medicine

Laboratory medicine has a well-established hierarchy based on the roles, responsibilities and educational preparation of the various laboratory personnel. Status and relations of power are defined in part by this hierarchy. Laboratory technicians are staff who have either been trained in college programs of several months in length or have been trained on-the-job. They are responsible for analysing laboratory samples and participating in laboratory quality assurance processes. Laboratory technologists are staff who have been trained in a 2-3 year college diploma program. Like technicians, they analyse laboratory samples, but in addition they are involved in the development of laboratory quality assurance processes and the interpretation of quality metrics. Pathologists are physicians who have speciality training in the study of disease. In the Immunohistochemistry Laboratory, the pathologists are anatomic pathologists and are responsible for examining laboratory samples of tissue, organs and tumours to determine disease type and stage.

Status within the laboratory is based on training or education. The pathologists hold the most status, followed by technologists and then technicians. With this status comes power, and the amount of power that any one person has is based on their position within the hierarchy. Relations of power within the laboratory hierarchy are evident in the opportunities that staff exercise in questioning or challenging the behaviour and opinions of other laboratory staff. For example, the power that the pathologists were perceived as

having within the laboratory prevented laboratory technologists and technicians from questioning the pathologists' opinions about who was responsible for events of ER/PR. The position of laboratory management within the hierarchical structure depended on their professional qualifications. Management staff who are also physicians have greater status and power than laboratory staff physicians and managers who are not physicians. The pathologists have more power and greater status than non-physician management.

5.2 The Experience of ER/PR in Laboratory Medicine

ER/PR testing is the responsibility of the Immunohistochemistry division of Pathology within Laboratory Medicine. A laboratory staff member, who was employed in the laboratory medicine program within Eastern Health when ER/PR began to unfold, shared her perceptions. She commented on her impressions of how the staff felt in the early days of ER/PR:

> [R]ight from the get-go, even before [the Cameron Inquiry] … I think the initial reaction was that people were afraid that they were going to be blamed personally, and not even … so much professionally, initially. Like, some of the people were thinking of, "Oh, my goodness, what did I do" … and some people were very, very emotional about all of that.

She described her early awareness of the Inquiry and her opinion that, "the blame game started very early."

She described how there was a hierarchy within the laboratory, stating that although "you're supposed to be considered co-workers" in actual fact "you felt that the pathologist was above you." She explained the implications of these relations of power for the functioning of the laboratory: "As lab staff, you feel that ultimately you have to give them [the pathologists] the right information in order for them to make the right judgement, so right away you felt like you're under the gun." The laboratory staff

member also was clear that the hierarchy was fundamental for shaping the way that blame was attributed during *Cameron*: "So, very early on, we felt that this was going to land on lab personnel [referring to technicians and technologists], ultimately, regardless of what was found."

A staff member explained that a power imbalance had begun to be exhibited between the pathologists and the technologists, a dynamic that was reportedly not discernible before Cameron. There are different classifications within the laboratory staff, and the staff member observed friction between staff based on those classifications, even before any cause of the ER/PR events was identified. She explained that some staff with less formal training had been grandfathered into positions in the laboratory program while in reality they did not have the background to totally understand the quality control processes that were supposed to be followed. The result, she observed, was that staff were no longer a team; "instead of working together, they were almost working separately" because, she argued, "one was better trained than the other." The outcome of these dynamics within the laboratory team was that staff "could hardly function." A divide that had started earlier had now become worse. She further described a divisiveness between the pathologists and the laboratory staff, with individuals on both sides trying to protect themselves, a situation that she referred to as "a huge wedge that … everybody was out to cover their own ass." She recalled that before ER/PR began, "the pathologists were very helpful … quite willing to share, and if you'd go to them and ask them for an interpretation or something, they were quite willing." With staff interactions strained and people no longer working in a collegial manner, the laboratory became a difficult place to

work. The staff member recalled that as it was coming closer to the actual time of the Inquiry, “things were so stressful.”

The lack of official communication from Eastern Health in the early weeks of the ER/PR investigation was a critical dynamic shaping the experience of laboratory staff. The staff described that they were not informed about the incident by the organization at the time of the discovery, and reported that they only eventually became aware of the details from other sources. One laboratory staff member expressed the frustration of waiting for details:

> I mean, we were weeks … whole blocks and slides and repeating things and not even knowing why. No one ever said to us, “We have a problem.” Well, we didn’t care who the person was or what the situation was. We didn’t even know why we were doing all this extra work. We weren’t even told that, “Well, there’s a possibility that there’s an error” or “We’re checking to see if, we missed something” or … nothing. It was just “Take these and do them. Take these and do them.”

Laboratory staff stated that they became aware of the events that were responsible for the additional work that was being assigned (that is, the rechecking of laboratory samples) during the social time of coffee and lunch breaks. Laboratory staff from all divisions tended to congregate for breaks in a common area of the cafeteria, and this common social time and space was reportedly a venue for sharing information about events across various divisions. The information that eventually reached the laboratory staff took the form of rumours. A staff member described how hearing the information in this manner led to fear and uncertainty amongst the staff:

> [We were hearing that] hundreds of wrong results [had] gone out and that was before we had even started truly testing hundreds, so how would you know there were hundreds. It was right away. It just went right off the rails right away. It was a big panic and … there was nothing right … it seemed like nothing was done right.

The staff of the Immunohistochemistry Laboratory were curious and had questions about the rechecking of samples, but they had not associated any anxiety or fear with the extra workload until their colleagues from other divisions, who were not involved but were hearing rumours, began to speculate about the magnitude of the wrong results. Staff from the Immunohistochemistry Laboratory who had interactions with colleagues from other divisions during coffee breaks became increasingly interested in trying to get answers from laboratory management about the nature of the problem that was creating the need for rechecking of samples. It was in the effort required to get answers that the hierarchy within the organization became evident. Participants believed that laboratory staff were unable to obtain timely answers to their questions because laboratory management were controlling the flow of information. As a staff member described, staff tried to get answers but they were not aware of the activities, decisions and processes that were taking place in the background, at the management level. In fact, as will be discussed later in this chapter, at the time that laboratory staff were struggling to understand and get answers, management were trying to understand and contain the event.

Even as the Cameron Inquiry began, laboratory staff still had not been officially informed about the actual events that had led to the Inquiry. Despite continued attempts to obtain information about the reasons for the rechecking of test results, it was months before an official explanation was provided. A laboratory staff member described her recall of the delay:

> I can remember, [Quality and Risk Management (QRM) staff] coming down, we were going through this process and we still didn't really know what *the* process was … or what was going to be involved, or where it was headed or … [QRM staff] finally came down and explained to us about the sentinel case and gave us the background. Here we were doing all the work. We had rerun all these tests.

> We were still in the process of doing it, and still didn't know why we were doing it, and the hearing was on at this point.

The Cameron Inquiry became very much a daily reality for the staff working within the laboratories of Eastern Health. A staff member recalled that laboratory staff would gather around and watch the proceedings on computers in the lab. She described the atmosphere as very intense and the communication pathways, although informal, "as fast as wildfire." She recalled the effect of the Inquiry on productivity in the laboratory:

> Very little work got done on some days … as certain people made certain comments, it just went through the lab like wildfire, and it was very intense … during the whole process it was very intense.

And then in their off-hours, at home, staff would watch the daily review and recap of the day's proceedings broadcast by local media outlets. There was usually a commentary associated with the broadcast provided by the media spokesperson, with comments added by members of the public, often by patients and patient's families. A laboratory staff member reflected on the role of the media: "It was like they didn't really have their facts right. … Until you're on the other side of it you don't realize how infuriating it is." Staff would debrief each morning about the comments of the media and begin again to watch a new day's proceedings. Most staff in the Immunohistochemistry Laboratory participated in the daily rituals of watching the Inquiry proceedings, including those who were slated to provide testimony at the Inquiry and those who were not.

Prior to the beginning of the Cameron Inquiry, the laboratory medicine program had been undertaking several quality initiatives to increase both the profile and the public understanding of laboratory services within Eastern Health. One of the initiatives resulted in the laboratory medicine management team inviting local media outlets to come into the

laboratories and take film footage of staff working within the environment. Unfortunately, the footage was eventually used to introduce and provide additional background images for the Cameron Inquiry daily reporting. Individual laboratory staff members became identifiable by the public, and in fact some staff were so recognizable that they were described as *the face* of the event. Staff were approached regularly, in public and private settings, and subjected to criticism and name calling during and after the Inquiry. Referring to a staff member in the Immunohistochemistry Laboratory who had inadvertently come to embody the face of laboratory error in this way, one staff member recalled that:

> She had the type of face that if you saw you would remember it, and she actually had a person in the supermarket say to her, "How can you be out here? Aren't you embarrassed to be out here when you're over there killing people … your work is killing people." Oh my god, she came to work, she was devastated.

She reported that the staff member "never got over it, never. Every day of her life it was with her. And that was (pause) oh, that was heavy for her." She described how difficult it was to watch colleagues "being hurt … it was absolutely devastating to her … I had met her several times and she would *always* [emphasis added] bring it up – always. Never ever left, never."

A laboratory staff member, who was not employed in the Immunohistochemistry Laboratory and therefore further removed from the incidents, described his impressions of being associated publicly with the events of ER/PR. He explained that in his view:

> … it affected everybody in the lab because you felt you were part of it, … at the [Gym] people would [say], "Where do you work," and you say, "Eastern Health," and they said, "Oh, you're the ones who misdiagnosed all the people with breast cancer."

He described “often times you felt the media wasn’t being fair” and, “they really didn’t capture what had happened” but it was difficult to explain the details so when he was asked he would say “No, that’s not really what happened.” He reported that “you couldn’t explain to them the details … [i]t wasn’t the diagnosis; it was part of the treatment.” From his perspective, trying to explain “was a waste of time”:

> … [It] was a waste of time because it was already in their minds what had happened and it was all the lab’s fault, and I guess you almost felt embarrassed in a way to be part of … I mean, I didn’t feel responsible, but you felt you were part of something that had hurt people and other people looked at you and they felt you were part of it.

Several laboratory staff members who were not directly involved in ER/PR described the sentiment of feeling the stress and not wanting to be identified as responsible when they had not even been involved, creating a self-protective response. Two laboratory staff members highlighted the sentiment of *guilt by association* when they used descriptors such as: “thrown into one bucket”, “every lab” and “everybody”. They respectively recalled:

> I think at that time we felt the stress of the people in the pathology lab, for sure and everything they were going through, but everybody got thrown into one bucket … and I know a lot of my co-workers say you wouldn't even tell anybody what your profession was back in those [days] … because that was all over the news and, everybody was like (sigh). You know, nobody wanted to admit where they worked, right? It was horrible.

> [P]eople were saying, “Well, they don’t know what they’re doing,” kind of thing and it got translated to all … like every lab and everybody that worked there.

Another laboratory staff member also described the sentiments of embarrassment, shame, feeling demeaned and feeling like one’s work was being undervalued or “forgotten.” She described how “no one wanted to say that they were a lab professional anymore. No one

wanted to say they worked for Eastern Health. … You kind of just wanted to steer clear of that conversation."

As the circumstances of the incidents became available to the public, the laboratory staff in the Immunohistochemistry division of the pathology laboratory experienced blame from other laboratory colleagues. The context in which the most blatant blame was described to have occurred was in a meeting organized by the organizational leadership intended to provide clarity about the circumstances of the events leading to the Inquiry and to provide support in the face of public criticism. All laboratory personnel were invited to participate and, as one laboratory pathology staff member recalled,

> They started finger pointing and, trying to fix things … and, people actually … standing up in front of everybody saying, "We're all taking the blame for something that pathology did."

She expressed her disappointment in laboratory staff who expressed blame, since the intention of the meeting was "to sit down and discuss what happened and where we [were] going from there." She further described the experience as "jaw-dropping" since laboratory staff were prepared to criticize the Immunohistochemistry division pathology staff directly:

> The whole way through it did feel like it was a blame game … people make inappropriate comments, insensitive comments … I would have thought that people would find it easier to blame someone if they didn't think they would find out, but in our situation they didn't mind standing in front of you and saying [it] … that was jaw-dropping … you know, because … you hear rumblings, and "I heard so and so say," but to say it right to you!

An Immunohistochemistry pathology laboratory staff member explained that the experience of ER/PR was stressful for the pathology staff, but being blamed by

colleagues was “devastating” for those people who had been directly involved with the events of ER/PR. She recounted the experience of observing a staff member who was so devastated by the comments of colleagues “that she left the meeting and never came back to work in the lab. She was a victim. … [S]he couldn’t deal with it at all. It really took her down, and so she never did any testing after.” A laboratory staff member recalled her disappointment when she experienced blame from her co-workers. She stated:

> [I]t was bad enough when you had the pathologists against you, when you had administration against you; but when you have your own co-workers against you, then it’s all for nothing … if even our own don’t believe in us, then how can I convince somebody [outside].

The manner in which the communication with staff was managed reportedly caused anxiety and divisiveness within laboratory medicine. One laboratory staff recalled, “there was a lot of not knowing, and then asking questions and not getting answers, and then some people would have information and not share the information, and so things became very divided.” Another staff member stated that “all of a sudden, they kind of went, ‘you’re on your own,’ ” referring to Immunohistochemistry Laboratory staff. She explained that “before, we were all just one big lab,” but from this point on they felt alone.

Staff who were required to testify at the Inquiry reportedly struggled with anxiety about how they would be supported and whether their jobs would be protected, as they watched other Eastern Health staff informants testify. Laboratory staff were aware that pathologists had their lawyers and the oncologists had their lawyers, but when the laboratory staff asked the question “Well, am I protected or aren’t I,” reportedly nobody “came to say … ‘Don’t worry about your jobs.’ ” This staff member surmised that

probably nobody knew about whether staff were safe in their jobs, but as she recalled "even to come and have that discussion with you, it never happened." Reportedly, reassurance and coaching to prepare to give testimony were eventually offered by organizational leadership, but only after laboratory staff "started to complain." One laboratory staff member reported that staff who testified met with lawyers and organizational leadership "to go over some of the scenarios." He described being coached about the types of questions that could be expected and "the way to answer." This coaching intervention was reported by laboratory staff as providing "some relief" for those staff who were experiencing intense anxiety as they waited for their turn to testify at the Inquiry.

Collectively, staff reported experiencing anxiety about their personal responsibility for the events, fear about job security and stress associated with trying to cope with criticism and blame from the public and their colleagues. Although staff tried to support one another through the period leading up to and during the Inquiry, they struggled with trying to carry on with the regular demands of their laboratory work: "Some of them didn't come every day, and some of them had very difficult days when they did. The ones that were directly involved, the ones that actually did the testing, were the ones that were more affected."

After the Cameron Inquiry concluded and before the report was released, staff continued to work; but, as one laboratory staff member described, those were "very dark days" and "everybody was kind of, like, in limbo once it was all said and done and waiting for the report to come out." Interactions between staff reportedly continued to be problematic. Up to this point there had been no formal supports provided for the staff,

other than to those who were providing testimony at the Inquiry, despite repeated requests. As one laboratory technologist in the Immunohistochemistry Laboratory put it, "people were getting support from their colleagues … just amongst ourselves, nothing higher up … we didn't get much recognition or support or talked to, any higher."

The release of the Cameron Inquiry report in March of 2009, six months after the conclusion of the Inquiry in October of 2008, reportedly resulted in disappointment for the laboratory technology staff. The laboratory staff believed that when the public and other staff in the organization understood *lab* they were referring solely to the technologists and technicians. After the report was released, participants described that there was no public clarification of how the ER/PR testing went awry. There was no clarification of the role of laboratory technology personnel in contrast to the role of pathologists in the events of ER/PR. By the time the Inquiry report was released, the technical staff believed that they were partially responsible for the events of ER/PR, but they believed that the pathologists were also responsible for ER/PR. The technical staff recalled that they were not in a position to challenge the pathologists about taking responsibility for their part in the events of ER/PR.

Within the laboratory medicine program, the relationships between staff reached a crisis point when the burden of responsibility continued to be placed on the laboratory technologists while, the technical staff felt, the pathologists refused to acknowledge their role despite the report findings. In a meeting held with immunohistochemistry staff after the report was released, several comments were made that staff felt indicated an attitude of blame by pathologists toward technical staff, described by one staff member as "demeaning" after all that they had been through. This interaction between the

pathologists and the technical staff was described as a turning point in the climate of the Immunohistochemistry Laboratory. A laboratory staff member recalled the intensity of the staff response:

> Well, we went back to the lab, the rest of us, and one [person] in particular – was just broken. Oh, (crying) she just felt that she worked so long … For them to have said that, was very … she was really upset. She was broken.

This particular interaction was described as the impetus that caused the organization to respond to staff requests for intervention. The same laboratory staff member explained that there was "some counselling" offered and there were "meetings with the staff" after there were multiple requests, but, in her words, "things were very, very slow in coming."

The actions of the organization also saw punishment meted out. Referring to a member of the laboratory leadership, a staff member described that after the Cameron report was released, a laboratory leader "showed up for work and her office was locked and she was removed" from her position. She claimed that, in her experience of Eastern Health, "somebody has to be the fall guy" -- an outcome that, she noted, seemed to contradict the Eastern Health policy regarding the management of adverse events. She described the frustration that surrounded the dismissal of the laboratory leader:

> Talk about following policies – there's no one to blame. Well, if there's no one to blame, how can one person be fired? You know, like, I don't know. I don't know if anybody or if everybody should've been fired, I don't know…

At first glance, it was interesting to note that laboratory staff reported that they felt unsupported by administration, and yet they rallied around this management staff member to show support. The distinction, as described by this laboratory staff member, was that the organizational leadership (executive) were considered to be the administration whereas the laboratory management (directors and managers) were not. In

the eyes of the technical staff the responsibility for ER/PR had been left solely with the technical staff and the laboratory management. Reflecting on the management of the ER/PR occurrences by the organizational leadership, a laboratory staff member emphasized that:

> The biggest error at the beginning was not telling us that we're being investigated and why they were doing it; and then, there was a lot of good changes that came … but it's still to this day … that mentality hasn't changed. You know, we're still … we're the ones that got [i.e., had] to do all the extra work.

The understood relationships within the Immunohistochemistry Laboratory provided tacit ways that the technologists and pathologists had worked together on a daily basis. The laboratory staff understood their relationships with the pathologists in certain ways, which they described as working closely together, having a good working rapport, and feeling comfortable to ask questions or seek clarification. The work of the Immunohistochemistry division of the pathology laboratory, like all divisions of the laboratory, was organized by the hierarchical structure through which the actual activities of the laboratory were organized and influenced. The laboratory technicians, laboratory technologists and pathologists each have their own policies and procedures that they have to follow that inform and shape their work. But quality assurance processes define the work of the department as a collective. The scientific and technical activities caused the work of the technologists and pathologists to intersect. The pathologists were dependent upon the work of the technicians and technologists to achieve their work.

When the pathologists reportedly exhibited overt blame toward the technology staff, this created the dynamic of being criticized by a group who had previously been understood to act respectfully toward other laboratory staff and to play a predictable role

within the laboratory. Now, suddenly their behaviours (described as "critical and non-supportive" by the laboratory staff in this study) were perceived by the laboratory staff to be outside of those previously understood relations. In essence, the working relationships between the pathologists and other laboratory staff became strained and the other laboratory staff began to recognize more and more the power differential at work in their relationships with the pathologists. The pathologists were no longer considered part of the understood work group but were perceived to be acting in a superior manner because of their credentials and status afforded them in the Cameron Inquiry as experts. Therefore laboratory staff did not feel comfortable speaking back or clarifying their position or perception. Before Cameron, pathologists did not exercise their status and power so blatantly within the pathologist-technologist relationship. And the most significant traumatic response by technical laboratory staff was reported when these pathologist-colleagues who were considered knowledgeable about the work of the Immunohistochemistry Laboratory were perceived by the laboratory technicians to be criticizing their work and blaming the technologists. The laboratory staff reported that they felt that the pathologists were blaming them unfairly.

The direct involvement of the front-line laboratory staff in ER/PR differed greatly from the involvement of staff in other areas of the organization such as QRM. The laboratory staff were unable to see the larger processes that were occurring; by contrast, the QRM staff were so deeply involved in the larger processes that they did not have the opportunity to respond to the anxiety developing among the laboratory staff.

5.3 The Experience of ER/PR in the Quality and Risk Management Department

Staff in QRM provided their view of ER/PR from the standpoint of the QRM program. A staff member recalled that in May 2005 "the flag was raised" that there might be "an issue with testing for the estrogen/progesterone receptors in breast tissue." A process began whereby laboratory medicine and QRM participated in the task of identifying women whose samples may have been implicated as an issue. A list was created by laboratory management, and a staff member in QRM was assigned the task of double checking the list to ensure that no patients were missed. A QRM staff member described how the list was double checked against "Meditech[59] and the Cancer Registry."[60] A QRM staff member was also tasked with beginning a concise investigation to determine the probable cause and scope of the issue. Another QRM staff, describing the process to me, related that "very quickly" it was determined "that examining the processes of ER/PR was beyond the scope of a concise investigation." She explained that the investigation required was so complex that the assigned staff member couldn't do it; she described the problem as "bigger than [her]."

The QRM program staff were required to make telephone contact with every women identified on "the list" but, according to one staff member, "telling them nothing" because at that point in time they "knew there were problems but [they] didn't know any specifics." The experience was described as "very traumatic" for a number of reasons, but particularly in terms of how difficult it was to call people, who were not expecting a call,

[59] Meditech is the electronic patient record system used in Eastern Health.
[60] The Cancer Registry is a database of cancer patients held in the NL Provincial Cancer Care program.

and try to explain that the test in question was "related to [their] treatment" and not their diagnosis. One staff member explained that it was very difficult to tell someone about a test "which may have affected their treatment, which they probably [couldn't] remember or may not even know that they had done." In the words of one staff member, "it was a difficult call to make and [they] had to make hundreds of them."

A staff member reflected on the trauma that she felt she was being forced to inflict on people, in her view perhaps unnecessarily:

> So this is what we were doing to people … and we were forced to do that. Like, none of us wanted to do this. None of us really felt that there was a need. That was in our mind at that time and we felt forced that we had to call all these people and do this traumatic thing. So, anyway, we did all that.… In some ways it's almost as if each client is an adverse event. You're dealing with the individual adverse events within a huge adverse event. Because each one was different.

She also reported that people often misunderstood the message that the QRM staff were trying to deliver and therefore multiple phone calls would be required to try and mitigate the confusion. She remembered one patient in particular who was confused after such a phone call:

> I can remember this poor woman I called. She went through all the cancers that she had had … all the cancers, all the treatments, everything else. She went through the whole thing – long conversation. I was on the phone well over an hour with her talking about all this stuff. … So at the end I did my little summary, "So this is what we've talked about and this is what … you know, it's been great talking to you and I will call you, in the future." First call next morning, "Did you tell me I never had cancer? I've been thinking about it all night."

One staff member recalled that, since the QRM team was not involved directly with any of the patients in the context of their normal workload, while making phone calls they also occasionally faced the unfortunate circumstance of asking for someone who, unbeknownst to them, was already deceased. She recalled the discomfort caused for

both the family and the QRM program staff when a phone call was made to a deceased patient's family:

> [W]e had to go through and determine from our list who was deceased; and, of course, you may have missed them … and then you hear the pause and then you know the person is dead … guaranteed, we had one of those a day, each one of us, and guaranteed they just died or something traumatic. So you're listening to that because I mean you're talking to … (pauses) *upset people*.

In addition, she described the trauma of laboratory results changing in the midst of an event that had already involved re-testing for changing results -- in essence, an occurrence within an occurrence. She recalled a patient who was very anxious to receive her updated results and so the staff member had the patient's name and number noted so that when her results came in she would "call her directly." She explained that when the results came in that should have included this patient's results, "hers weren't there." Unfortunately, the out-of-province reference laboratory had "lost her blocks" which then required a new sample and another period of waiting for the patient. The staff member described how the patient's results finally came back and indicated a change in result, which turned out eventually to be an error at the reference laboratory, because "there were some inherent issues with ER/PR." She recalled the distress of having to explain the patient's results:

> It was traumatic. … So we were after telling her that she was going to retest, wait for months to get the results back. "Your results are different. We're going to have to do something for you. Oh wait now. No, they're not. They're all the same. Go back to normal?" Now, if that wasn't traumatic, what was traumatic?

During the time of making hundreds of calls to patients, the QRM team supported each other but reported receiving very little other support. A staff member recalled one organizational leader who would "call down and check on us all … and see how we were

doing" and ask "what kinds of calls are you getting now." So this support was, in one staff member's opinion, in part "to check on everybody" but also in part "to get information too." She described this organizational leader as "a nice person" who provided "some support," but in her opinion "that was it" for support. During this time of contacting patients, she recalled that there was "no contact with the laboratory medicine program or other organizational leadership."

A staff member explained that the QRM staff had no expertise in the area of ER/PR testing or the treatment option of Tamoxifen; in her words, they "had never heard of Tamoxifen before, let alone ER/PR," and yet they were required by the organization to call all the patients and explain the purpose and possible outcome of the re-testing. She went on to describe how "QRM staff were working long hours with no compensation and very little acknowledgement." She explained that "[t]he calls were on the weekends, nights … there was no pay … there was no acknowledgement. Other than [they] were getting the job done. That was the only acknowledgement that [they] got, as [they] went through."

One QRM leader was asked by the organizational communications department to speak with individuals who had questions, even though she had never worked with the communications department and was not a previously designated organizational spokesperson for the public. Reportedly this expectation created a great deal of stress. The QRM program staff were not only managing the notification to every patient, keeping track of laboratory samples and reports as they came and went within and outside of the organization, but they were also required by the organization to take on roles that had not previously been part of the role of QRM.

The perspective of one QRM staff member was that although the decision to retest was made by a group of Eastern Health staff, including laboratory and organizational leadership, by the time the Inquiry happened QRM was left "holding the bag" and all the other people were "gone to the four winds." As time moved on, the roles and responsibilities of Eastern Health staff in the ongoing work of ER/PR changed. As a result, the QRM program staff were left with a responsibility which would normally be fulfilled by the laboratory program, coordinating the management of patient results. A QRM staff member was eventually (inaccurately in the staff member's view) identified to government, by a spokesperson for Eastern Health, as the person coordinating Eastern Health's response to the ER/PR events.

A staff member described a lack of understanding by organizational leadership of the effect that the QRM staff's work assignment was having on them. She described how she had shared her distress with an organizational leader who stated, "You are upset, over this?" The staff member interpreted the leader's response as "shocked" that the staff member would "even be upset." She went on to explain that the support she was receiving was not from the organizational leadership but from her partner and co-workers in QRM. The staff of QRM were also required to testify at the Cameron Inquiry. In one staff member's opinion she "never would've gotten through it [referring to the Inquiry]" without her partner at home and the staff from QRM.

One QRM staff member described the very taxing workload and the trauma that the collective demands created:

> We had an Access to Information and Privacy request from a reporter, so then as we went on we had the class-action lawsuit [referring to Verna Doucette v. Eastern Regional Integrated Health Authority, 2010] where we had to do stuff for

> … that. We had to provide notification to all the participants in that. So the lawyers then said, basically, "Good luck with that. We'll put the ad in the paper. Here's the letter you've got to send out to everybody."

In addition, the QRM began receiving new phone calls, from the women who had been contacted for ER/PR results, asking for information based on the media coverage of the class-action lawsuit.

> So on top of all the people that you were talking to … meanwhile, they were all still calling in, right? "I saw this in the paper. Is this what you called me about last year?" … So besides talking to all the public, then you had all this other … work, because you had work too. So, anyway, it was a very traumatic time to go through.

The anticipation of the Inquiry and then the beginning of the Inquiry itself caused distress within the QRM program, similar to the level of distress that the laboratory staff had reported. One QRM staff member who was required to testify described her experience of feeling frustrated as a result of being misunderstood and unsupported by the organizational administration in the face of the media coverage:

> I needed someone to say, "You did good, we knew you did … as best as we could hope you could do in the circumstances that you had," and that was it, nothing. … Get on the stand. It was terrible. You know, it was absolutely … the press coverage was terrible. It was just bad.

According to staff members, the organization had made a decision that staff who were testifying at the Inquiry would not be represented by the Eastern Health legal department and had not informed them that they would not be represented. Staff members had the experience of testifying at the Inquiry and expecting to have support from Eastern Health lawyers yet receiving none:

> I found out after, that the decision was made by Eastern Health not to defend any of us. We were not to be defended. However we did, we did. … I … fended for

> myself. That was it, so that hurt – totally undermined by the organization, absolutely.[61]

The lack of support reported to be provided after the Inquiry experience was consistent with the lack of support that staff recalled throughout the entire ER/PR process. One staff member described how she was offered employee and family assistance program support and the counsellor discussed the "trajectory of recovery" (Scott et al., 2009) with her. Reportedly, the counsellor used the Scott et al. model of recovery, in particular "Stage 6: Moving on" to explain how an individual may move through the stages of recovery following an adverse event. The staff member felt she was directed to choose one of three paths: "dropping out, surviving or thriving (Scott et al., 2009, pp. 329-330)," and whatever she chose, she felt the take away message was "good luck with that." When asked what support would have looked like for her, she explained that, for her, a supportive statement from the organizational leadership would have been:

> "I have good staff here.… These are good people and, given the circumstances that they were in, they did the best they could; and, yes, mistakes were made and, yes, I think they all own up to them all, but you know, they did the best they could, given the circumstances that they were in." From the top on down, that's what should've happened there, and it didn't happen at every single level.

One QRM leader reflected on what she viewed was the failure of the organization to use ER/PR as a learning experience, and the risk that was being created by the lack of

[61] Physicians who testified at the Cameron Inquiry had their own lawyers. Some staff had assumed that the lawyers who prepared them to testify at the Cameron Inquiry would "defend" them and therefore many unionized and management (non-physician) staff did not seek legal help through their professional bodies or personal resources. It was not until they were on the stand that they realized that they had no legal support. It is important to note that as much as this was not technically a trial, in fact participants felt that they were being required to defend their actions, as indicated in the participant quote above. In other words, while EH lawyers helped them to prepare for the Inquiry, the staff commented that they did not feel defended during the Inquiry.

opportunity for open communication. She stated that in her opinion "we don't talk about it here and we won't learn from it because we're going down the [same] road again. … [W]e've cut off education, training, which we did before. It's all focused in on money." She described how she believes that the organization is "leading up to the same thing again, and there's no recognition of that, and now there's no one even to talk to. … [P]eople aren't approachable!" One staff member stated that if she had received support at the time of the Inquiry the outcome "definitely" would have been different for her. It was suggested to another staff member that she take some time off and complete some academic work which was in process, an indication for her of the lack of understanding that the organizational leadership had of the devastating ways in which this experience was framing her everyday world.

5.4 The Experience of Public Criticism

QRM staff reportedly experienced criticism, similar to laboratory staff, from people who were not involved in the incidents but took the opportunity to comment. One staff member described taking her daughter to a specialist after her daughter had [a health crisis] and the specialist said, "Well, you know, you've put your family, including your daughter, under such stress. It's only to be expected." Another staff member described experiences of being verbally assaulted by strangers in public:

> I went to a house party. This woman cornered me in the kitchen and said everything to me, said everything – called me down to the dirt, and she was very strategic, though, because she kind of blocked me off in the kitchen, and everybody kind of drifted out. [Partner] had no idea I was still in there getting told off.

A laboratory technologist from the Immunohistochemistry Laboratory reported similar experiences. He explained that it was difficult to get any relief from the incidents, even away from the environment:

> We went to an Immunohistochemistry conference and the opening speaker … one of the first statements was about this, fiasco in a little place in Canada, and you're sitting there with your name tag, so you (slid down in the chair) … I can't even remember exactly now what they said about it, but just as soon as they said it, it's like when the doctor says "Malignant" and you don't hear anything else. For the minute I think I forgot exactly what they're talking about.

Another participant, who was not directly involved with the events, reported having a similar experience of attending a conference in the United States. A conference speaker made reference to a lab in Canada that had an ER/PR event, and although the conference was in a large auditorium the staff member was feeling self-conscious thinking that this was her laboratory. She explained that the experience of ER/PR still haunts her and she was not directly involved. In her opinion "if you had been directly involved and you had just moved on … that would've been a slap in the face all over again." She described that the conference was a place she never expected ER/PR to come up.

5.5 Suffering Immortalized

The *Graces* monument was created by Canadian artist James C. Smith. The monument, made of granite, depicts three life-sized female figures seated on three extensions of a cross-shaped plinth. One position on the plinth is empty to suggest the absence of a fourth figure. One figure holds a rose representing grace, love and beauty; the second figure holds a caduceus representing health and healing; and the third figure holds a heart representing optimism, hope, resilience and virtue (Eastern Health, 2013b).

Figure 5-1: Graces Memorial

As part of the class action lawsuit brought against Eastern Health in 2010, described in Chapter 1 ("Verna Doucette v. Eastern Regional Integrated Health Authority," 2010), the monument was commissioned by Eastern Health and erected at the Health Science Centre. A laboratory technologist described what she perceived to be staff being repeatedly traumatized by the statue. Another laboratory staff member explained the response of laboratory technology staff when the plan to erect the monument was announced:

> [It] put the nail in the coffin, so to speak, when they decided that they were going to put up this monument in honour of those … [referring to the women in ER/PR], we felt then it was like, nobody asked us if this was a good idea. That was further trauma to us because we felt every day we have a reminder now (crying).
>
> Oh, I remember when we heard that, I mean, the place just went on the rocks – "Are you serious" – like, and, we tried to understand where it was coming from, because, obviously, the patients wanted it. They felt it was going to help them.

In the absence of official communication from the organization to staff, and because there was ongoing mistrust of administration, intentions were misunderstood. Initially when the monument was placed, the laboratory staff thought that the organization had decided to create the memorial perhaps in part to punish staff for their role in ER/PR and to remind them of the organization's perception that they had done wrong, although clarity was later provided. "We could see when things were explained, but first it was … (crying) hurtful." Similarly, another staff member described her view that this is, "the organization's way of continuing to punish the staff." Staff have come to understand that the decision to create the memorial was outside the organization's control. However, they did not understand why Eastern Health located the memorial beside the main entrance to their workplace.

Two laboratory technology staff from the Immunohistochemistry Laboratory shared that although they understood that the monument was placed at the HSC because both the Immunohistochemistry Laboratory and the Cancer Care program are located at this site, they never enter or exit the building through the main entrance because of its proximity to the monument. They described efforts to find alternative routes of travel to and from the building to avoid the daily reminder of the hurt and pain of ER/PR. Another laboratory staff member said that she only goes in the main door in the winter when the

monument is covered with snow, "when it disappears, completely covered, that's the only relief."

Figure 5-2: Graces Memorial partially obscured by snow

5.6 After the Storm

ER/PR, like any severe storm, left damage and significant memories for those who lived through it. After the Cameron Inquiry report was received and new mechanisms were put in place to respond to the recommendations of the report, including instituting Ontario Laboratory Accreditation standards within the organization, the work for those Immunohistochemistry staff who remained[62] continued. They were directed to create procedures and guidelines that reflected enhanced quality processes. Those staff who had stayed through the Cameron review period understood the importance of the recommendations as part of the organizational plan for laboratory medicine. Simultaneously the organization was recruiting new management team members for laboratory medicine. In addition, government had created the Provincial Office of

[62] Several Immunohistochemistry pathology staff did not remain in the department after the Cameron Inquiry report was released; this is discussed further in Chapters 6 and 7.

Adverse Events (POAE) (see Chapter 4) which required annual updates about the progress of achieving the recommendations of the Cameron Report. The POAE had a staff member hired specifically to act as a liaison with the health authorities, whose role was to contact the NL Health Authorities each year and obtain a progress update. An immunohistochemistry staff member described the struggle in not achieving the required progress in following the recommendations of the Cameron report, when she recalled: "then Cameron was coming back for their yearly thing, and I was going, 'No, we're not doing this' and 'No, we're not doing that' and 'No, no, no.' "

A staff member described periods of reliving the events of the Inquiry, including the months leading up to the Inquiry. He believed that:

> When an adverse event happens and the organization doesn't support the person, they end up devastated, and that support would've looked from the beginning—like, people acknowledging that this is difficult. I can catch myself … I can ruminate for an hour and just relive … "I should've said this. I should've said that. I should've said the other thing." Like, I can … and I catch myself and I have to stop and say, "Okay, stop, that's enough of that; I can't go down that road," but I'm down that road before I even realize I'm down there.

He reflected on the difference between collegial support and organizational support, in his perception of events surrounding the Inquiry:

> [Name] and [name] never went on the stand, but they carried the weight just as if they did. [name], I mean, she was there for me. Like, it was the same crowd that came to support me over there when I was on the stand. … You know, like, it was just great support, but it was them. It wasn't any of the other crowd [referring to the organizational leadership].

A QRM staff member described what she believed is the key element of her experience, as described in detail earlier in this chapter, "there's a couple of things … the key thing, though, is that they made the decision not to defend us and never told us. So I'm like a fool, given all this stuff." She reflects on moving forward:

> You know what … I can't get rid of it. I don't know why I can't. I know I get frustrated because I can see it coming again. I can see it coming, and we're going to have another thing and it's all going to come … it's all going to blow up. Apparently, we'll never have an Inquiry again, but stuff will blow up and there'll be all this inner turmoil and all that, and I find that frustrating because we never learned from it; but, you know, I should be just saying, "Shag it," and move on.

Another staff member, summarizing her experiences, described the trauma and finally the future as she sees it, in the wake of Cameron:

> Through all that I gave this my all. Like, that was it. It's a terrible thing to say, but this is as good as it gets for me. … I did it [work related to ER/PR] every night, every weekend … I sat in that office and I did … whatever – for what – for absolute what? … This is not who I am … I mean, it was just ... it was hard what happened to me, and then it's hard what happened to ... [referring to her co-workers], we were all broken.

Several participants, reflecting on their experiences, shared a common perspective that the organization did not learn from the events that occurred throughout the ER/PR testing scandal. They believe that, as a result, staff have suffered further disappointment and staff morale has suffered further. A staff member described her perspective of how some individuals were left to shoulder the blame:

> After ER/PR … that's when we started noticing the difference because from an ER/PR issue … there was so much that we could've learned from that issue that we didn't. It … boiled down to people did the wrong thing in the lab and [QRM] did the wrong thing with a number of people and the disclosure and stuff, and it was our errors and move on. It became focused on individuals. Absolutely, and, really, when you look at it now … we have never talked about it. We have never had any kind of lessons learned or anything like that from it, except when we did it for optics during the Inquiry, and then even that got tossed, so we just didn't learn from it. So, how could we even grow?

Many staff who had endured the entire process of ER/PR subsequently left their respective disciplines, moved to other positions, resigned, or retired early, reportedly having felt unsupported, criticized, humiliated and publicly shamed. Others were removed from the organization, removed from their positions or given alternate

assignments, for what was perceived by the staff who remained to be an inability to work effectively within their respective roles.[63]

This chapter has provided a comprehensive perspective of the experiences that staff described in ER/PR and the Cameron Inquiry period, including insight into the ongoing pain and suffering that staff report. There are a number of key factors that shaped the experience of the staff: communication; blame; power; support; being given status as *rightful knowers*; and management behaviour. The presence or absence of these factors will become more poignant in the next chapter, as experiences in the years following ER/PR are examined.

[63] People who were removed from the organization, their positions or given alternative assignments included front-line staff, management staff, as well as a number of senior staff and government officials – individuals at all levels of involvement were affected.

CHAPTER 6

After the Storm: The Question of Safety

I joined the organization in the summer of 2009, just a few short months after the Cameron Inquiry report had been released, and it was clear that while the storm of ER/PR had passed, the memories were vivid. The 618 page, two-volume report was given a prominent place in many Eastern Health offices. The Client Safety Reporting System (CSRS) had not been in place long and staff were integrating the new policies and organizational expectations around reporting and disclosure into their work in a variety of ways. Some staff were using their direct experience of the outcomes of the Cameron Inquiry, having been directly involved in ER/PR, in the way they integrated the new policies. Other staff were using their indirect experience of having been a staff member of Eastern Health during that period, or having heard about the organizational responses to ER/PR and other adverse events, in the way they integrated the new policies. This chapter examines the experiences of staff in the months and years following ER/PR and the Cameron Inquiry.

An adverse event report within Eastern Health follows a certain predictable path from the identification of the event to the closure of the report, but the permutations of the experiences of staff are too many to count. When an incident occurs within Eastern Health that may or may not have resulted in harm to a patient, there is an expectation that the incident will be reported through the CSRS. Within the CSRS, the reporter of the adverse event is asked to provide details about the incident (as was described in Chapter 4). The reporting mechanism and the event itself create a number of activities involving

the reporter and people in the wider organization. When an incident is reported as a *Level 0*, which indicates a close-call (an incident that did not reach the patient), the manager of the program/service area is notified by email that an incident has been reported and the manager is required to review, investigate and document his/her recommendations. Quality and Risk Management (QRM) is also notified of every incident and the Quality Clinical Safety Leader is available to assist the manager to examine the incident. There are a number of close-calls where it is appropriate for staff to notify the patient and their family, such as in the case of a potential future error due to similar circumstances, for example, two patients with the same name. Other close calls may involve staff reviewing organizational processes or equipment use.

For an incident reported as a *Level 1 or 2 -- Low/Minor* (an incident that reached the patient but resulted in no harm), again an email notification is sent to the manager and QRM. An incident reported as a *Level 3 or 4 -- Medium/Moderate* (indicating an event that resulted in harm) results in the same email notifications as above but, in addition, may require a concise investigation and thereby involve more staff in the resolution of the event. The medical director of the program may be asked to review the standard of medical care and the Quality Clinical Safety Leader may meet with staff to further examine the details of the event. An incident reported as a *Level 5 or 6 -- Serious/Severe* (indicating an event that resulted in near death or death) results in email notifications to the program/service manager, Quality Clinical Safety Leader, QRM director, QRM risk management consultant, program/service director, clinical chief, vice-president for the program/service and CEO. Every individual notified or having access to the CSRS for a specific program/service can review the incident report.

The activities that result from a *Level 5 or 6* incident are complex, involve multiple players, and can extend over several weeks. These activities typically include several meetings with staff, program leadership and the patient and their family. The patient, if they have survived, and their family may be invited to pose questions that will be used within the review process to examine the incident, with the expectation that at the end of the review they would receive feedback on their queries. The incident may result in media reports and government health department staff involvement, up to and including the Minister of Health. The types of activities described are activities that staff are aware of and in some cases have experienced.

The chapter begins with the identification of an adverse event and then continues with different perspectives within event experiences including the perspectives of management and front-line staff, namely the second victim, other staff, program managers, and program leadership. The experiences are examined through the lens of the staff and program management and leadership.

6.1 Identifying an Adverse Event

Before an adverse event can be reported, an event must be recognized and understood by staff as an unexpected outcome within a planned action. Depending on the experience of staff, an outcome that has happened repeatedly in the past may be understood as commonplace and therefore not unexpected. In these cases, staff are usually not concerned about the event or harmed by it. However, when an adverse event is identified and staff identify personal responsibility within that event, the second victim experience is possible. The lived experience of staff within the reporting and subsequent organizational processes can magnify the second victim experience. An adverse event

predictably involves many people within the scope of the event, from report to closure. And each individual experiences the event in a unique way; how other people and the organization respond to the individual is also unique or experienced in a unique way.

A nurse cried while she described a medication error that had happened a few years before. She described feeling physically ill when the adverse event was identified:

> I nearly fell. I still have the weak feeling thinking about how I felt. It was just this sick, sinking feeling. … [I]t was like the room just started spinning and I just felt like I was going to be swallowed up in a hole, and that's what I wanted to do.

In addition, she described the intense disappointment she felt that she had made an error, "Oh my god, what have I done and how stupid … how stupid to have done that." She recalled feeling such distress at having made an error that, in her words, "could've potentially killed someone" that she took a sick leave and never returned until over a year later. She explained her impression that when she came back to work "it was all forgotten by that point, except by me, and I've never forgotten it to this day." She reported her discomfort that the patient underwent procedures at the time of the medication error for which an explanation was never offered:

> [I]t was never disclosed to that patient. No … or to his family … Nooo. You just gave him orange juice. Said, "Drink this up." Gave him dextrose in his IV and said, "We're going to give you a bit of IV fluid now." "We're going to poke your finger every half an hour. Don't worry about that." Yeah, and he never questioned it and, yeah, don't even remember any family being involved … No.

The nurse retained a detailed memory about the event, even after several years:

> I remember where I was, what the patient looked like, where the other nurse was, where she was standing, the feeling … and every time I go to that unit, that room … I'm, like, "That's where it happened." Yeah, [I] have never forgotten it.

In her description of the event, she used the expression "sticking like glue" to explain her ongoing recall about the details of the error, a reality she attributes to the potential

seriousness of the incident. She explained, "I could've killed someone … I almost ended this man's life through my own negligence or lack of attention. … So when I go back in that room, now, I get the same physical feelings I had at the time." At the time of this study, now many years after the incident, she stated:

> Even describing it to you … I still sort of get that feeling like … it's like a queasy feeling. … It's like this veil comes down over you. Like, this dark feeling comes down over you … it's like your stomach falls in your boots, really.

She recalled feeling supported by her nursing colleagues and the physician, but had no recall of support from the manager:

> Like, I know I certainly never felt judged by any of the nurses that I was incompetent, and, I would've filled out the incident report and submitted it and that. The physician was very supportive … but, I knew that … I almost killed him; but, I don't remember anything from the manager.

The nurse described the concern that she has retained throughout the years of being judged as incompetent based on her error. Although she uses the incident as a learning opportunity for her colleagues and nursing students, she continues to try and assess how her description is understood by others:

> [A]s I tell people about it, I gauge their reaction too, and I'm thinking, "Do they think I'm incompetent? Do they think I was a good nurse?" So I do wonder. Some people will say "Yeah, I've done something like that too," right, and then others are, like, "Oh, I've never made a medication error." "Okay, then!" You know, so some people do judge you. "My god, how stupid was she" or yeah, you just feel judged. You just feel, like, they think, "Oh, well, you must've been incompetent."

When the nurse had the experience of being questioned about how it was possible to make such a mistake, she mentioned the patient. "Like, how could anyone do that," right, and I'm, like, "Well, you know, the patient stuck out his arm."

A very senior nurse recalled the experience of making a medication error and the adverse event being identified by the pharmacy:

> I gave a … narcotic … I'll never forget it. … [I]t wasn't picked up for a couple of days until pharmacy noticed that the count was off … the manager called me up and I was, like, "Oh my god," and I didn't realize that I had done it until … this point and, … it was horrifying to me that I had done it … I just felt horrible.

Another nurse described what was in her view, a poorly executed procedure, the result of which was possible harm to the patient. She described the event as something that "took a long time" for her to get over it. The parents of the patient involved were described as "mentally challenged" and she was unsure whether the care provided would have been the same in other circumstances. She described being "sure [that] the child had to have been mentally affected in some way." She recalled the incident as "a horrendous situation" but stated that she "didn't do anything about it, even fill out an occurrence. I didn't do anything, really, at the time. I was just shocked, and it was just horrible." Although the nurse was not certain of the outcome for the patient, she was focused on how "horrendous" the situation was rather than on the occurrence as a reportable event.

An adverse event is identified typically by the person who is directly involved in the event itself, but in some circumstances the event may not be identified until hours or days later or, in some cases, several months or years later. Most often, an event involving a single patient is identified almost immediately by the person or people present in the immediate environment. The experience described by staff begins at the point when they recognize or acknowledge that there is in fact an adverse event. Much of the work at the beginning involves coming to terms with the reality of what has happened and their personal role and/or responsibility as it relates to the event. Some staff reported initially experiencing denial or shock and described attempts to prove that there was no adverse event. Participants also reported that the work required in relation to the identification of

an adverse event often involves convincing colleagues that an event has happened and that it is reportable, as well as dealing with their own distress and emotional response to the event.

It is clear from the descriptions that staff experienced trauma, retained detailed accounts of the events and questioned their own competency, but how they experienced the decision of whether or not to report the events is less clear. Official texts (orthodoxies, in the language of Bourdieu [1977]) inform the requirement of reporting once an adverse event is identified and yet some staff described not following that directive. In this next section, I explore staff and management experiences about reporting adverse events.

6.2 Feeling Safe to Report an Identified Event

Reporting adverse events is also an important part of the experience of staff involved in adverse events. On occasion staff experience so much anxiety or distress in relation to an adverse event that they fail to report in a timely manner. It was clear to me from the reports of participants that this behaviour, perceived as avoidance or lack of reporting, may be a reflection of the distress the individual is experiencing. Participants described the reporting process as stressful and as creating angst about the possibility of punishment. They explained that reporting an adverse event is not usually accompanied by any support mechanisms or any enquiries about how they are feeling within the process. The response of the person receiving the report often sets the tone for the experience health care providers reported. Despite ongoing messages within the organization about CSRS being a patient safety reporting tool and not a disciplinary tool, staff continue to frame reporting as it relates to themselves. This was evident in the

language used by staff when they discussed reporting. For example, a nurse, noted, “I haven’t felt the need to write myself up which I totally would if I had to.” Other staff reported feeling criticized or “getting flack” for reporting or considering reporting. They described the types of statements that other staff tend to make when someone discusses a need to report, “What, are you looking for brownie points for how many you can file in a year?” and “Why are you filling that out? We don’t do that. Why are you doing that?”

A senior nursing program director reported that she was confused by the conflicting messages about staff perceptions of safety in reporting. On the one hand, staff would verbally report, when asked by her, that they felt safe and comfortable reporting, but when the results of an anonymous Patient Safety Culture Survey were examined the opposite was found. The program director reported that there was “a disconnect between what people say anonymously and what they say to your face.” She was referring to an incongruence in answers about comfort in reporting, when responding verbally if asked by a manager or director, compared to responses given in the anonymous survey. It is reasonable to expect that the most honest answer would be captured by the least threatening mode of enquiry. So if staff do not feel comfortable reporting, when it is an organizational requirement, it is reasonable to expect that they are not going to feel comfortable telling a manager or director when asked. Responses of participants imply that there was a self-protective mechanism that may have been operating when staff were verbally asked about reporting, that was not required in the survey. I felt that the difficulty that the director had in accepting the survey results as valid when she had asked the same question and received a different answer was an important observation. In her view, the discrepancy put the validity of the survey results in question.

A nurse described the difference from one manager to another in terms of staff comfort with reporting events. She made the distinction that the new "approachable" manager was likely to create an atmosphere where staff would bring things to her attention and try to address an issue:

> Staff are more open to her and more willing … to go to her with concerns.… [T]he new manager you … know that if she comes back and says no that she exhausted her options. So she's more approachable. She's more … supportive, and just seems more like somebody who cares, someone who understands. I think people are more comfortable.

A director described the process of conducting a quality case review and the response of individual staff in the context of the reporting and investigation processes. She noted that staff would often go home without reporting and then would later state, "I don't know what to do." A laboratory supervisor described her view of increasing staff comfort in reporting, and of the importance of staff involvement in the resolution of occurrences. She described her personal approach to making herself available to staff and identified the importance of support:

> I get a phone call. "I just did an occurrence. I just wanted to tell you about it. This is what happened" and I say, "Okay, if I have any more questions I'll come back to you. If you want to talk about it I'm here" – always open-door policy here if anyone has any concerns about any occurrence.

A pharmacy staff member explained that staff are deeply affected by adverse events and she described several avoidance type reactions, including "calling in sick the next day" or leaving the workplace for a few minutes or hours.

A nurse described the attitude of senior staff toward junior staff related to how junior staff perceive the importance of reporting. She related that junior staff seem to report more often and view it as "they're reporting an event." Whereas older colleagues

reportedly state "Oh, you don't have to waste your time with that" or "That's such foolishness to be bothering with that." She commented that she herself wondered how long junior staff would continue to report to such an extent before they also begin to say that doing so is "a waste of time." A laboratory supervisor described the increasing comfort in her particular division with reporting, although she recognized that this is a relatively new phenomenon that did not begin until years after *Cameron*.

> It seems like it's been better … Over the years people wouldn't put it in, … they just refused, but … now with encouragement they're starting to do it a little bit more … and now they'll even come to me and tell me they've got it done, so … that's a big improvement.

She also described the support-seeking behaviours that she saw in staff as they participated in the reporting system, such as calling her "to debrief what happened, just to get support." She further described how staff appreciate the opportunity to discuss the event, because in the past they felt they had "to defend their work or their action." She believed that staff now understand that adverse event management is "just looking at what went wrong and what could go wrong again, and preventing that." The laboratory supervisor further explained her actions to model a systems approach[64] to thinking rather than individual responsibility:

> So almost every day you have to demonstrate that "this is not about you; this is about what happened.… This is to prevent something from happening again; and if we can do that, we're helping somebody. We're helping another lab, because it can happen again."

[64] In the systems thinking approach, the focus is placed on the conditions where the individual works i.e., the system, rather than on individual responsibility or blame (Queens University, 2016).

Some participants described a cultural shift within Eastern Health in terms of more open discussions about events. A nurse manager described "disclosure," a term that she is using to refer to reporting as "welcome." The nurse manager explained that events were "hidden" and "[n]obody talked … people knew in little pods … that a significant occurrence happened, but there was never any discussion; nobody talked." But she reported that more recently "disclosure is more prominent … very important – big relief, I think, for the staff."

Fear, anxiety and discomfort were all described within the process of reporting, but the source of that fear remains unclear. It is important to note that in some cases the fear of reporting was a stronger motivator not to act than the organizational requirement to act – causing delays or failure to report. The perspective of management and staff differed according to the descriptions of reporting, therefore the remainder of this chapter explores in more depth these perspectives across the adverse event experience.

6.3 Differing Perspectives of Management and Staff

In what follows, I consider the responses to adverse events from multiple perspectives: those of second victims, other staff present at the event who also interacted with the care provider or patient and may be second victims themselves, staff who may not have been present but are aware of the event, and management and organizational leadership.

6.3.1 Experience of the Second Victim

A surgeon described an adverse event experience following a surgical procedure, whereby the patient died at home and the surgeon was not aware of the incident until an anaesthetist mentioned it. He recalled that he "didn't hear about this for a whole week. I

couldn't believe it … I didn't know about it." He described his own response and the response of the anaesthetist:

> That was devastating. I had to take a week off. I could not work that week … one of the anaesthetists said to me, "[name], did you know?" I said, "My god, no, I didn't know" or I would've … gone to everybody … "Did you know what happened? This is what's happened."

The surgeon recalled supporting the anaesthetist, who was "quite upset," by reassuring him that "it wasn't his fault." During the time of providing support to the anaesthetist, the surgeon continued to process his own feelings associated with the experience, examining and debriefing on the events surrounding the procedure, and seeking support to manage his distress. He described, in a voice filled with emotion, how the event was "very difficult" and "completely unexpected." He recalled getting support from surgeon colleagues, a family member and a nurse manager who was described as "very supportive" and who reportedly said, "These things happen … Did you do anything different?" He described this event as "probably the worst of the adverse events" that he had been involved in. He recalled feeling "like the bottom dropped out," reporting that he "couldn't think, couldn't concentrate, couldn't do anything else for that day at all." He described how he couldn't focus on his academic work, his office work or talking to students -- "couldn't do any of that. Couldn't talk to anybody, couldn't … process … I took a week off … I just knew I couldn't work."

The surgeon recognized the limitations of trying to provide safe care in the aftermath of an adverse event. When the event happened he explained that he felt unable "to listen to anybody or do anything that was safe to anybody." He described how "even just talking to patients, I wouldn't process the information properly. I wouldn't be able to

take any history and make any sense. Like, I knew that there was no way." He explained that initially he wasn't sure a week was going to be long enough. "I didn't know how long I might need for that, so I said a week." He recalled calling his secretary and saying "I can't work," and I told [name] what had happened, and I said, "I can't work next week." In addition, he recalled informing his colleagues: "I called [name of surgeon colleague] and said, '[name], this is what's happened. I can't work. … I can't,' and he said, 'No problem. I got your patients.' "

The surgeon also explained that the culture of managing adverse events has changed during his working life. The surgeon described his experience, as a resident, of not being able to acknowledge adverse events or the feelings associated with them because, "you weren't allowed to make a mistake, right, so you couldn't possibly be upset about it because you weren't allowed to do it in the first place, so it didn't happen." He described how difficult adverse events are even when the care provided is not an issue: "it's hard on us. … I was knocked over cold. … I was devastated by all that." He also explained that some of his physician colleagues hide the devastation better than he does; as he stated, "You wouldn't know he was devastated by anything, and only those of us that know him extremely well would pick it up." He further reflected on the change in the culture of adverse event management since he was a resident:

> [W]e talk about it … teach it. … We do debriefs after bad circumstances even if they're beyond our control because we want to make sure that there was nothing we could've done differently or should've done differently or, if we could've called someone else or done something else.

A paediatrician described the experience of rescuing a baby from near respiratory death, as a result of an adverse event, and the significant feelings that remain. She

recalled “the baby was in my arms and had stopped breathing. … At that moment my heart stopped because this baby probably would’ve died in my arms.” She recalled waking at night remembering the events:

> I still wake up in the middle of the night with that on my brain. Thinking, oh my god, if that baby had died, I don’t know if I would’ve survived.… I’ve talked to [another physician]. I still tell her, right, “Oh my god, that baby nearly killed me.” You know, let alone the baby dying, I nearly died.

A program manager described the response of individual nursing staff in relation to an occurrence where there was patient harm but not death, with a system cause determined. She recalled that the staff “were crying, upset, couldn’t believe it happened, questioned their own ability. It was very, very hard on the staff … that’s a significant occurrence, and needing to know, ‘okay, was it me.’ ” The manager explained that she supported staff by stating this is “no blame … we just want to find out [what happened] and prevent it from happening again.” But according to her recollection “staff did blame themselves … I mean, the patient had to come back … for another procedure which is putting the patient at risk, so there was a lot of guilt on their part.” She recalled that one nurse in particular had great difficulty moving beyond the event. The nurse had asked to speak to the Quality Clinical Safety Leader who was investigating the event, a few days after the nurse had been interviewed by the Quality Clinical Safety Leader, “because the nurse was unsure what [she] had answered or how.” The manager further described that this particular nurse had a difficult time; the nurse was concerned about who was responsible. The manager reassured this particular nurse and reported that other staff continued to seek support as well to answer their own questions. The manager made note that in this particular adverse event there were no ill effects for the patient, and yet the

event was "huge for the staff." She explained that, from her perspective, if the patient had been harmed it would have affected the staff even more negatively than it had.

It was evident from the descriptions of participants that, following an adverse event, it is common for an individual to exhibit protective behaviours toward other patients to shield them from someone who they believe was responsible for a past negative outcome. A nurse recalled caring for a patient at a time when the physician on-call was someone who, she believed, had harmed a patient in the past. She attempted an intervention with the patient to avoid needing help from the physician on-call; she recalled, "if perhaps some other doctor had been on, I would've said to the patient, 'Well, I think you need some help and I'll get Doctor so and so to come in.' " As a result of having been involved in a past adverse event, she was trying to protect her current patient from being subjected to a similar adverse event with the same physician.

A related concept to protective behaviours is the guilt associated with the sense of perhaps not having done enough to try and protect the patient. A program leader described her devastation after an adverse event when she felt that she should have done more to prevent a certain care decision, although she recognized that the decision was not within her scope of practice:

> [It] took a long time to get over the guilt that I was involved in a process like that, and that I knew what I had done from my job description I had done properly, but should I have said, "You're not allowed to"; and while … I had no right to make that judgement.… If I had put up a fight. Even though I knew it would've been fruitless, should I have put up a fight? I was devastated.

A nurse described how the experience of being aware of another nurse involved in a significant adverse event, who became a champion for patient safety, helped her to cope with her own adverse event and also to become an advocate for patient safety. She

recalled that the other nurse went to various nursing units and spoke to nurses; her thoughts at the time were that the nurse was "brave to face all those people," and that she was empowered by that bravery when she had her own adverse event. She recounted that the experience of observing the other nurse's behaviour at the time of an adverse event "gave … a bit of strength, knowing that someone had done this and … people can learn from me." She became a champion for patient safety by sharing her experience with other nurses and nursing students:

> I practically had it beat into everyone's heads. … "Look, guys, I made this mistake; you can make this mistake," because I considered myself a really good nurse, and to this day still do, but I was careless, so … I wanted people to know.

How an individual will respond to an adverse event is related to how the event is defined by that person in relation to other adverse events that the person has been involved in or aware of. An organizational leader referenced the phenomenon of "moral residue crescendo" described by Gingell Epstein and Hamric (2009).[65] He described behaviours observed within Eastern Health in relation to moral residue:

> If you have that exposure … to unfortunate situations … then you have exposure to it again and again and again.… You don't get back to point zero and start all over again … there's always a residue from the last time, and the next time and the time after that until it becomes breaking time when people just can't take it any longer. It accounts for why a lot of people experience significant personal emotional turmoil … which goes hand in hand with professional decisions to leave their jobs or quit or retire or use sick leave.

It appears from examining the descriptions of participants who reported having been involved in multiple adverse events that a cumulative effect was evident in the

[65] The moral residue crescendo refers to the effect when moral distress occurs that leaves moral residue and with repeated exposures to stress events the moral residue builds in a crescendo-like manner (Gingell Epstein & Hamric, 2009, p. 3)

experiences of Eastern Health staff. Following an adverse event, the level of distress may be so high that staff may feel unable to function. In the stories told to me by participants, there were several accounts of staff leaving the work site temporarily, stories of staff leaving the work site and never returning to that particular role, and reports of staff resigning or retiring as a result of the distress of the adverse event; without exception, staff I spoke with reported feeling traumatized, stressed or physically ill, and acknowledged difficulty in providing safe and effective care or completing tasks in an effective manner. Blame was also evident in the accounts of staff either blaming themselves for making an error or blaming themselves for not protecting a patient from someone they knew was practicing in an unsafe manner.

6.3.2 Experience of the Second Victim with Other Staff

A nurse manager described a plan to undertake multi-disciplinary quality rounds, with all staff, to examine the processes that contributed to an adverse event. Quality rounds are meetings with staff of all disciplines for the purpose of explaining the findings of the quality case review and providing staff an opportunity to brain-storm ideas about recommendations or policy changes to prevent future similar events. She noted that physicians were invited but none participated either in the debriefing or in the quality round to examine processes and improve safety. She reported that nursing staff were frustrated by the lack of engagement by physicians in the review process:

> [We] invited physicians also and … they didn't go, so that was frustrating on the staff … they found that the physicians were not involved, at that level. … So they [staff] did feel, like, "We're all here and we're trying to make a difference. Why are the physicians not here … any physicians?" so that was frustrating for them.

A nurse recalled an event that he believed would have resulted in unnecessary surgery for a patient if he had not recognized the problem. He had taken over the care of a patient and found that the patient's intravenous was not functioning and that therefore the medication the patient was supposedly not responding to, was not actually infusing. The patient had been booked for a surgical procedure based on the understanding that the patient had not responded to the medication. The nurse was describing the situation to the physician, in the context of asking for more time to resolve the problem before the patient was taken to the OR, when he was overheard by the patient care coordinator and asked to report the medication error in CSRS. He recalled his experience of reporting, his feelings of having to report, the potential risk of unnecessary surgery for the patient (that is, the harm that he believed could have been done to the patient had the nurse not intervened by discussing the medication error with the physician in charge) and the response of his colleagues to his reporting the medication error. The nurse explained that he felt badly reporting because he knew "what was going to happen," that "the person who had had the patient overnight was going to get in trouble, which is what happened." He recalled that other nurses had stated that he "should've kept [his] mouth shut and let the patient have [the procedure]." The nurse described how he did disclose the medication error to the patient and to the doctor and felt that was sufficient in terms of preventing the harms of an unnecessary surgery but, in his words, was "unfortunately" overheard by the patient care coordinator. He explained that once he filled out the occurrence report, the nurse was disciplined and he was shunned by his colleagues for having reported. He described feeling "terrible" because in his view this was "unnecessary surgery ... it was major surgery … there's always risk (of things going wrong in surgery)" and yet his colleagues

stated they preferred this outcome for the patient rather than reporting the occurrence. The nurse reported that he had tried to defend his actions to his colleagues, by explaining the position he had been in that had led to his need to file an official report:

> I just felt terrible that everybody was angry with me, and I had to explain to everyone, "Look, I didn't want to fill out this occurrence, but my PCC overheard me telling the doctor and insisted I had to do it, but I didn't want to do it."

He explained that if he had had a choice he would not have reported the occurrence because he knew what the outcome would likely be: "[I] knew what the outcome was going to be … for that nurse, and probably for myself to some extent," meaning that the nurse who had made the medication error would be disciplined, and he would be socially shunned for having reported the error.

The nurse recalled that the anger from his colleagues lasted for several weeks as different nurses found out about the occurrence report. He stated that he felt that his colleagues assumed that he was "deliberately trying to report somebody." He recalled being subjected to comments from colleagues at change of shift, such as "Make sure you don't [naming the incident] because you might get reported," or "There's too much of this reporting going on here. We can just come to work and do our job and just keep everything quiet." He described how "… it eventually goes away because someone else does something, and then they can move on to attack that person." Key to his telling of this story is that, in his opinion, staff were prepared for a patient to undergo unnecessary surgery to avoid reporting the actions of another nurse. What is significant about the story is that he describes a culture of resistance to reporting, including both his own resistance to report and what he sees as a general resistance by staff to report, and he frames that resistance in terms of a punitive health care system that perpetuates a non-reporting

culture. His description was echoed in those of other participants (described below) whose narratives of living through the experience of adverse events also describe a culture of resistance to reporting. That culture, in which reporting by staff is resisted through complex inter-personal coercion, shapes the experience of second victims. In this case, for example, the nurse who was rescuing the patient from potential harm became a second victim by virtue of the response of his colleagues to the reporting.

When an adverse event happens in one program area and staff from another program area become aware of it, even though there may not be any discussion of the event with the directly-involved staff, the other staff may be affected, according to several participants. A staff nurse recalled that "the nurse who was involved [in an incident] worked with us at one point, and this person was devastated. Didn't say anything. Never ever commented but was stressed and still had to work anyway." The staff nurse describing the incident felt that the affected nurse didn't feel "the support that they should've felt." She explained that the staff on the unit where the adverse event had happened were impacted, but she also explained that there was an effect on her floor, an indication of *being involved by association*. The nurse explained her impressions at the time of the event:

> … it was hush-hush … investigating what happened. I do know that the staff that were directly involved felt very vulnerable and not supported, and I know that it impacted both floors because it's our sister floor so it did have an effect. … It did play a role on both floors.

The nurse described how the work processes changed as a result of the incident. The program leadership reviewed the existing policies in the context of the event investigation and began to enforce old policies that had never been enforced, which she described as *a*

new standard. She described how staff on the unaffected unit were also disciplined for the same lapse in policy that had caused the event on the affected unit. Some staff of the unaffected unit became second victims of the event by virtue of their knowledge of the outcome for the staff on the affected unit and their experience of also being disciplined by program leadership. The nurse was likely identifying as a second victim, when she spoke repeatedly about the nurse whose career had possibly been affected:

> I just feel sad for the nurse who … the nurses who it directly affected – one in particular … because this person was such a good nurse … and to be so badly impacted … that this person would possibly change careers. Like, it was that bad.

A nurse described the difference in experience between reporting an incident involving a nurse and an incident involving a physician:

> I think you get less negativity if I report the doctor than if I report one of my colleagues, so it's okay for me to fill out an occurrence because the doctor did A, B or C … don't report your colleague but it's okay to report it if it was the anaesthetist or the doctor, and maybe they feel the same way, I don't know.

She explained that when a physician is involved in an adverse event and it is reported, then there is an expectation by nurses that physicians *should* experience a punitive consequence, but rarely if ever do. Note that this is in contrast to the expectation, described earlier in this chapter, that incidents involving nurse colleagues should not be reported because there could be punitive consequences. Not only was there a different attitude about reporting physician colleagues as opposed to reporting nursing colleagues, there was also a different expectation about consequences for the individuals involved. The nurse explained her perspective that reporting incidents involving physicians when there would be no punitive outcome is "a waste of time." She described her experience of her colleagues who she says believe:

> Nothing gets done about it anyway. ... This doctor has been here now for 20 years and we've reported 15 things on this doctor, and he or she is still there so why should I waste my time filling that out; nothing gets done.

In addition, she described the difference in her observations of novice nurses and more senior nurses:

> You have, a few nurses that are filling them out, or maybe the younger nurses … they haven't got the baggage so they may fill them out more promptly, but those of us that have been in the system for 10 or 20 years, it's like, "Oh well, like, this person's still here. He or she has had, 20 dead [patients] over their career. Nothing gets done so why am I going to fill that out?"

A nurse described the response of colleagues when she reported a transcription error that had put a patient at risk of harm and that, if not corrected, would have put future patients at risk of the same harm. She described the surprise she felt when her colleagues challenged her about reporting the incident rather than being concerned about patient safety:

> They were mad.… Well, they couldn't understand. They were indignant. Like, "Really, you wrote that up," … "Yes, I did …" I was actually shocked that the reaction was the reaction it was, because these are grown women and we're not in high school … there were definitely whispers in the hall.… When I get there, everybody disappears, so you know what they're talking about … and this is just right after the occurrence happened. … [I]t had to be written up.… You felt the animosity. They were angry and you could tell, but I'm pretty … like, I don't really care. I do care. That's a lie.

She also noted that this group of colleagues were not her team; she was working on the "other side" of the schedule.[66] The nurse reported that she was shocked by the reaction of this group of staff and explained that her experience with her usual colleagues would have been quite different. She defined this experience by the reaction of the staff rather

[66] The other side of the schedule refers to a staffing model where the staff are divided in half and each half works together and rotates shifts together. The staff usually only work with the people on their own side of the schedule.

than by the potential outcome for the patient. If she had felt supported, her experience could have been quite unremarkable since the incident did not reach the patient.

Another nurse was asked whether she felt that her workplace was a supportive environment and whether she felt that people received support from their colleagues. She responded "yes" -- if support "meant that things get covered up." She explained that in her experience staff are "reluctant to report things because they're afraid they're going to get in trouble or they're afraid it's going to make them look bad." And in other instances she reported that staff provided support by downplaying the importance of adverse events by stating "Ah, don't worry about that. That's no big deal. Sure, the patient is fine. What do you need to report that for?" She described how most often what she had:

> Seen more than not is probably a cover-up of things. Yeah, I think there's still this feeling out there – "Oh no, we'd better not tell them because, that'll show that we did something wrong and we could get in trouble" – so I think there might be a little bit of secrecy.

The avoidance of negative consequences, as a form of support, was reported as a rationale for not reporting adverse events or for covering up adverse events.

The experience of the second victim very much depended on the response of staff who were indirectly involved, involved by association or not involved in the event. When staff incidental to the event were in agreement with the way that an event was managed and reported, the response tended to be supportive. Whereas when staff incidental to the event were in disagreement with the perception of an event or the reporting of an event, the response was reported as hostile and critical. These types of responses, both supportive and critical, could be observed to continue for weeks or months after the event. Staff reported feeling vulnerable and not supported, they described fear of getting

in trouble or being perceived in a negative light, and they demonstrated that harm to patients can occur when there is a resistance to report.

Having considered the experience from the second victim's view, the next section considers the second victim experience through the lens of management.

6.3.3 Second Victim Experience through the Lens of Management

The second victim experience was explored from several vantage points within the organizational management structure. Consideration will be given within this section to the views of program managers, program leadership (directors) and QRM program leaders, and to how staff and managers experience this management view. The way that adverse events are experienced within the organization is dependent upon the lens through which the event is viewed and the person's proximity to the event. Management staff are most closely aligned with the experience of staff, whereas leadership staff have a more distant view of staff experiences. The QRM staff tended to have a more system-wide, organization-wide view of adverse events. This section explores the view from these various vantage points.

6.3.3.1 Through the Lens of Program Managers

A program manager described to me how staff experience adverse events and where and how support is provided. She provided her interpretation of adverse events in the context of staff as second victims. She described her impression that staff are "really traumatized, I think, by the whole event, and they demonstrate it in different ways, depending on the individual." She recalled two events in particular, and stated that in both events staff found it "hard to focus, initially, very traumatized … they almost couldn't [do] their day-to-day functions and tasks." The manager observed that staff

"seem to carry a big burden and … they don't really talk a whole lot about that." She described that in one of these adverse events there was formal support provided when staff were brought together and other support people were brought in "to help the staff people through [the event]." In her recollection, the process of formal support tended to "work a little bit better" but even despite the support, "within a very short time" staff moved positions or changed jobs.

The program manager also talked about the challenges faced by staff trying to garner support when they are unable to share confidential information in the context of their support-seeking behaviour, and the response of colleagues and the organization. She reported that in her experience she didn't think staff were able to get support from their families because "they couldn't disclose a whole lot." In her opinion, "that's where the facilitator really helped … because you'd be so stressed … on two levels – stressed with what was going on, but they also had to continue their day's work, on top of that; and then they'd go home." She recalled one nurse reporting how difficult it was to continue with activities of daily living: "just the thought of getting supper – [she] didn't want to do it anymore, and [she] couldn't cope with that." The manager explained that her impression was that because staff were unable to get support at home due to the confidential nature of the event, she "didn't see a lot of leave used in these employees because … the only support they got was at work." She reported "there was a period of time when, their productivity wasn't very good" but "management at that point used some extra assistance." She explained the work environment:

> I can't say they "weren't functioning." They weren't seeing as many [patients], and they were using time in the office to kind of heal, which we saw very valuable because they couldn't get it at home because … unless someone fully understood

> what they were in the middle of, because it was so severe that … your co-worker got fired.

She described how the staff involved in this particular event, which had led to the termination of their colleague, had had their confidence shaken, for example coming to believe that they weren't "as good a nurse" as they thought they were when they learned that their "documentation wasn't as it should be and they didn't do the reporting when they should have."

A community health manager described her perspective that staff never experience healing following a traumatic event. She described her personal experience of identifying a breaking point when trying to manage the stress of an event involving children being apprehended, in the face of comments from other staff who were only aware of the event through the media. She explained that since no one had ever talked to her about the event, she created "barriers" to protect herself, and then when staff made comments about the event, she responded in a reactionary manner by "snapping" and making a rude comment back. She stated "to hear that they 'did all that they could' was just like … hitting the … button of a time bomb that had been building for years that didn't really go away." When she tried to discuss the situation with a manager at the time but she did not get any support, she felt there was only concern for the facts and whether the program was "covered."

> I told him [manager] about the event, but that was it. It was concern with the factual parts of it and did we have our program covered, but there was never a discussion, no. Noooooooo, there was never a discussion at all to say, "Well, how does this make you feel," so you could add the personal element to it. That never did occur.

In this circumstance, she reported the response of the organization as not supportive, in contrast to the response of an external reviewer who had asked her how she felt about the event at the end of the review process. She reported some closure as a result of the reviewer's simple question. During our conversation she returned several times to the adverse event and used a variety of ways to describe how she couldn't let it go -- in her words "You're like a dog with a bone that you can't bury. It keeps coming back to the surface."

Another manager recalled a significant adverse event and described the process of managing the needs of the staff. She reported that staff were included in debriefing: "[Quality Clinical Safety Leader name] came in … and went through the whole process of the occurrence." She recalled that "the staff involved were very upset about the incident," but that, from her perspective, "there was no blame." She described how her intention with staff was to achieve several purposes: to "prevent this from happening again … to know exactly how it evolved … [and] can we make a difference?" She explained that it is important for staff to have "input into the solution" when trying to "solve the problem." Her assessment of the outcome of this event is that it was "really a group effort and group support that we did, and I think it's important."

The description by some managers of the second victim experience was similar to that of staff in two significant ways: adverse events are difficult and sometimes traumatic for staff; and it is important that support be available to staff at the time of an adverse event. It was clear that although some managers recognized the challenges of adverse events, they reported limitations in being able to support staff due to competing demands

and having to fulfil many roles within the adverse event management process which often prevented them from being available to staff.

6.3.3.2 Front-line Staff Experiencing the Managers' View

A staff nurse (Nurse A) described an experience she had had one evening, when she was working a night shift with her usual colleagues on a medical unit. A call bell rang; one of the other nurses (Nurse B) answered the bell and then came back after a few minutes; and then the nurses continued to go about their business. About 10 minutes later, a phone call was received at the nursing station. The charge nurse took the call, and then appeared upset. Nurse A assumed something was wrong at home from the charge nurse's expression. The charge nurse called out to Nurse B – the one who had answered the call bell earlier -- and asked, "What happened when you went and answered the call bell?" Nurse B responded, "Nothing happened, I helped him to use the urinal, came back here, that was it". The charge nurse then went on to explain that the patient's daughter had called to say that her father had just called her from his room to say that he had been assaulted by a member of the nursing staff. The family member reported that the nurse had tried to choke the patient when he had called for assistance with toileting.

Nurse A explained to me what she had understood from the event at that time. First, Nurse B had not been gone "long enough to have done any such thing;" second, the patient "had a little bit of dementia;" and third, the man "never had a mark on him." Nurse A further described her impression that "there was no way … if she [the other nurse] was going to choke you, you'd have a mark on you. There was no way that they'd examine you 10 minutes later and there would not be a mark on you, right?" She recalled that Nurse B ended up being sent home and that she (Nurse A) had been questioned about

the incident. She stated that "it was a pretty big deal for four or five days." Nurse A described the events that followed: "The managers were called in, it was a big investigation." Her description of the investigation included statements about the quality of the questions and her ability to be a reliable informant:

> They ask you all these … questions. … "I don't know what happened. I was on the other end of the hallway." "But what if" … I said, "But I don't know what happened. I was on the other end of the hallway." "Well, could" … I said, "But I don't know. I wasn't in the room so I don't know what happened. … They said, "Well, what about the privacy curtains?" I said, "I don't know if they were pulled or if they weren't; … Like, they ask you all these kinds of inane questions, I find.

Nurse A further reported that Nurse B was off for several days and then, when she returned, "it was just never discussed again."

Her general impression of the investigation of incidents is that "things get reported and investigated that are so silly, just so over the top." Despite working in an environment where dementia is a common occurrence, she stated that:

> you would think that the management would understand and the patient care coordinator would understand dementia a little bit … nobody takes their side [referring to the staff], it doesn't matter what anybody complains about here, they never come down on our side. [They] always end up … coming back and, "Well, you never did this" or "Now we're going to do this." They never say it's tough.

The nurse stated her opinion that despite all the communication, in the wake of Cameron, about the reporting system and the importance of reporting, "the management are still reacting the same way they've always." She stated that "staff morale is really poor … a lot of people, they just feel unappreciated." In addition, she explained that in her opinion the current climate is one where staff are afraid and where, instead of reporting, incidents are being concealed:

> People are actually afraid to report the silliest little things because they're so afraid of being punished or suspended or getting in trouble … Morale is just …

> ooh, it's unbelievable … They're very afraid of stuff going down, afraid of losing their jobs, being suspended, being investigated by their licensing bureau … just basically doing whatever we need to do just to cover so we don't end up, being disciplined at some point … which is a terrible way to be trying to practice.

6.3.3.3 Through the Lens of Program Leadership

A program director described the quality case review process (outlined in Chapter 4) and noted that a quality review is initiated when there is significant patient harm. She expressed the feeling that "it's very stressful for frontline staff, whoever is involved, whether it's a physician, a nurse, [or] a pharmacist." She acknowledged that the review process usually involves the whole team, since an event does not occur in isolation. The program director explained that a review process is rarely initiated over an "individual competency issue." She reported that she has been involved in "lots" of quality reviews and in her experience "it [is] never related to an individual's practice. It's related to the systems and the supports that are in place, and it's usually a team [event]."

The program director reported that it is challenging for people to recognize their contribution to an event. She used the example of physicians having difficulty recognizing their contribution to an error when it is reported by nursing. She stated "[i]t was a bit of a challenge in [program name] to actually get physicians to see when there was a nursing error how they contributed to it, but … it is a team and it is a team response to any of these issues." She also observed that staff respond to the stress they are experiencing by avoiding completing the report and reaching out for help in the days following an event:

> [T]hey went home and didn't do it, only to call their manager the next day and say, "I didn't do it. I don't know what to do. Can you help me, walk me through it," and they'd come back in and their manager would coach them.

The program director explained the process that is initiated when a critical event is reported with a severity rating score of 5 or 6 (defined earlier in this chapter):

> So that immediately would trigger … which is a death or permanent harm … an investigation by the manager or by the leadership team, depending on the occurrence. So … myself and the chief and the quality [clinical] safety leader would have a discussion; ask the manager to do a quick review of the patient's chart; talk to the people involved [referring to staff].

She noted that the initial examination is preliminary to determine "the lay of the land" and whether the event is "preventable." After the preliminary review, a decision is made about whether the incident has met the criteria for a quality review, and then the manager and Quality Clinical Safety Leader are asked to do an investigation. Again, she acknowledged the stress involved in the review process:

> That's very stressful for everybody involved. So they [manager and Quality Clinical Safety Leader] would … interview … all staff that were involved, the patient or their family members … if the patient was still alive, other patients in the room, other staff, physicians involved, that kind of thing, they would gather evidence for us [the quality case review committee].

She also described a process that occurs in professional practice and HR, at the same time as the quality case review, to examine whether the behaviour of the staff meets the standard of care. The program director viewed her position within the quality case review as removed from the investigation but leading the examination of evidence. The program director relayed that the difficult piece for the quality case review committee is communicating the review results to the patient or their family, and she specifically named support of the patient and/or their family as an element of the responsibility of the committee:

> I guess what I found … the difficult piece for us is … it was our responsibility to meet with the family to communicate the results of the quality review and to help support the patient and/or their family through this whole process.

Beyond the committee's distress in relation to reviewing an event, the program director reviewed the various levels of distress experienced by people within the adverse event and review process. She demonstrated contradictory messages when just a few minutes earlier she explained that these events "never" related to an individual's practice, and then in the following description of the factors that contribute to distress, she named the possibility of going "down the discipline route" which is indicative of problems with an individual's practice:

> [F]rontline staff are obviously very distressed because it may go down the discipline route; or even if it's not a discipline route, it's, very stressful because there's been an adverse event to a patient which we've deemed could be preventable. So that whole investigation piece is stressful … on the manager and the quality safety leader because it's just a very highly charged environment, and they're trying to get the facts only and keep opinions out of it and keep the whole process running.

The same program director explained her view of the role of support and her belief that the key to achieving an open and healthy environment for disclosing errors is to offer critical incident debriefing:

> One of the things I learned quickly in [program] was that … if it's really bad and if staff need support we offer them the employee and family assistance program. We offer them counselling – this whole, critical incident debrief … supporting our staff through this along with the patient and their families is key to, I think, to having an open, healthy environment for disclosing errors … it's a process.

Critical incident debriefing is an intervention that could be offered by the employee and family assistance program staff and is usually used somewhere in the organization about once or twice a month. The program director explained that even though there was anger expressed by staff and frequent dissatisfaction expressed by patients and families about the quality case review approach, she is comfortable with the process:

> Sometimes staff are really angry because we're perceived as accusing them … and they're not happy with this process. Lots of times the family and/or patient aren't happy with the outcomes because we're not blaming someone and disciplining someone, so it's a whole balance, but … overall, I'm very comfortable with the process.

The program director described the process of the quality case review and the position of the manager within that process. She explained her belief that the manager is in a good position within the quality case review since the manager does not sit on the review committee and is therefore at a distance from the review process. However, she also explained that the manager does the investigation and gathers information from staff, which would indicate that the manager is indeed an integral part of the quality case review process. In addition, there is an expectation that the manager will support staff, which is very difficult when the manager is in the midst of an investigative role. From the program director's perspective, the process is "better for the manager because most of the time they don't even sit on the quality review team. They do the investigation. They feed the information to a group that makes recommendations." She explained the manager role as often having "to implement these recommendations which are difficult," but from her perspective the manager role "doesn't pit them against the staff. They did their investigation. They collect the facts. Someone else is reviewing it all from a systems-wide performance." She explained that "managers are part of the team who's helping to fix this problem."

The same program director described how the experience that the manager has within the quality case review process "depends on the experience level of the manager." She stated that a new manager can be "very traumatized … very, very traumatized because they don't understand the process and they can't see the light at the end of the

tunnel, but the more experienced the manager is … the more comfortable they are with the whole process." Further she explained that "it's a lot of work for a manager; and if it doesn't turn out well" it can be difficult. She also described the complexity if there is also "a discipline piece" which in her view is "very difficult because you're trying to say we're looking at systems and improving systems, but then you also pick up a breach of standard. It's very difficult because it gets very muddled and they're never always separate, unfortunately." As a director, she recognized the need for support, but at the same time described how the manager who is expected to be the support person for staff is also leading an investigation. So, in essence, the unspoken plan within the Quality Case Review guidelines for staff support depends on the manager. However, managers have such a complex role within the review process that they are unable to support the staff.

I believe there are several important observations to make about the role of the manager within the quality case review process. First, there is a conflict of interest which makes it difficult for the staff to seek support from "the investigator" despite the ongoing identification of the need for support in the context of adverse events. Second, as long as the manager is involved in the investigative or review process it is very difficult for the manager to support staff despite the identification by the organization that support should be provided by the manager. Third, managers report moral dilemmas when they have to watch their staff being disciplined for something that was a systems problem. And finally, the managers are not at the table where those disciplinary decisions are made, but they are the ones who communicate and follow through on those decisions. It is not surprising, then, that so many staff reported feeling unsupported. The program director described her perspective about support:

> I think we can do more around providing support to people when they're going through this. The manager is looked to be the supportive person for staff, but when they're leading an investigation, it's really difficult. They can't support staff … because they're in a conflict they're trying to keep their distance and not judge, so I think in that aspect we can have better supports.

So her final statement "we can have better supports" is an acknowledgement that the organization, from this director's viewpoint, does not have a solid plan to support staff. There are a number of observations that are important to draw from this statement. When staff describe their challenge in finding support they would not be aware that the program leadership are concerned but do not have a plan in place to ensure support. The managers who are involved in investigations and are identified as responsible for supporting staff are not available and there is no other plan. As well, the person in the position that is identified by the organization as the position ultimately responsible for ensuring support to staff does not feel there is a plan. It makes sense then that staff do not feel supported and struggle to find support when they need it.

Another director, who was asked about the types of supports available to staff in the context of quality case reviews, mentioned the critical incident debriefing program and said that it was no longer available, stating that although it existed until 2003/2004 it was "no longer an established organizational program." When I asked other organizational leaders about the program, it was described as "dissolved" and "gone by the wayside;" whereas another program director reported still using it. Program leaders who are expected to be able to provide the same types of interventions for staff differ greatly in their knowledge about the resources available.

6.3.3.4 Management Staff Experiencing the Leadership Approach

A manager recalled events when she challenged the outcome of a review because the organizational leadership planned to suspend an employee for an "honest mistake" that "did not harm a patient." The "mistake" resulted in a financial loss for the organization that the employee was prepared to pay back. The manager explained that the employer's plan was to suspend the employee and she described how she "fought that they not suspend her [the employee]" and the manager "managed to talk it down to an 18-month … letter on her file." She reported that "the letter did as much damage as a suspension would" since in her view the sanction was unjustified. She described her struggle as a manager "to mitigate this [decision] because I know this is a really good nurse. She had good intentions. She's remorseful. … I don't agree with it." The manager anticipated the outcome when organizational leadership makes decisions that are viewed as inappropriate; she recalled thinking at the time "if this nurse is suspended, we will never get disclosure again in this organization." She reported she was "willing to be suspended for her" to avoid the negative consequences for the nurse and her program.

The manager took on the role of trying to convince the leadership team (consisting of her own director and a HR representative) that the employee did not deserve a suspension. She expressed her concern about the impact that a suspension of an employee for an event that was considered "an honest mistake" would have on staff willingness to disclose in the future (using the term "disclosure" to refer to an employee reporting his/her own mistake). The manager was prepared to "take the suspension" to avoid a punitive outcome for the nurse. Although she tried to convince the nurse that the punitive action (the letter placed in the nurse's file) "didn't mean anything," the

manager's efforts to avoid this outcome indicated that she herself believed otherwise. The manager indicated that "there's a lot of things that we can do," referring to what managers can do to protect employees by negotiating with leadership or helping employees cope with leadership decisions that the manager does not agree with. The role of negotiation or protection in relation to organizational leadership is a critical component for understanding the adverse event experience of managers in Eastern Health.

6.3.3.5 Staff Experiences of QRM

The QRM program is intended within the organizational structure to act as a support program to staff at all levels of the organization from front-line staff to the CEO. Staff experiences of QRM, at the time of adverse events, are described in this section from several perspectives. A laboratory manager described the variation in responses between QRM staff in relation to investigations. She described the experience of working with me as the Quality Clinical Safety Leader for her laboratory division prior to the study. She explained that in the past, some QRM staff had responded to incidents in the laboratory with the laboratory staff feeling tense and as if they were "being investigated", whereas I had responded in a non-reactionary manner of "examining the facts." Both types of responses resulted in the outcome of understanding the occurrence, but the second type of response, as the laboratory manager recalled, "also left the staff feeling supported."[67]

[67] Bringing myself into the description as a staff member may seem to be self-aggrandizing, but the point – whether or not it is in fact true or just a participant being kind -- was too importantly illustrative to not include.

One of the recommendations of the Cameron Inquiry was development of enhanced processes within Eastern Health to manage adverse events and continued expansion of the QRM department, with increased staff and clear policies and procedures. As a result of this direction, adverse event management processes have become centralized within the QRM program. A program leader, who has been present in the organization pre and post Cameron, described what she said was the organization's "efforts to try and bring in service areas to take charge of things; there was a naiveté that we can have people in quality who have expertise to handle the issue." She further described her experience of the change in responsibility for adverse event management from program to QRM:

> Even though you were there when that event happened, you don't need to be bothered with it. You know, "We're [QRM] going to take it over. We're going to handle it. We're going to manage it," and a lot of it is just putting the spin on it, how we're going to describe it and that kind of stuff, so people who were hands-on to it, were never kept in the loop.

This program leader reported that in her experience, "people say … they really felt that they were intentionally cut out of it [the investigation] because the experts were called in to handle it so, [their] involvement was ignored, and [their] worries [were ignored]." In her experience staff were told "Well, we'll get in touch with you if we need you," but her understanding of the meaning of such statements was, "If we need you to give us more information for our sake or we need someone to blame it on."

She stated "the creation of the Quality and Risk Management department has produced a further *separation* [emphasis added] between the event and the people involved, including the manager." In the process of expansion of the QRM department and centralizing the responsibility for the adverse event management processes into the

QRM department, staff perceive that the adverse event is managed away from the program and away from the staff and manager who were originally involved. I believe this move away from the program is what the program leader refers to as "separation." This perception of separation has staff and managers, in the words of this program leader, experiencing "worry and torment" and "loss" in terms of involvement in the adverse event process. The activity that occurs as a result of the QRM role in the adverse event process, which the staff do not participate in, contributes in large part to the storm that surrounds the second victim.

The program leader reported that staff feel that the QRM program staff took the investigation of the event away from the people most directly involved and only asked for input when information was needed for the sake of the organization – to protect the organization, or if the organization needed someone to blame. As well the program leader described the staff's perception that the QRM program was "putting a spin on it," when referring to the way in which adverse events were described, a statement that indicated the staff's belief that the description would not necessarily be an accurate portrayal of the event. The perceptions of the QRM program described in this section demonstrate how a program intended to be a support program specifically for the purpose of managing adverse events alongside the program leadership team can be redefined based on the experience of staff.

It was communicated to me when I started as a Quality Clinical Safety Leader within the laboratory medicine program that staff had the perception that the QRM program had not been acting in a supportive manner. A laboratory leader went on to

describe the experience of working with my Quality Clinical Safety Leader style of investigation, one that I refer to as "collaborative incident analysis":

> What we had when you came on-board, it was … different … there was no reactionary kind of mode to it or tenseness. It was all about, examining the facts as they are, and then we'll get to some point to find out exactly … we might never find out exactly what a root cause for something was, but at least, we all sit down. We examine all the different facets and, helping us think through that.

The laboratory leader recommended sharing the model that I was using within the laboratory medicine program.

The opportunity to integrate knowledge about the outcome of an event weighs heavily in the experience of an adverse event for a staff member. Equally important is the opportunity to be informed about the management and organizational response to the event. The role of QRM in analysing and reviewing each event, facilitating a system view and sharing that analysis back to involved staff, is important for ongoing engagement in patient safety. I believe staff who are making an effort to follow the organizational expectations and report adverse events are not aware of how their efforts are contributing to patient safety when the decisions and learnings of the organization are not shared.

6.4 A Reflection of ER/PR

The experience of the organization in adverse events since ER/PR continued to be reminiscent of the experiences of the staff during ER/PR. Although the organization was now responding to events in a much more prescriptive manner, one participant described how "management are still reacting the same way they've always [done]." Despite policies that describe a desire to view all events from a systemic perspective, the overwhelming impression by health care providers that I spoke with was that there continued to be staff who were penalized for events that were described as systemic or

"honest mistakes." Management and organizational leaders reported that staff are no longer afraid to report and that staff enjoy the processes of quality case review and quality rounds; and yet, when staff had the opportunity to speak anonymously within a survey or candidly within this study, they reported that fear still exists and reporting remains difficult.

The experiences reported to this point describe the perspective of the second victim. Many participants also described their impression of how other staff would be expected to experience adverse events. This next section gives voice to how participants perceive the experience of others in adverse events.

6.5 'Othering' Adverse Events

It was common in the narratives of this study to encounter perceptions -- and often misunderstandings -- about how *others* experience adverse events. The others, for example, may be other disciplines, other specialties or other programs. It was common for informants to describe adverse events as more significant, stressful or traumatic from their disciplines' vantage point or based on their own specialties' limitations in resolving the issue. The experience and perception of the adverse event seemed to depend on who else was involved and the response of those *others*.

A physician in a medical sub-specialty described his perception that other specialties (that is, specialties other than his own) were less impacted by adverse events, because the events were perceived as expected and therefore less significant. For example he described his perception of surgery as potentially dealing better with adverse events since they expected adverse events or they were able to correct their incidents without anyone knowing about it. By contrast, he described how in his speciality his perception

was that, “we might be a bit wound up more tightly about adverse events than our surgical colleagues.” His perception was that a surgeon would say, “That was a potential outcome and it was on the consent and we move on.” He also made the distinction that a surgeon could keep adverse events confidential, whereas a physician in a medical specialty could not repair the problem and would therefore have to request the help of a surgeon to intervene, thereby exposing him- or herself by revealing the adverse event:

> I don’t do surgery so I can’t deal with a complication that comes up in one of my patients. I have to rely on someone else to deal with that complication … so then someone else knows your mistake. … I don’t even want to call it a mistake. … They can know about your complication and what happened, whereas if a surgical colleague does the same procedure and there is a complication, they take them to the operating room and they fix it themselves. … [Y]ou’re not airing your dirty laundry out to everyone.

Although it appeared that the physician was describing the benefit of being able to keep adverse events confidential, he described the constraint of medicine having to involve surgery as a possible benefit, as it forced reporting and created a quality assurance environment.

In turn, I asked a surgeon to describe the stress of the responsibility of surgery and the feelings associated with an adverse event, so that I could compare it with the perception of the physician in a medical sub-specialty:

> The buck really stops when the surgery doesn’t go right with the surgeon. … If you perforate something … you’re the one that was working on it, and you always carry that … you don’t have an unloading. … “Well, the medication didn’t work” or “The disease was too severe.” … I think there’s a degree of burden there that you carry…. in your physical … manual dexterity skills, and that’s a very visceral thing; and when it doesn’t go completely as it should, there’s absolutely no one [to blame]. … It’s your patient. You are the one replacing the left hip. You made the incision on the wrong side.

Describing the feeling when something goes wrong in the OR, the surgeon stated "you get this kind of sick-to-your-stomach feeling or … I'd use words way worse than 'bad feeling,' but that's the reality of it." The surgeon described the dynamic of returning to the OR after an adverse event:

> You have to … this is done; this is over, and there's another one and you've got to try to distance [yourself]. I'm not saying it's easy. I'm not saying we all do it as well or as good as we could, but we try to.

I decided to clarify, with a second surgeon, the impression by the physician in a medical sub-specialty (described above) that surgeons are not significantly affected by adverse events. The second surgeon responded:

> Man, people have the wrong idea about us, don't they? No. Nooo, it's not just another day. We always strive to never have a complication. I mean … at least that's what we all do as surgeons. We all aim to never have a complication, and you can't possibly meet that expectation, but you have to try…. That's what makes it stressful, because it's kind of an unattainable goal. Which is why you wake up at night sometimes. … Things are swirling around.

A program manager described the perception that nurses held of physician engagement following an adverse event when a quality round was undertaken to examine the event. She highlighted what she described as "a little division, which is historical," referring to the division between nursing and medicine.

> None of the physicians came to the quality rounds so they [nursing staff] feel that they're not engaged. So the physicians are not engaged with the staff on that level, which is frustrating for the staff. So they get support from their nurse colleagues, but not their physician colleagues…. So that's difficult on their part [nursing staff], and [it] is not for lack of asking the physician group to be included, but it's just a little division, which is historical.

I believe that the othering of adverse events and the lack of insight into the perspectives of other disciplines and specialties is a reflection of the separation between disciplines both from an educational perspective and a practice perspective. It appears from the

accounts of participants that a portion of the distress experienced within the adverse event process may be due to some individuals misunderstanding each other's roles and responsibilities.

6.6 The Legacy of ER/PR

It is clear from the experiences described and analysed within these last two chapters that the experience of an adverse event can be a very personal event, a group event and even an organizational event. In Chapter 5, the experience of ER/PR was examined. Health care providers' accounts emphasized the feeling that individuals were assigned responsibility and culpability for that large scale adverse event. In this chapter (Chapter 6) the experiences of adverse events in more recent years were examined from the perspectives of second victims, including those far removed from a particular event and its management. The narratives of experiences of second victims illustrates strongly that the legacy of ER/PR continues to shape current experiences of adverse events in Eastern Health. The commonalities across experiences and over time provide solid ground to describe the second victim phenomenon as experienced in Eastern Health, an experience that may be easily applied to other health care settings in other organizations.

There are a number of key findings that remain important as this discussion moves forward. The experience for second victims begins when the adverse event is recognized and often involves shock, denial and the need to convince colleagues that an event has happened and is reportable. The response of an individual depends on their past experience with adverse events; but without exception, staff reported feeling traumatized and having difficulty providing effective care immediately following the event. The potential harm to patients was evident when resistance to report due to possible punitive

outcomes for staff created a non-reporting culture. All staff reported the need for support at the time of adverse events, but the limitations and conflicts that managers face in trying to provide support, with competing demands within the investigator role, make it very difficult to accomplish. Directors identified the importance of support mechanisms, however participant accounts indicated that there does not appear to be a solid organizational plan in place to provide support. Staff who shared in the anonymous survey about their comfort in reporting described how the fear and difficulty of reporting remain. Managers reported having to participate in disciplinary processes in which staff face punitive outcomes for system issues. And finally, the descriptions of adverse events by staff and management are incongruent. A key observation from the experiences of these participants is that the way in which ER/PR emphasized individual culpability at the expense of a system-wide consideration, shaped and continues to shape adverse event experiences within Eastern Health.

In the next and final analysis chapter I will describe the key features of adverse events -- specifically, support, blame and powerlessness -- that define the experience of being a second victim.

CHAPTER 7

Experiencing Adverse Events: Key Features

The adverse event experience is characterized by some key features that shaped the experience for the second victims of adverse events who participated in this study and allowed them to integrate knowledge gained from the experience into their practice. This chapter examines three key features shaping the experience of second victims of adverse events: (1) support; (2) blame; and (3) powerlessness. I will examine each of these three key features in turn. How these features were experienced in a positive or negative way was unique to each individual person and each event. In what follows, I examine the perception of support, since the importance of support as a definer of the experience of second victims has been named or described by most participants.

7.1 Support

Support can be categorized as occurring at three important points in time within the adverse event experience: prior to the event in the form of anticipatory support, support at the time of identification or reporting of the event, and support in the aftermath of the adverse event that includes the period from the beginning of the investigation to the final outcome. Support, or the absence of support, is a key feature shaping the experience of second victims in adverse events in this study. The work required by staff to realize support is very informative of the culture and relations of power within the organization. Support was described by study participants from the perspective of the person being supported and the person supporting; it includes perceptions of sources of support and perceptions of a need for support. The experience of being supported or not being

supported, the role of the supporter in the experience and the role of the organization in support are each, then, important considerations. Support will be examined in five different ways: the perspective of the person experiencing being supported or not being supported, in this case, the second victim; the role of the supporter; the role of the organization in providing support; support seeking behaviour and finally, planning for support.

7.1.1 The Experience of Being Supported or Not Being Supported

A senior nurse recalled her experience of support and her perception that nurses "today" are not getting support from management:

> You supported yourself and carried on. I think nurses are more vocal than we were. … We put up and shut up, because it was a culture, and I think today staff support each other more because they don't get support from above.

A nurse who worked permanent night shifts described the lack of support she had received in the past, a pattern that she expected to continue in the future:

> No, not at all – not at all – and I do nights, so there's no supervisor there; but I don't think if I was there in the daytime that [manager] would come up to me and say, "Are you okay? Is this bothering you? Do you want to talk about it? Can I get somebody?" No, I've never heard of it happening, not on any floor.

A physician described the experience of being responsible in the care of a patient who died unexpectedly and was so traumatized that her own safety was at risk as she drove home:

> I was involved in a major event … a death … it was incredibly traumatic. I remember leaving the hospital … and going through a red light and almost getting [into a car accident] because I was just in another world, thinking about what had happened.

The perception she had was that the nursing staff were well supported in the event but the physicians (staff physician and resident) were alone:

> [T]here was support on the floor for the nursing staff. … There was a lot of support around the nurse and nurses who were involved … grief counsellors … and I remember myself … and the resident we just kind of clung together because there wasn't anything … there was the Employee Assistance Program … but, at that point, I didn't even know that existed.

She was disappointed by the response of colleagues; she recalled:

> A lot of other physicians were aware of what happened … and it was like, "Ah, don't worry about it; you won't get sued," and I was, like, "Well, that's kind of the least of my worries right now," and it took a long, long, long time to get over it.

She described her own self-reflection at the time, as she wondered whether everything that could or should have been done was done: "you had to ask yourself – was there anything I could've done differently, that this wouldn't have happened." In addition she described her impression that if she had had someone to discuss the events with, "to talk it through" and talk about her feelings, the outcome for her may have been different. Unfortunately she did not receive the support of her physician colleagues, as their primary concern and focus was on litigation and not feelings or processing of the events.

> [T]here was … one or two physicians … their focus was on – is there going to be a suit – which was not my primary concern; but, still, that was where the conversation started and ended, they didn't want to hear about my *feelings* (uses sarcastic tone for emphasis)... when I thought it through … obsessively for about a year or more afterwards, there wasn't a whole lot I could've done differently. I don't think I could've done anything differently.

One physician, who had the experience of not having anyone to talk to following an adverse event, reflected on providing support to a colleague related to another event:

> I had looked after a patient who was subsequently transferred to another physician, and then subsequent to that died relatively unexpectedly, and the physician who was involved was distressed, and, I made sure … that I would talk to him on a regular basis about it because he knew I knew.

In this circumstance, the physician felt comfortable offering peer support because of her prior involvement with the case and the pre-existing friendly relationship with the physician in question. She reported that if the situation had been different, there would not have been the same opportunity to offer support and quite possibly the support would not have been welcomed. She described the importance of peer support for reducing the feeling of being the only person to have ever been involved in harm to a patient:

> There would need to be a peer support that would make you feel less like you were the only person in the world that had done something or been involved in something that resulted in somebody's harm … in harm to somebody, and … because there's a shame associated with it too, if you think you are actually culpable.

When examining sources of support for physicians, a physician clinical chief suggested that while the organization believes that the Quality Clinical Safety Leader in the Quality and Risk Management (QRM) program should be a source of support, physicians may perceive that the QRM department is organizational and therefore not a potential support to the physician:

> You don't think of the organization protecting your interests. Therefore, I think there'd be some … even if they knew that's who you're supposed to call, there'd be some reluctance to call. They're associated with the organization.

Another physician clinical chief described requests for support from staff in his program and the reactionary nature of managing events. He expressed his belief that staff just want the event to go away:

> The support thing has been more of a reactionary thing. There's a complaint lodged and I have to deal with it. As far as offering support … emotional support kind of things, not much. I think it's something that's needed and necessary, but I think for the most part it's usually that adverse events have a degree of embarrassment or humility associated with them, that they just want to make it go away and not have it happen again.

As well, he described a lack of formalized preparation to provide any type of support, although he alluded to *hoping* to have something to offer from his personal resources:

> I have no training in it. I mean, just... like, most of the stuff in this job is just hoping you've got something to offer because it's not really a job you're trained for. You know, you spend decades in school learning how to do something, but... This wasn't part of it.

Exploring the source of support as a potentially important determinant of the adverse event experience, a surgeon stated that he gets the best support from "somebody who has the same expertise." This surgeon explained that although other people, including family members, try to be supportive, it is not entirely helpful because of their lack of insider knowledge: "it didn't mean anything coming from [spouse] because she had no idea." For him, it was important that the person providing support understand the specific experience:

> She's never … held anybody's life in her hands either, which we do all the time without … not without thinking about it, but because you do it all the time it becomes your job. It's what you do, right; and it's only when you lose one you think, "Oh my god."

He described receiving support from colleagues with the same expertise:

> [Colleague] said … "You sounded upset. You don't normally sound upset. … I was worried." … It was good … he went through it first … it's funny, he knows. He went through the detail with me first. He said, "So tell me about that day. Tell me about the patient. Tell me what happened. Tell me. You know, did you do this? Did you do that? Is that your normal? Is that your routine? Is this the way it normally goes?" … That made me feel better. It did.

He reported on a similar approach taken by a second colleague:

> He said … take it apart. "Is there anything you would've done differently, anything you would've changed?" He had called me to see how things were going, if I was okay.

He described providing support to this second colleague in an earlier incident involving the colleague's patient:

> I had had to do the same thing for him. … We talked about it, and he said a couple of things and I think he feels he can come to me with that stuff. We talk it through.

The surgeon reinforced the importance of having support provided by someone who has the same expertise and understands the specific situation:

> Again, it's the same thing, right – somebody who knows what you do. You talk through the detail. You need someone who understands and knows the surgery, we talk about it, sometimes you just need to talk about it, and we do.

A laboratory staff member described her perception of receiving support, when asked "Who do you turn to or where do you turn to get support at the time of an occurrence." She responded, "Just amongst ourselves, really, and our manager. I mean, [manager name] was a really good support." A nurse working in a general medicine area described the support she received from her manager and others at the time of an adverse event, one that had been reported by the media:

> [Name of manager] was good. [Name of manager] was around a lot at that time because, obviously, when you need her she's there then; and what I mean by that is when we needed support, she was readily available there for us. … She's the one who got us all together, discussed it all with us.

When asked if the manager's support was unusual she stated, "No, it was just a natural part of her regular support to us. I would say it's natural because we've had a few issues. It coincided with other issues on the floor." A pharmacy staff member reported that she receives support from her co-workers, people with whom she has a long-term relationship and who understand the work:

> There are four of us [co-workers]… we tend to talk to each other. … So you build a relationship with someone you trust… we do the exact same thing… for us it works, I think because if we're crooked we know. It's a mutual understanding.

One of the limitations some health care providers expressed in the context of seeking support was the nature of information that was often highly confidential. A nurse

described the difficulty in getting support, “You kind of can’t go and talk about your day at home to your spouse or your friend or whatever, so you kind of got to talk about it there [at work] or when you come back [to work].” She further described the discomfort created when confidential information limited her opportunity to share her feelings:

> You go home sometimes and something bothered you … like, the other day there was a [patient] … [who] has a lot of deficits, … all that night I was thinking about, that [patient], but there was nobody I could talk to or tell, but then the next day I went back and I was, like, “My god, I can’t get that [patient] out of my mind from yesterday. I feel so bad for her and her mother,” … I had to bring it up again because, if not, it would’ve eaten away at me.

She also described the reduction in stress which resulted when she was able to discuss her feelings with a colleague who knew the patient: “that nurse had looked after the [patient] as well … so we just sort of had a little conversation about it, and now it’s kind of … the stress is a little bit gone.”

A nurse described another nurse getting support in the context of a team of trusted nursing staff, well known to each other:

> What [name] had going for her was that there was a half dozen of us who have been there, who may not have made a potentially fatal error, but … I’ve made a med error and my gut sinks, “Damn it,” … I think if I was working with somebody who I didn’t know or trust … I don’t think I’d be able to open up and discuss it. [E]ach one of us acknowledged, “It could’ve been me this morning.” It could’ve been anybody, but I think she’s very well supported, but it bothered her, it stayed with her.

This particular nurse who had received support was described as someone who became an advocate for policy change:

> She’s … the proponent of these changes in policy, she’s the one who will remind you, “Look, you have to check this.” Not just … “Don’t just give me an eyeball on the way past. I want you to see this,” and that’s a good thing. It made her hyper vigilant.

Others described getting support from friends and family:

> I'll say to my husband, "I need to talk about this." I think I do it more home. I just say to him, "Now, I don't expect you to solve this or have any answers" You can't fix it, so I'll just say, "I just need to vent."
>
> I have a couple of really, really, really close friends that … we may get together for a drink or something, and then I'll say, "This happened at work," and I find I [share] … more … outside of work.
>
> Well, they're not nurses. They're not medical people at all, and sometimes I think you're almost better off there because you just [talk] and they just say, "Oh that was terrible" or something like that.

Other nurses described how trying to share feelings at work tended to result in negativity and less than helpful outcomes:

> At work you sit at your coffee break and everybody vents and you don't feel any better afterwards. I think it's too much negativity.
>
> [Y]ou do it at work as well, but I guess I don't know that I expect support from my colleagues. I think they just listen and then they say, "Oh yes, this person is an idiot" … which … really, that's not the answer. … I think there is no answer. Like, not in the system that we have right now, there is no answer.

A nurse in the role of program leader explained that although the program had several mechanisms in place to support other staff and families, it was not usual to provide support to staff within her own program:

> If we feel that [other] staff are upset about something, we'll get ethics involved, and we … offer counselling. We'll direct families towards grief sessions … but we never look after ourselves. We always say, "If after seven days you're still crying, get some help." We bounce it off each other. We rely on each other.

She further described the way that stress was translated to the family environment:

> You know, there is a stress involved, and … everybody knows that after you … go through a process that's stressful like that, whether or not there's an adverse reaction, we may be a little bit *more bitchy*. We tell our families and they now know … that we will go home and probably take it out on our families.

In some scenarios, staff colleagues take the approach that an incident shouldn't bother the person. If colleagues do not recognize the event as troublesome for a staff

member it is unlikely that they will provide support. A nurse explained the responses that she had observed toward someone involved in an adverse incident:

> "You're crazy; get over it," or, maybe she's got one colleague who's kind of a little bit supportive. Maybe she's got, a manager whose, like, "Suck it up, buttercup," and to us maybe she was totally overreacting.

One nurse acknowledged the importance of recognizing that individuals will respond differently and that the need for support is potentially missed when someone is not present during the incident but self identifies as a second victim:

> [W]e have to keep remembering that her reaction is her reaction, and that's what we had to deal with, and, it's the same thing … you may be missing somebody who … you think, "she must be fine about that. She wasn't even there."

The perspective of giving and receiving support across disciplines was described by a senior nurse as limited by the realities of self-protective behaviours and trust:

> Sometimes … the residents will [share their frustrations] … they'll get a bit of support … from the nurses. You may get some verbal support from the residents … at 3 o'clock in the morning and we're all having coffee, but I think the nurses know very well that … although the residents might seem supportive, they would very quickly hang you out to dry if a situation arose where they needed to save their hide, so I think there's a lack of trust.

A physician described the process of seeking support, "Well, you're going to talk to somebody who's going to be compassionate. Choose carefully. … I mean, you pick who you talk to." He recalled getting support from another colleague in a different profession, in this instance, a nursing colleague. He described the support as a form of reassurance, "this has happened and it's unfortunate, but it does happen."

A physician claimed that someone who had experienced a complication or adverse event was more likely to be sought out for support: "You'd feel more comfortable talking about it to someone who is sympathetic because they've been in the

same boat." Another possibility for support from colleagues in some organizations is Morbidity and Mortality rounds.[68] One physician clinical chief expressed the opinion that Morbidity and Mortality rounds do not happen in Eastern Health due to "the concern for litigation," but also wondered if the absence of such rounds was due to "difficulty acknowledging adverse events." Another physician similarly described his experience with Morbidity and Mortality rounds and how he and his colleagues managed the need for collaboration and support:

> So there are presentations of complex cases, and that would be probably as close to Morbidity and Mortality rounds that you'd see in [sub-specialty] medicine. … I have one colleague who I'm very close with, so we talk about … so when I have a complication that comes up … I'll often run it by him, so we have like our own personal mini [Morbidity and Mortality rounds] … but I can't say I feel comfortable talking to all my colleagues about that.

Similarly, another physician suggested that, in his speciality, to contemplate discussing an adverse event, the person would need to acknowledge that it occurred ("the whole idea [of] not wanting to acknowledge the adverse events"). This physician explained that in his speciality "we sit down and tell people, 'You could have a complication by having a [procedure],' but most people think, 'Well, it's really rare that it's going to happen.' " His view is that the surgical program is more open about adverse events because they are expected to happen. As he described it, "there's a floor full of people … who have just

[68] "Morbidity and mortality (M&M) conferences are considered to be powerful opportunities for learning and reflection. Traditionally, the goal of M&M conferences is to provide a forum for faculty and trainees to explore the management details of particular cases wherein morbidity or mortality occurred. In carefully reviewing the records and specifics of care, a primary goal of these sessions is to revisit errors to gain insight without blame or derision" (Kravet, Howell, & Wright, 2006, p. 1192).

had surgery who got complications and abscesses and their wound breaks down … that happens and they [surgeons] deal with it and move on."

Reflecting on seeking support to cope with a stressful situation when the outcomes for a patient are not ideal, a physician confirmed that she was not necessarily looking for content expertise when looking for support:

> Someone who understands medicine … and doesn't necessarily know the expertise of my area … of my particular specialty … but understands the stress of having an unhappy [patient or] family. One of my [close colleagues] and I have offices [that] are quite close to each other, so that sort of helps to facilitate these kinds of conversations.

A laboratory staff member described the response of her and her colleagues at the time of an adverse event:

> We talk amongst ourselves. … I wouldn't say we share out[side the department] … anything that's happening to us … out to other labs or anything … we seem to be … containing it to [our] own area.

The importance of debriefing following adverse events was emphasized by many. A physician clinical chief described support in the form of debriefing following a particular adverse event, "everyone really … the bedside nurse … and the nurses in the [department] and the nurse in charge and the nurse manager and the house staff who were involved, so it was very unique and very interesting." This physician explained that the staff didn't recognize the nurse's distress until the actual debriefing:

> She was fluent and able to communicate her concerns; and I think, with talking and discussing and interacting and reassurance. There was no blame. You know, she hadn't been negligent in her duties. She hadn't overlooked anything, and I think she did believe us when we said, "Look, you really could not have headed this off. You couldn't have recognized it. Remember, we were all around you. No one else saw it either."

A nurse provided a thorough description of what an effective debriefing would consist of from her perspective, noting that this was not happening on her unit. She stated that the debriefing should involve all key players, including the anaesthetist, specialist, resident, and nurses. It should be led by the specialist, who should open the discussion with a general question about whether anyone present feels that something could have been done differently. She stressed that all those present should be given the opportunity to put forward suggestions:

> "This is how we could do it differently"; and if there were some system errors, you could say … "how can we improve that?" … [I]f the person leading it is good, you could work it into something where everybody learns from it, and we could do this better next time.

A nurse, with many years of experience, described her view of the limitations of debriefing with organizational leadership. She believed that if debriefing were to be done by management that it would turn into a review of the process rather than being a support mechanism:

> I think we do a fairly good job. Between ourselves. Nurse to nurse, I think if we did have a formal debriefing with management I think it would turn into a discussion of process. "Did we do this right? Are you feeling poorly because you don't think you did as well as you should? Do you think you were off on your CPR count?" I think it would turn into, an evaluation more so than, a supportive conversation.

She offered her experience of not seeing support being offered by the organization but acknowledged that she had never specifically asked for support:

> No, I don't see it, but I've never seen Eastern Health be emotionally supportive, and you know what, it may be there if I went looking for it. If I went to my nurse manager after that event and said, "You know what, this is bothersome" … I don't know what's out there. Maybe doors would open. Maybe it's just me having to go and look for it, but it's never been offered and I've never seen it.

Collectively, participants described their experience or vision of effective support as a prompt, respectful, voluntary and supportive venture that does not involve collecting information and is not part of any further inquiry. Some participants described the experience of receiving support while many others, in the recollections above, described not having the experience of receiving the type of support that would have assisted them after an adverse event. Having examined the experience of being supported, and not being supported, the role of the supporter is the next logical facet to be examined within the experience of the second victim.

7.1.2 The Role of Supporter

Whether or not the need for support was identified by a potential supporter was a critical determinant in whether or not the role of supporter was filled. A nurse described this dynamic:

> You may not be [supported] and you'll hear one nurse alongside another nurse say, "Oh, don't let that bother you. That's no big deal." It might've been a medication error where the person was a diabetic and you just gave them twice the amount of insulin that they should've gotten and one nurse may say, "That's no big deal. He'll be fine," and walk away as if that's a non-event.

Another nurse, describing how a medication error identical to the one described above had occurred with no harm to the patient, cried; this was three years later. She stated she had never really gotten an opportunity to talk about it because it was dismissed by her colleagues as a non-event.

When an event is acknowledged as worthy of attention, the response of supporters and support mechanisms will provide a potentially different outcome for the individuals involved. A nurse manager described her willingness to have a counselling professional

come in and speak to staff, but also emphasized her own "open door" policy for managing stressful staff situations:

> My door is always open. Anyone wants to talk, I'm always here. The other staff, I went to each of them individually who were involved and spoke to them all. "Are you okay?" "Is there anything I can do?" "Anything you need?" "Anyone you want to talk to?"

A pharmacy program leader described her approach when she provided support to staff:

> They do talk within themselves, and some of them will come and ask us for support, or I try to volunteer if they're having an issue; or if I walk by them and I see someone who is upset, I'll look at them and say, "Are you okay?" "Do you need to talk?" … A lot of times they use each other for support … once a week they'll use 10, 15 minutes to talk out a situation that's happened or … to see if they can fix it or come to a conclusion how to fix it, and then we try to help implement it.

The role of supporter may be defined in part by the potential supporter's experience of having been supported. A laboratory manager described the approach she took to provide support to front-line staff. She had worked with supportive managers, and she drew on those experiences when managing staff distress during events when large numbers of samples were being repeated by her own staff:

> I'm there in the background, so if they want to talk about it … I probably stayed, like, until 6:00 or 7:00. I probably went home, got something to eat, changed, and I came back then like until probably 10:00 or so. … I just wanted to let them know that I had their back and, even if it was just sort of an emotional support.

A pharmacy program leader described providing "anticipatory support." Prior to investigating an adverse event, she would approach anyone that she knew was directly involved and provide them with support before sending an email informing all staff about the occurrence.

> If I know the exact person I speak to them before I send the email. … I want them to know beforehand so they don't read it and go, "She's blaming me for that."

Sometimes staff would offer support to someone who they did not normally have a relationship with. A nurse coordinator recalled such an incident:

> I went up to ICU the other day, and it was the younger nurse who had looked after [name], so afterwards I said, "I know that was really rough and it was a lot to it, but you did a really good job," and she turned around and hugged me, and I didn't know this girl.

The role of supporter appeared to be able to be played by individuals in varying relationships with the person receiving the support. The important determination of the effectiveness of support is reported as openness to receive support and willingness on the part of the supporter to provide it. Having considered the experience of an individual receiving support and the role of individuals in providing support, we now turn to examine the role of the organization in support.

7.1.3 The Role of the Organization in Support

The role of the organization in providing support depends on whether individuals identify a need for support, whether the need for support is recognized and confirmed by others (including management and organizational leaders), and whether sources of support are available. The role of an organization in providing support is often refined over years of identifying the need for support and the role support plays in health care provider coping. For Eastern Health, the history of amalgamation has played a key role in shaping the provision of support. When the legacy boards in Eastern NL amalgamated in 2005 and became one organization (Eastern Health), the policies that existed were no longer in effect. According to a leader in the QRM program, the removal of policies resulted in the elimination of previously existing support mechanisms, and resulted in the

need for program directors to bridge this gap. A QRM program leader[69] related her impression that everything that any of the health boards had done before amalgamation, including any policies, was "out the window" -- "We were starting from scratch, and so we weren't continuing to build on where we were." She further described the critical incident debriefing process that was in place in 2003/2004 and how, in her words, it "dissolved":

> There was a set group of people throughout the Health Care Corp[oration] that were trained as critical incident stress de-briefers … they were a team and they were on call. So if something happened you could call one of those team members. … I saw it work really well. … But that drifted away because that team drifted away. It just dissolved and went by the wayside. We didn't have that resource anymore. So then it was all dependent on the program director.

She also reflected on the quality of the support resources available to staff in the current organization. "Inconsistent is the biggest thing I find, and inconsistent is not enough, and I can't say whether or not... like, employee and family assistance program and all that, whether or not that's going down the route of being helpful." A management staff member recalled her personal experience of receiving inadequate support following an adverse event in the current model: "being on the other side and seeing what resources were given me -- it's like that didn't even touch anything."

A nursing program manager explained that support and debriefing are most often organized by the management of the impacted program or, at the very least, with the approval of the program management. The determination of who is appropriate to be

[69] I use the term "program leader" or "leader in the QRM program" for the QRM staff to avoid participants being identifiable, since there are individuals who hold a specific title. The term program leader for QRM is inclusive of Quality Clinical Safety Leaders, Managers and Directors.

included is usually the decision of the manager and director, and occasionally that of the Vice President. Although other individuals who self-identify as wanting to be included may be welcome, they may not be aware of the availability of organized support or debriefing. Providers of supportive interventions with whom I spoke, including staff in pastoral care and the employee assistance program, reported that the availability of support is not widely advertised when an adverse event happens and so therefore uptake is less than what is desirable from the perspectives of both managers and front-line staff. In a very significant adverse event at the children's hospital, a staff member who had been very involved in supporting staff throughout the event recalled that he had not been invited to a debriefing, similar to the physician who described not receiving support when the nurses seemed to have been well supported. He recalled, "They had a debriefing, but I wasn't included. I just thought I would've been considered, you know, I was there the whole time." The description by the providers of support and this recollection by a staff member demonstrate two very different reasons for staff not availing of support. Low uptake can happen when the staff member is not aware an intervention is happening. Low uptake can also be the result of the staff person not being invited when the people providing the invites didn't know that this person needed support.

Several participants identified the importance of including everyone who felt the need, meaning that the opportunity needed to be widely offered:

> How wide are we casting the net … because a lot of times people's response is very individual; and while I may look at you and think, "Why would that bother you; you were barely there," maybe we're casting our net and we're catching who was in the room that day, but are we not catching the physiotherapist who dealt with this patient every day for a month, who wasn't there that day, who was maybe off that week, but, I think everybody should be offered the opportunity.

A senior nurse, when asked what support mechanisms are built into the process of dealing with the aftermath of an adverse event experience, replied that in her opinion there are no supports: "They [referring to Eastern Health] don't [provide support]. They do not, exclamation point."

This statement is very strident and accusatory in relation to the organization. It is important to note that while this sentiment was widely shared by the participants in this study, this study does not capture the voices of those who did not require support because they were not traumatized by second victim experiences. The focus of the study was the experiences of second victims of adverse events. Participants in this study are those who continued to feel traumatized (that is, those who are "second victims"). By contrast, those who experienced an adverse event but did not come forward to participate in this study may have felt adequately supported by the organization; or they may have felt that they had adequate support from elsewhere and therefore did not need formal support provided by the organization.

A nurse who was among the 'indirectly involved' second victims of an adverse event, described being given the directive to attend a child's funeral, an activity viewed by the organizational leadership as a supportive way to respond to staff distress. She recalled that there was no discussion about the desire to attend the funeral with those who were directed to participate. In this case the intervention seemed to reflect an organizational leader's mistaken perception of what support would involve:

> We had a child arrest. I was told the best thing I could do was to go to the funeral. I went. I didn't think I should be there. I didn't know the family. I didn't know the child. I felt like a fish out of water, but … everybody who was on shift that day went. The doctors, the nurses. I think administrative staff of the hospital actually went.

She further described her experience of attending the child's funeral, an activity that she perceived the organization thought would be helpful:

> It was not helpful to me. I don't think I needed to see the family suffering. I didn't need to see the grandma and the little cousins who were, four and five years old who were absolutely devastated. Aunts and uncles … the mother's best friend … everyone – I mean, it was just terrible, the most horrible thing ever, but I didn't need to see that. That stayed with me and it didn't give me closure.

The nurse recalled the feelings and perceptions she experienced during the funeral:

> God bless this little child, but I didn't know her. I didn't need to say goodbye and, again, I didn't need to see the family suffering … I felt out of place. I kind of felt like they were saying, "Who are all these people and why are they [here]" … this row of seats in the back, and it stayed with me. We were told, "You really should go. You need to be there." I think it was probably out of respect for the family that maybe we'd be there – that, we were still supporting them; we were still doing all we could for them.

She described how her preference would have been a chance to debrief, an opportunity that was never given:

> I would've liked some kind of a debriefing, a post-incident … I think we all should've been able to talk about. … I think we all should've been able to talk about that, people's grief reactions and … no opportunity, never. Never.

The program leaders that I spoke to were unsure how to effectively provide support to staff. One director described how organizational support could be provided by an "unbiased group," similar to the support provided during Cameron. As described in Chapter 5, the laboratory staff and others involved in Cameron would not recommend the model used for support in ER/PR. Another director described the dynamic created by the process of the quality case review and highlighted how the role of the manager and the Quality Clinical Safety Leader actually "isolated and alienated staff." The organizational policies indicate that the program manager would support staff, and yet this director felt the dynamic created by the manager's role is not positive for staff. In addition, she

indicated that the program manager and Quality Clinical Safety Leader are not available; since they would be conducting the investigation, and according to this director are in a conflict based on their assignment as "investigators". Clearly the staff who are expected to provide support (program manager and Quality Clinical Safety Leader) are not available and there is no other viable plan described. Without a clear plan for support this director was left hoping that in the end they "might feel alright."

The description by different program leaders of their uncertainty about how to provide support was echoed in the experiences of staff. When a nurse was asked about her experience of receiving support from her nurse manager, she recalled:

> Nil, none, no acknowledgement of what happened. If something had gone wrong or if the Intensivist who answered the code had questioned what was done or how the code was run, then we would've been interviewed by the nurse manager, but in terms of … offering support, nothing. I've never been, no [offered support].

In this scenario described by this senior nurse, it was possible that the program manager did not identify this event as adverse for staff since the outcome was not entirely unexpected, but it was the nurse's summary of "never" being offered support that was more telling.

A community health nurse described the sensation of seeing an event reported in the media and not having had any support from her manager. She described the support of an external reviewer who had provided her with some closure after not feeling supported by the organization:

> You're just standing there looking at the screen, and you're watching it with family sometimes. You can't make a comment … We don't look for a lot [of support]. I don't think it's a lot anyone needs. … But [for] someone [the external reviewer] to say … "My god, tell me how that must've made you feel," that was worth … that was it. And it works. It does. It works. It was almost like the book was closed then.

A relatively new staff physician summarized the impression of the support expected from within the organization following an adverse event: “So the word on the street is Eastern Health cares just about Eastern Health and doesn’t care about me. I need to call CMPA [Canadian Medical Protective Association], so that’s the first call.” A surgeon described the difficulty in seeking support from within the health care organization in terms of trust, “My perception is I can’t trust them so it doesn’t really matter if it’s true or not. I DO NOT TRUST THEM [loud voice]!” As was mentioned in the introduction to this dissertation, many participants, as was the case with these two physicians, personified Eastern Health, transforming the complex, large, multi-faceted system into “the” villain in the process of making sense of their experiences.

Inconsistency in the organization’s provision of support in adverse events comes through in the descriptions of staff, as well as in this director’s comments:

> People are embarrassed. … [I]t says that in the Culture of Safety Survey … they’d try to hide it … and fear of discipline is part of it too. It’s back to your *just culture* and it really bothers people too when … you’d have one negative experience in one workplace; and if the system is applied differently in another workplace, they don’t have the trust of the system, obviously, because we’re not all on the same wavelength when it comes to this.

In addition, this director speculates that an organizational leader’s ability to respond “depends on experience, support and mentoring” that the leader has received.

Some staff report that they are not receiving support in a timely manner or at all. Staff have speculated that the lack of timely support is because organizational leaders are not present 24 hours a day, seven days a week. It is clear from the reports of informants that, even when events occur over several days and when there are many leadership staff

involved in the management of the event, support is still not evident for many.[70] A pastoral care staff member recalled providing support to a staff member after a near fatal adverse event: "It was a nurse who identified that we were killing him because we were giving him the wrong chemo[therapy], and he was getting sicker and sicker." When this staff member approached the nurse to provide support, he recalled his own words at that time: "I just want to say thanks for what you did," and described to me his surprise at her response. The nurse had replied, "You're the first person to say that." No one had acknowledged her role in identifying the problem. The participant described the shock he had felt at the time, "thinking there she is with all these people around in the [name of unit] and nobody said, 'You did a good job to identify this.' "

An organizational leader, working in a support program, was asked to debrief with a group of staff following an adverse event. She reported that the program leadership behaved in a non-supportive manner in relation to her attempts to meet with staff:

> I've been involved in situations where I had a manager say, "You know, that's all grand, but you're going to have to do it on your own time," and it was really hostile. It put the staff in a very difficult situation. It felt very hostile … the way the manager spoke about it, and the director in the program … and I was ashamed of it myself – ashamed to be part of a management team where they were so insensitive.

A pastoral care worker described the outcome for staff of feeling the absence of support for themselves and their colleagues on an ongoing basis: "I would tell you morale is non-existent, and it's getting worse week after week after week. You can just see

[70] While this study sought an indepth understanding of a key informants' experiences, this finding illustrates the need for survey-type statistical research to examine the extent to which support is available or lacking for second victims. This will be returned to in the recommendations.

people are drained. They come to work; they leave." When support is not offered or provided either by individuals or the organization, then support seeking behaviour is required by second victims. The need to seek support and the associated difficulties accomplishing that was commonly described as a disappointing reality for many staff.

7.1.4 Support Seeking

Support seeking behaviour was very difficult for health care providers at all levels and across all disciplines. It was clear from the descriptions of disappointment when support was not provided that lack of support added to the negative perception of an adverse event for the second victim. All participants reported seeking the support of someone whom they trusted who would be supportive and yet they were seeking support for situations and events that involved highly confidential information about patients. The expectation of the organization was that supports were available to staff through employee and family assistance program or their professional organizations and they should seek support through those venues. What remained unclear was whether the organization was cognizant of the potential challenge that an employee faced trying to reach out for support from external sources, following a potentially devastating event. Most staff reported that they were unsure about where to get support, and so reached out to colleagues or family. Most described how they experienced support when the person understood their work and there was usually a predefined relationship that they described as a safe place to share.

Staff, in particular physicians, described feeling vulnerable in relation to support-seeking behaviours, specifically they identified fear of judgement about their professional competence. Edrees et al. (2011) would concur with this observation that, "in a medical

culture in which errors pose risks to performance evaluations and liability claims, it can be difficult for second victims to seek emotional support" (p. 102). Physicians also commonly reported that they sought support from a trusted colleague who understood their work and would not be judgemental. This strategy demonstrated the desire to avoid potential criticism or ostracism by colleagues, with Morbidity and Mortality rounds described as a possible vehicle for a negative outcome to occur. This experience of study participants was echoed in the findings of Silversides who reported that one physician described, "except for one or two friends, I felt abandoned by my peers, it was as if they thought what was happening to me might contaminate them" (2008, p. 309). Several physicians in the study shared the view that if a physician were to receive support in a nonthreatening environment, then that would reduce the feeling of being defensive and guilty, a finding also reported in Briefings in Patient Safety (2008):

> The fact is, errors are distressing for healthcare workers … but there was not a lot of conversation about providing support; promoting a non-punitive culture will facilitate these discussions; to be a safe and effective clinician, you need support after an error; being able to talk about errors will make clinicians less likely to make future mistakes because they will have learned from a process that is nonthreatening and as supportive as possible; you just need to give [staff members] permission to talk about their experiences; and it's much easier to go forward and change your practice, admit you made a mistake, and not do it again if you're not constantly defensive about it and feeling guilty (pp. 2-3).

Scott et al. in a 2009 U.S. study of second victims proposed that, "institutional programs could be developed to successfully screen at-risk professionals immediately after an event, and appropriate support could be deployed to expedite recovery and mitigate adverse career outcomes" (p. 325), an approach that would support involved staff without depending on their personal resources or experience to find support.

The ways that staff worked to receive support and the energy expended in support-seeking behaviours tended to define the adverse event experience. It was evident throughout the reflections of the events of ER/PR that staff repeatedly asked for support from various levels of the organizational leadership and finally described support only from family and close, carefully selected colleagues. There were numerous examples throughout the narratives of participants who sought support and spoke with a tone of disappointment when the support they sought was not forthcoming. Leaders in the organization described their disappointment in their colleagues when supporting staff was not a priority, and in fact in one instance staff were told they would have to obtain support "on their own time."

7.1.5 Planning for Support

Adverse events are a daily reality in most health care settings, with Eastern Health being no exception. Denham speaks of the moral obligation of the organization to support its employees: "Your employees are going to make mistakes because they're human, and they're operating in imperfect systems. Mistakes are going to be made, and it's our moral obligation to support our employees and support our team members when mistakes are made" (2007, p. 111). As described earlier in this chapter, managers were identified as the support network for the staff and yet, as one director described, when managers were leading an investigation it was really difficult for them to also support staff. So the organizational plan for staff support was earmarked for the manager who, according to the program leadership, cannot provide it.

7.2 Blame

Having thoroughly explored the various aspects of support and its role in the experience of second victims, it is now time to examine another variable within the experience -- blame. The role of support or non-support in the outcome of an event for a staff member was heightened when the staff member experienced blame, a perception frequently described within the study narratives. The next section of this chapter examines the specific instances and descriptions of blame reported by second victims and how those instances define the experience for the second victim.

Blame was reported from a number of perspectives. When an adverse event is examined and understood as being the responsibility of an individual or program there may be evidence of blame in response to that event. When an adverse event is understood to be the responsibility of an individual or program and that individual or program has difficulty accepting their role within the event, blame may be directed elsewhere. The projection of blame to a person or a program may be done directly or indirectly. Direct projection of blame is done in person or in writing directly to the person or program identified and allows the person or program the opportunity to respond directly. Indirect projection of blame is done through a third party such as a patient, family member or staff member or through the reporting process and does not provide an opportunity for the person or program to respond. The projection of blame can be done by an individual, a group, a program or an organization. In any case, misdirected blame, as described in this study, created difficulty for the blamed individual or program to reach any closure with the event experience.

Staff reported that they experienced direct blame when another person who had assigned the responsibility of an event to them was prepared to communicate that opinion directly. The blame observed by nursing staff was described as sometimes happening in a very overt and sometimes aggressive manner. One form of blame comes directly from the patient, sometimes in the form of a legal suit. Reflecting on the experience of having a suit filed in relation to an unexpected outcome, a physician specialist described how he had received a telephone message from the plaintiff's lawyer asking for information, prior to him having any knowledge of the patient's intention. He recalled, "I mean, it gives you a physical sensation when you listen to the voice message from the lawyer. The message was there for a few months. I kept it and listened to it a few times, but I didn't sleep that night." He found support and "a lot of reassurance" with CMPA and was given the direction to have contact with the patient and her family:

> [I]t's good to have someone who's reliable there to talk to too. The first thing he said is, "Did you go up and see her after it happened," and they had encouraged that. [K]eep the lines of communication open, and … go visit her on the surgery floor.

Indirect blame was a more commonly reported occurrence. In this form of blame, the person being blamed is informed indirectly, a dynamic that may be indicative of the discomfort of the person placing the blame. A physician reported an experience of blame in the form of a letter written by a group of nurses to her clinical chief, a situation described with evidence of pain and hurt, but with "no closure." She described "some finger pointing happening in the letter … which was … factually incorrect." She recalled that her clinical chief discussed the letter with her and she discussed it with the manager. She reported that "it was very unsatisfactory … to this day … it was never satisfactorily

resolved." This physician recounted that "the nurses who had signed the letter when they realized how I felt about it offered apologies such as 'We didn't mean to suggest that you didn't do your job,' etc., etc., so it was very unsatisfactory." She summarized the experience saying:

> It was horrible. It was terrible. It was a horrible experience … I think my worst experience of the whole situation was when I spoke to the nurse manager to whom this letter had gone, and … I realized she had not reviewed the chart … that was my lowest point. … and then I wrote a letter in follow-up and taking responsibility, apologizing for all the issues that had ensued and wanted to extend my apologies to any nurses who were harmed or … I never had any acknowledgement of that letter. There was never a closure, no closure.

Indirect blame also reportedly happened from a distance, when a department was blamed in the Client Safety Reporting System (CSRS) or through email. CSRS, similar to any electronic reporting system, creates the perception of distance from responsibility for the content, thereby allowing an opportunity to blame and criticize from afar. The staff member who reported the occurrence would in all likelihood never interact with the person being blamed or the program being criticized in the report. A pharmacy staff member reported that most CSRS reports to pharmacy come from nursing. I believe this observation was indicative of the reality that the pharmacy's work of filling prescriptions is almost entirely for nurses to provide to patients. However when asked whether or not pharmacy felt blamed by nursing, she reported:

> Yes … there is blaming. They'll actually … say, "You're always making mistakes; can't you get this right," so they're actually saying.… "There needs to be someone made to fix this. You need to fix it." There's a lot of that kind of wording.

When asked "Do you think the people would say the same thing if they were standing face to face or sitting across the table?" she said, "No. It's easy to be making statements

like that when you're not facing the person that you're accusing or that you're blaming." Because of this dynamic of blame and criticism within CSRS reports, managers reported finding themselves wanting to vet the reports before sharing them with staff, to protect staff from the harm posed by this type of communication. One manager described her approach to managing the criticism in the written text:

> Sometimes I'll take out some of the harsh wording and I'll only send some of the content with the recommendation afterwards. Sometimes, if it's not too harsh, I might let the whole thing … go, but you['ve] … got to read it and temper it at the time.

Several participants verified the dynamic of blame or criticism when the person who is blamed or criticized is not present. A laboratory staff member explained that in her department the staff "used to point fingers and yell, and now we just go to the other room and point the finger through the wall where the person is not there. Definitely so, yes." A nurse described how she herself has blamed other people when the responsibility for an incident rests with her:

> The person will never know they just got blamed. "The night shift should've done this but they didn't, and now we got to do such and such" -- but it wasn't that the night shift didn't do it; it's because you fooled something up.

Another nurse reported hearing staff blaming other people who were not present and able to respond:

> I hear that all the time from various people saying, like, "You're only still here because radiology doesn't want to do your thing" or that sort of stuff … The faceless radiologists, lab people, I think, do bear a lot of the brunt of this blame.

A pharmacy staff member reflected on how staff feel about the blame that they are aware is happening:

> I think … some of the staff get really frustrated when they are being blamed for everything that happens because they do get blamed for everything bad that

> happens. “That pharmacy’s fault”; and, we’re down in the basement. People don’t even know we exist most of the time … other than … because a pill is missing or whatever. “That’s pharmacy’s fault. They didn’t send your pills.”

Both the laboratory medicine program and the pharmacy program are support programs to clinical areas; staff in both programs reported experiencing blame either directly or indirectly. In each instance staff of support programs reported that clinical program staff were blaming the support program rather than taking responsibility for their own part in an adverse event. What appeared to be another instance of blame, was an issue of disclosure, where it was easier to blame the support program than to tell the patient the details of an adverse event. A laboratory supervisor described the case when a new laboratory staff member had received a serum sample from a department on the evening shift and proceeded to process the sample and provide a result. During the course of the evening another sample was received on the same patient and analysed, that analysis indicated an unexpected result. A second technologist repeated the samples and discovered the same unexpected result. According to two laboratory staff members the first sample had been drawn by the program staff too soon after the treatment was initiated which became clear to laboratory staff when the second sample produced an unexpected result. The physician involved met with the family and blamed the laboratory for providing an inaccurate result for the first sample, a sample which was the basis for the change in clinical care. In the words of one laboratory technologist:

> It was the sample. … but they’re saying we gave the wrong results … and the treatment was stopped based on that result so it was the lab’s fault … it’s easier probably for the clinician to not have to say, “We’ve mucked this up,” … because the patient died.

The laboratory investigation indicated that the analysis was accurate. Laboratory staff were feeling vulnerable because of the blame that was being directed at them and the fact that the disclosure to the patient's family indicated that the laboratory was at fault. In this case, the family was told by the physician that "It was a lab mistake" rather than the physician taking responsibility for his role in the adverse event. The supervisor described how "all fingers are pointing to us" but in her view "the family has a right to know … what happened. We hope they'll be told eventually what happened, what really happened."

Similarly, another laboratory supervisor, explained her impression that laboratory medicine is commonly blamed when other disciplines have made errors in collecting specimens such as labelling or handling the specimen:

> You phone the doctor and you say, "You're going to have to recollect this [name of sample]", you just feel in your heart that they're telling the patient that the lab wouldn't accept it … you're still thinking the people are holding the lab responsible … are we getting blamed; or if the nurse or someone mislabels a specimen or there's a mix-up … when it gets back to the patient at some level, they're thinking "the lab mixed up again."

When a systems issue is identified, the responsibility or *blame* rests with the organization, and that culpability can create discomfort for organizational leadership. The discomfort of organizational leadership may result in the deflection of blame to a staff member. Although there may be multiple factors involved in any one adverse event, the deflection of blame to staff members can be interpreted as misplaced and result in anger and frustration. A program director recalled a serious adverse event resulting in a patient death. The event was described to me as "a systems issue," however, the director reported that there was a breach of standard and, even though that breach did not contribute to the

patient's death, the staff members responsible for the breach were disciplined. Participants' described how when what appears to be a *systems* issue results in a punitive response from the organization toward an *individual* staff member, then staff are angry and, as in this case, may remain angry for some time. The director explained her response to this event and identified the probable cause of the staff's anger as being the punishment of staff, although her tone indicated confusion over why staff were still angry:

> We had an adverse event, a major adverse event where there was a patient death, and it was a systems issue we determined, but the staff on that unit are still really angry and mad, and we've offered employee and family assistance program. We've done counselling. We did quality rounds. We've done it all.

She described that the staff involved in the counselling intervention found it "really beneficial" but she further described how the anger may be linked to disciplinary action by the organization:

> [T]hey're still angry and mad at us because, we determined, I guess, that there was a breach of standard as part of our [investigation] … that didn't contribute to the patient's death, but certainly it was one of the factors and there was some discipline done so they're really angry still.

The director was open about the challenge she faces trying to effectively manage the anger that staff exhibit:

> I have not figured out how we resolve some of those issues. I think we have a really good employee and family assistance program. I don't find people avail of it enough. I find peer support works, getting the group together to debrief formally works better than sending an individual or two off.

She also acknowledged the possibility of "people's careers ruined over … an adverse event that … was a systems issue." Participants' reported that when they perceive that they have been treated unfairly, anger and frustration result.

A pharmacy supervisor recalled an occurrence that was indicative of blame being used to deflect responsibility away from a nurse. She believed it was easier for the nurse to blame pharmacy than it was for the nurse to take responsibility or disclose the truth to the patient. A nursing staff member had told the patient that the pharmacy was to blame for a delay in receiving a medication. The pharmacy became aware of this blame incident when the patient called the pharmacy directly. It was considered highly unusual for a patient to contact pharmacy directly when a nurse had blamed pharmacy for a medication delay. It was reported that pharmacy staff sometimes overheard communication by nurses to patients, communications in which pharmacy would be blamed. As unusual as these events were, they provided an indication for pharmacy of the ways that blaming was directed toward their program.

Staff in several different programs reported blame being directed toward their respective programs from other departments. For example, one participant described how an adverse event involving a laboratory sample had occurred and how, subsequently, a staff member in another program had discussed the incident with the patient's family, placing blame on the laboratory, without waiting for an investigation and a conversation with the laboratory program:

> [T]he doctors told the biochemist, "Yeah, the lab made a mistake," and we [the laboratory staff] have the proof there and, "No, it was not our fault," and they got up in clinical rounds and said, "The lab made a mistake," so, that's how everybody feels, and I think … Yes, that we will be blamed for everything. You know, doctors, nurses, we're being blamed.

When staff were subjected to blame, and blame was inaccurately ascribed to a particular staff member, it was not unusual to see the deflection of blame to someone else as a result. For example, in the context of a significant outbreak of an infectious illness on an

inpatient unit, the nursing staff felt that they were blamed for the outbreak based on the timing of a report released about handwashing. A nurse on the involved unit speculated, "What's to say it wasn't a porter that came and got the patient? What's to say it's not from when they came into Emergency before they came up to the floor?"

Experiences of blame also created generalized anxiety that extended beyond the actual event. A nurse reflected on an application for a new position that happened just prior to an adverse event. She explained that she thought she may not be awarded the new position based on her involvement in the adverse event, despite her assessment that there had been a cultural shift away from blame. She recalled that she had applied for the new position and then shortly afterward found out about an adverse event that she was involved in. She reported that her immediate response was "Gee, there's no chance in the world that I'm going to get that job now." She attributed her response to the "culture of blame," although she stated "we don't tend to be that way; I guess historically there has been more of a culture of blame – always trying to point a finger at somebody, right, and I think we are moving away from that." She stated "nobody tried to blame me, but yet it seemed like I was blaming myself." She described her fear that the incident "would change how people looked at me as a practitioner – as a professional."

Blame that is directed at an individual not only inflicts harm, but magnifies the harm that may have already occurred to individuals who are second victims of the original event. Participants explained that whenever blame was used as a mechanism to deal with an adverse event, they experienced unfortunate results -- results such as loss of trust among colleagues, difficulty interacting with other programs and services, anger and

frustration that are unresolved and feeling mistreated or misrepresented. These results can have long lasting effects both for an individual and an organization.

7.2.1 Unintentional Projection

It is evident from the study findings that sometimes blame is so engrained in an organization that behaviours exhibited and language used are not even understood as blame. Unintentional projection of blame to other staff and patients is an example of how blame can become a part of the fabric of an organization. In describing a wrong-site surgery, an OR nurse, although not consciously blaming anyone for the event, mentioned both the surgeon and the patient. She explained that "the physician got consent for the wrong side:"

> [The patient] was awake and, included in the conversation. Still didn't voice any concerns about what we were doing, and we even had him rolled up so he could see the side … and then when he woke up in the recovery room he told them that … we had operated on the wrong side.

She described how she had created processes for herself that were to act as a safety net to prevent such an incident, but she discovered that her safety net failed:

> I had thought that based on how I conducted myself in my work in talking to the patient, and in checking the paperwork … and, I had my own … hurdles that I had to go through … if I couldn't get past that, well then, we didn't move forward. So each one of those was going to be something that would stop me from being part of a wrong site surgery for sure.

The nurse described her disbelief that the incident had happened when she recounted that a couple of days after the incident, her manager sought her out and informed her that she had been "part of a wrong-site": "And I'm like, 'No, no I wasn't.' She's like, 'Yes, you were.' I said, 'No, it must have been the drugs in recovery.' " The nurse recalled her resistance in accepting the facts about the incident when she stated, "I didn't believe her

and it took an awful lot of effort on her part to convince me that it was true." In the process of describing the circumstances of this surgical incident, the nurse again mentioned the patient, stating: "I just thought that there was no way, if my patient was awake and I was confirming with him verbally what we were doing, that there could be a mistake." Even in the face of overwhelming evidence to the contrary, she continued to question whether the incident had in fact happened. She recalled that she checked the patient's chart:

> I wouldn't believe her. I went back [to] … his chart … and looked through the history, found the clinic notes – and then sure enough, "Yeah, yeah, you're right." … like, I told you I felt … all the checks and balances were in place … in my mind it could not happen to me, right, but it did.

She struggled to accept the facts she found in the documentation:

> It made me want to throw up… even when I looked at the documentation in Meditech … your mind does funny things to you. They didn't have right or left spelled out. They had like … an "L" or an "R" and I tried to convince myself that that was what we did.

And finally, after talking at length about her disbelief and the fact the incident had happened because the checks and balances had failed, the patient was mentioned again in what this nurse considered the summary to the story: "The bottom line is he consented for the left side and the lesion was on the right." Similarly, in an incident described earlier in this chapter, a patient who was given insulin by mistake was unintentionally blamed when the nurse reported, "Well, you know, the patient stuck out his arm."

7.2.2 The Language of Incidents

The manner in which language is used can be an important indicator of culture and power within a specific context. The phrases, "being reported" and "reporting someone" were evident in the conversation with a pharmacy program leader. She

described incidents involving the pharmacy program in two ways, either "they're reported" or they "report someone else." She stated they never "report someone else, they never do it unless I specifically tell them [to]." I was particularly interested in the use of language about "being reported" and "reporting someone" because these concepts seem to be intrinsically related to blame. The perspective of staff was very interesting because the organization described CSRS as a tool for reporting adverse events and identifying systems issues, not reporting behaviour or people. I pursued this avenue of enquiry by asking whether this pharmacy staff had had experiences where she had felt *reported,* as an individual; the answer was "yes, often." The pharmacy program leader described her efforts to avoid staff taking on misplaced blame because she believed the result may be "pharmacists walk[ing] out" or "quit[ting] over it." She also described the range of responses by staff, "I've seen pharmacists that are reduced to tears sitting there" and "I tell [other staff] about it and they don't care [about being blamed]." She stated "the ones that you worry about are the people who do care" and she described how she has attempted to create systems learning:

> So you try to make it a system. Let's figure out how the system failed. How did it fail you? Is it because we have these two products too close together, they look too much alike? Can we fix something? So that's how we approach it – so try and take away the internalizing.

The same pharmacy leader stated that "most of our staff are really good about telling on themselves." So although she explained that "we don't have a punitive thing … we don't treat it punitively," the descriptive language used to depict reporting was punitive. She also described an incident in which she demonstrated self-blame and used

punitive language toward herself when referring to reporting the adverse event. She described the event as her "biggest mistake":

> I was devastated. I almost quit, Oh god … I remember where I was standing doing it. … I remember everything about it, and I even remember that I happened to be in the office faxing off the casual slip when I found out about it, like … But two of us did it wrong, so when you think about it, it was a shared blame but I took it all on because I was the last hands on it.

She described reporting the event to her manager, "I went and told the manager because I always tell on myself." She described the trauma of the event and walking out of the department:

> I remember just sitting there, and I just said, "I got to go," and then I walked out. I just left. … I said "I can't do this" and I left and they didn't think I was coming back. Like, I walked out screeching and bawling. I went home.

When asked about the word *blame*, she said she blamed herself: "Yes, indeed I did. I was angry." Note that her anger was directed at herself. It is evident that individual responses to the requirements and experience of reporting varied between staff and was understood in varying ways by staff and management.

7.2.3 Harming in the Process of Teaching

One of the responsibilities of the QRM program is training about disclosure (as was discussed in Chapter 4). In the context of that training, scenarios of previous adverse events within the organization are often used to demonstrate the key principles. Examples are held up as evidence of staff becoming champions for patient safety or used to demonstrate the kinds of activities to avoid. In either case, staff who were involved in the events and had been traumatized reported being further harmed by these teaching moments. Staff described being required to sit through multiple presentations with the same examples being repeatedly used, examples that referred to incidents that they

themselves had been involved in. They reported that these learning sessions made it impossible for them to put the experience behind them, and that they were being repeatedly harmed by reliving the event over and over again. In addition, they sometimes had to listen to the interpretation of the event by people who, in all likelihood, did not fully understand the context nor realize that the person being discussed in the case scenario was in the room. One nursing coordinator reported that, in the context of an organizational in-service, her staff member shared the distress of hearing again about an incident the staff member had been involved in:

> It was such a negative experience … when people use examples in quality presentations, I don't know if they're paying attention to the continued harm to the staff from hearing that example over and over … because I didn't know that she had been involved, and as soon as the talk came on … "Why do they keep using that same example? Can we just go past it?"

Again, it was interesting to note how long an incident may remain fresh for the person involved. As this nursing coordinator said, "I'd say … when [the story of the incident was used in a learning session] it's a number of years later … and it was that raw for her."

7.2.4 Fear of Blame

Aside from blame itself, the fear of being blamed was very evident in the descriptions by the participants. Fear of blame was reported when a staff member felt at risk for the security of their position, credibility or professional status. Often the fear of blame is not based on the individual's personal past experience but, rather, on hearsay from other staff who have been involved in adverse events. ER/PR created a substantial amount of fear in relation to adverse events, as most staff who were employed at the time experienced ER/PR as an organizational event and observed the fall-out. Those I spoke with who had been employed at that time reported that they have a fear of being punished

and that that fear stems from their experiences with ER/PR: moreover, they reported that this fear means that they are cautious about participating fully in patient-safety initiatives (As was illustrated in Chapter 5). As Leape reasons, the single greatest impediment to error prevention is "that we punish people for making mistakes" (Marx, 2001, p. 4). Fear of repercussion is reported within the literature as one of the key reasons staff do not report adverse events. Such fear is based on experiences of feeling blamed in the context of adverse event investigation and management. Wachter and Pronovost in a review of the Institute of Medicine's *To Err is Human,* report that, "Most errors are committed by good, hardworking people trying to do the right thing. Therefore, the traditional focus on identifying who is at fault is a distraction" (2009, p. 1401). Similarly, Paparella argues that, "Historically, the punitive approach to errors in health care has been to 'Name,' 'Blame,' 'Shame,' and 'Retrain' the individual(s) involved in the error. Instead of carefully examining the safety system issues that may have contributed to the error in the first place, staff are told to be 'more careful' and 'follow the five rights.' " (2011, pp. 263-264).

7.2.5 Absentee Blaming

Blame was described by both laboratory and pharmacy staff as having occurred in the context of conversations, in emails, in CSRS reports and through third parties such as patients or family members. The blame was often described as inappropriate or misplaced. Interestingly, blame often happened when the person was not there to hear it. A new term I have coined to capture this dynamic is "absentee blaming," meaning an individual is blamed when they are not present during the discussion of responsibility. This blame may be assigned by someone who knows the person being blamed but it may

also be assigned by someone they do not know and who does not know them.

Several informants reported instances of absentee blaming, when an individual was explaining a situation to a patient, and was trying to avoid taking responsibility for an event. The person would then explain the event by placing blame on someone who was not there to address the accusation. For example, a blood sample that was mislabelled or lost by nursing staff would be explained as a laboratory error; a physician who mislabelled a pap-smear would tell the patient that the laboratory made an error; or a medication that was late coming from pharmacy because the order was never sent, would be explained as a pharmacy failure. Managing this type of blame is quite difficult because the individual or program that is the target of the blame cannot address the issue and correct the patient's impression, and individuals within that program are left not trusting that colleagues in other disciplines will treat them fairly.

Wu (2000) has addressed this phenomenon in relation to physician blaming:

> In the absence of mechanisms for healing, physicians find dysfunctional ways to protect themselves. They often respond to their own mistakes with anger and projection of blame, and may act defensively or callously and blame or scold the patient or other members of the healthcare team (p. 726).

Support and blame have been explored from many positions within the adverse event experience. The perspectives of the second victim and of other staff and management, the role of leadership and the organization in those experiences and the reality of the pain of the second victim have been explicated. However, the pinnacle of the pain that the second victims in this study describe is the trauma of being rendered powerless by virtue of events over which they have no control.

7.3 Powerlessness and Resistance

Many of the stories recounted about the trauma experienced by the second victims of adverse events involved being caught up in something that was perceived as unjust and feeling powerless to address the situation. For example, some staff described the difficulty of whether to report an adverse event when doing so might expose a colleague to a punitive outcome. Others struggled with the difficulty of watching a colleague being disciplined when the event was a system failure. Still others described the difficulty of knowing that the patient or their family may never know the truth of what happened because physicians or the organization were being protected from scrutiny. Members of the QRM program staff experienced difficulty having knowledge of unjust situations, as they were party to information that seemed to indicate a systemic problem whereby, they felt, organizational welfare was placed ahead of the welfare of staff and patients. The difficulties experienced by staff were described by an organizational leader, who stated that situations where the quality of care is not what you feel it "ought to be, … becomes more burdensome and takes more out of everyone … until it becomes breaking time when people just can't take it any longer." He believed that the accumulation of knowledge of unjust situations resulted in "significant personal emotional turmoil … which goes hand in hand with professional decisions to leave their jobs or quit or retire or use sick leave." The themes of powerlessness and resistance emerged particularly in relation to discussions of being silenced in the context of the adverse event experience.

7.3.1 Staff Perception of Being Silenced

Within the period of identification of an adverse event, the silencing of staff was described as a significant dynamic that interfered with reporting and created discomfort.

The silencing of staff was reported as most often originating from colleagues who downplayed or denied the significance of an event, but silencing also reportedly occurred from superiors at all levels of the organization. Often the purpose of the attempted silencing was to avoid the reporting of an occurrence that may result in negative outcomes for themselves or staff colleagues. When staff were forced to acknowledge a reportable event the response often involved verbal attacks or shaming to reduce the likelihood of future reporting.

One nurse recalled an adverse event that resulted in a patient death, and the communication from the physician was that no one was to discuss the event outside the room.

> The baby was born. It was deceased, unfortunately, by this time, and I can actually remember – the obstetrician looking at us and saying, "You guys will not discuss this outside of here. This is as far as it goes. This will not be discussed" … That was a very traumatic event because the baby had been alive, all day, and now it had deteriorated to the point where it wasn't born alive.

It was clear from the physician's behaviour and messaging that this event would not be disclosed if the physician controlled the outcome. However, silencing was not reported as an issue when the description of an event involved reporting across disciplines (for example, when nurses were reporting events believed to originate with a physician or the laboratory or the pharmacy). Although staff held the belief that physicians were being protected by each other and the organization through silencing, the physicians themselves did not feel protected.

There are a number of ways that participants invoked the concept of being silenced, in a way that revealed that *being silenced* was also *choosing not to speak* – describing both being oppressed and effectively resisting the oppression. Staff

consistently described behaviour indicative of a lack of willingness to openly report in the CSRS system. They also described a lack of willingness to share their concerns about patient safety issues with their superiors both verbally and in the context of the staff culture survey. The reluctance to report in CSRS or share concerns involving adverse events did not seem to depend on whether an adverse event had already occurred or whether an incident would be considered a 'close call' or 'near miss.' As Morrison and Rothman (2009) detailed in their analysis of the power-silence relationship, power is believed to be the most important variable in silence. Staff were consciously withholding information or concerns from organizational leaders who might otherwise have been able to address the issues; this behaviour, which was on one hand the result of fear of being punished by speaking out (and hence, feeling silenced and unable to speak out), was one form of resistance to power (that is, staff were choosing not to speak out and choosing to opt out of the reporting protocol as a means of self-protection).

Employees who are in a subordinate position to another person experience a power gradient in the other person's favour referred to as a "power imbalance" (Morrison & Rothman, 2009, p. 112). This power imbalance is reported as *the* most important factor that makes employees exercise silence as a common phenomenon (Morrison & Rothman, 2009). The employees in this study were in a position of relatively low power and the managers were in a position of relatively higher power. While neither type of participant explicitly described their experience or their behaviours in relation to their position of power, both staff and management contributed to the silencing process consciously as a display of, and resistance to, power. Power works best when it is nonconscious and hidden from view (Bourdieu, 1977) – in this case the use of power, and resistance to

power, is even more complicated because people understand their role or status in relation to power and choose not to talk about it, choosing instead to underemphasize the role of power. Intentionally the employees do not speak about power: they specifically cannot speak about it because doing so is dangerous. Power works in subtle ways – neither the managers nor the staff articulated to me how power works (the orthodoxy of power, in the words of Bourdieu (1977); yet the use of power (including resistance to power as a result of feeling powerless) was made explicit over and over again in participants' stories.

There are two key judgements described in the literature as being at the root of employee silence: speaking up is futile and speaking up is dangerous. Both of these key judgements were evident in the descriptions of staff in this study:

> Nothing gets done about it anyway. … So why should I waste my time filling that out; nothing gets done.

> We didn't report and I know that was the culture: don't. You know, "We'll take care of it internally. Don't be reporting anything." We didn't feel safe. … It was dangerous because you or your colleagues could get in trouble. People lost their jobs.

Ashford et al. (2009) described that employees are reluctant to share information with people above them in the organization who might be threatening. An important dynamic about the CSRS system in Eastern Health is that any reporting within the system is automatically reported or shared with people above the person reporting, in the structure of the organization, by virtue of its functionality. As noted earlier, the report may be shared as far up the organizational reporting structure as the CEO. Staff who have been orientated to the use of the system would have received information about the way the reports are distributed within the electronic system and may weigh that knowledge in

their decision to report or remain silent. As one director reported, when staff were asked "Do you feel safe reporting an error," most people would say, "No."

Ashford et al. (2009) also described how leaders influence the use of voice by virtue of their leadership style. Several participants reported that their manager's or director's style of management was a direct determinant in their decision to remain silent in relation to an adverse event or the potentially inappropriate actions of a colleague in relation to patient safety. On the other hand, but having the same result, Tangirala and Ramanujam (2009) described that loyal employees may remain silent as a means to protect the organization. Participants in this study did describe in a number of scenarios remaining silent to protect their colleagues or themselves, but protecting the organization was never specifically named as a reason for silence. However, it is reasonable to expect that when staff were given direction to remain silent or not report an incident by their superiors, a part of the motivation may have been to protect the organization.

Despite the global move toward transparency and accountability in reporting adverse events and errors in health care, Jackson et al. (2010) reported that participants in their Australian study of nurses "felt that systems and organizations that they worked within conspired to create and enforce a culture of silence" (p. 2197). The experience of my study participants similarly suggests that in some cases staff feel that adverse events are not acknowledged as such, and that this may be related to a culture of fear that has developed as a result of past organizational responses to adverse events. Staff reported their perception that punitive actions as a result of adverse events are common within the organization, and that in some cases employees have been demoted or terminated from their positions.

An important concept to consider in the discussion of silence and powerlessness is the notion of *moral distress*, a term first introduced by Jameton (1984). For him, moral distress "arises when one knows the right thing to do, but institutional constraints make it nearly impossible to pursue the right course of action" (p. 6). Subsequently other scholars, including Hamric (2012) and Lutzén and Ewalds Kvist (2012), have explored Jameton's core concepts. Hamric concluded that moral distress is powerful and destructive to the moral agency and integrity of health care providers. It is clear within the narratives of the study that participants are experiencing distress of varying types, including moral distress. The types of organizational constraints that have been described in this study include: limiting the involvement of front-line staff in the review of incidents, failing to inform staff when an event has been discovered that involves their work, failing to communicate organizational activities in relation to an event, and failing to keep staff informed as an event is being investigated in terms of outcomes or decisions. All of these types of constraints keep the staff at arm's length from the event as they experience the distress of *not knowing* what is happening.

Participants' descriptions of an organizational behaviour of keeping the most involved staff from being involved in the event investigation are similar to the experiences described by nurses in the Grange Inquiry, when nurses reported not having been given a place as *rightful knowers* (Buckley Day, 1987, p. 31). In essence, the staff of Eastern Health who are deeply involved in an event feel that they are often not given a place within the investigation as *rightful knowers*. This type of marginalizing of staff translates into more distress on top of the distress of the original event -- the distress of not knowing what is happening. Many of the participants in the study described the

feeling of "wondering what would happen to them" and the feeling of "anticipating being blamed."

7.4 Summary

This chapter examined three key features identified as shaping the experience of adverse events: support, blame and powerlessness. Support, or the absence of support, was a key feature shaping the experience of second victims in adverse events in this study. It is clear that the ways that staff worked to receive support tended to define the adverse event experience. It is evident that staff repeatedly asked for support from various levels of the organizational leadership and finally described support primarily from family and close, carefully selected colleagues. There were numerous examples of disappointment from front-line staff and organizational leaders when the support sought was not forthcoming. Next, blame as a feature in the experience of adverse events was examined through the concepts of language, harming and fear of blame. Blame was experienced in a variety of ways including direct blame, indirect blame and absentee blaming toward an individual or a program. Health care providers described experiences of blame as creating generalized anxiety that extended beyond the actual event. Blame was not only felt to inflict harm, but also to magnify the harm that may have already occurred to second victims of the original event. And finally, the features of powerlessness and resistance in the adverse event experience were examined. Many of the experiences recounted were perceived as unjust and participants described a feeling of powerlessness. Powerlessness was attributed to having been silenced during adverse event management. While silencing reportedly occurred from superiors at all levels of the organization the silencing of staff was reported as most often originating from colleagues.

Resistance to powerlessness occurred by silencing, a move that inadvertently served to reinforce the very relations of power that were being resisted.

Again, although many participants personify Eastern Health as a villain, the "truth" of individual experiences described by participants may or may not be shared by others. What is important for this study is that the staff who reported their experiences felt they were true and in keeping with their recollection. The intention of this study is not to inadvertently or intentionally perpetuate the personification of the organization as a villain, but rather to examine the accounts of those who do so, to provide opportunity for the organizational leadership to examine the experiences of second victims and the practices which have contributed to them, attempt to understand the perspective of staff and commit to change for the sake of improving the future experiences of staff.

In the next and final chapter, I present a summary of the key findings and contributions of this study, discuss the limitations and provide recommendations in the areas of: education, practice, recommended future research and policy possibilities.

CHAPTER 8

Reframing the Experience of the Second Victim

The experience of being involved in an adverse event may leave the health care provider traumatized as a second victim. This study examined the second victim experience of health care providers from front-line staff to organizational leaders. The result is a comprehensive understanding of what it means to be a second victim. In addition, the study gives concrete direction about how a health care organization can better support health care providers to reduce the impact of adverse events on second victims and patients, and to reform adverse event management.

This concluding chapter provides a description of the major findings related to the experiences of staff, describes how power factors into the experiences of heath care providers and outlines the contributions this study brings to an understanding of the concept of second victim. The chapter then provides some key recommendations that apply the knowledge and experience of second victims in education, practice, research and policy.

8.1 Who are the Second Victims

The focus of this study was the experiences of second victims of adverse events. Participants in this study were those who feel traumatized (that is, those who are "second victims"). The accounts of health care providers (HCPs) who have been involved in adverse events demonstrate that HCPs are being harmed by the experience. As a result

they have great difficulty participating in quality assurance processes (such as reporting) or trusting the organizational leadership to treat them in a fair manner.

Health care providers become second victims as a result of their involvement in adverse events and many health care providers are left with long-lasting and painful memories of the experience. The experiences of second victims in this study are both shaped by and in turn reshape Eastern Health, the organization within which the second victim experience unfolds and meaning is constructed in relation to power. That is, Eastern Health as an entity does not just shape the experiences of health care providers experiencing adverse events; "Eastern Health" is (re)imagined and (re)constructed through the second victim experience. In this study, the experiences of health care providers were examined for the express purpose of discovering how organizational culture shapes the experiences and to identify how organizational strategies and supports figure in to the experience. As my analysis of victim accounts unfolded, the dialectical process of how Eastern Health is also "remade" through individual and collective experiences of victimization became clear. Blaming, as described in this study, is always relative to someone else, with the result that Eastern Health in several descriptions gets personified by participants as a monolithic entity that harms.

At the outset of the study, I believed that there would be distinct experiences that staff would report, depending upon their location in relation to an adverse event. As a result of that belief I began from the premise that I would explore with staff their experiences of being involved in adverse events directly, indirectly or by association. In reality, it was very difficult to separate those levels of involvement in the descriptions of staff. One exception was the case of ER/PR; in that event, it was possible to distinguish

direct involvement from association. In ER/PR, there was a clear delineation for staff about whether they were directly involved (that is, described as working in the Immunohistochemistry Laboratory) or associated (described as working elsewhere in the Laboratory). Interestingly, beyond the laboratory program, staff in the wider organization across all disciplines also reported feeling associated with and traumatized by the event of ER/PR, simply on the basis of their employment with Eastern Health.

In contrast to ER/PR, from my discussions with participants about all other adverse events, it was clear that staff were unable to separate their experiences by the descriptors of direct, indirect and by association due to the variety of experiences they had each had. No person described or recalled only one incident; there were always multiple examples with varying levels of involvement, and the intensity of the experience seemed to be unrelated to the level of involvement. The intensity of experience appeared to depend not on their personal responsibility or decision-making role within the event, but rather on the outcome for the patient and on the support the health care provider in question either received or provided. The compassion that health care providers exhibited towards their colleagues and how strongly they identified with the event in terms of their own vulnerability tended to be a determining factor in the experience rather than how directly they were involved. Many of the most intense responses expressed were as a result of a close relationship with the other health care providers involved or a negative outcome for the patient.

Similarly, when considering the outcome for staff following an adverse event, it was reasonable to expect that the farther in the past the incident had occurred, the more resolved the staff member's feelings would appear. In reality, the length of time since the

incident had no correlation with the emotions that were expressed and exhibited by participants. Many of the participants cried openly when recalling incidents that had happened years prior.

One of the criticisms that some participants had been exposed to following specific adverse events was that health care providers in Eastern Health "didn't care about their patients", reported as having been said by political leaders and in social media by patients and families. Every participant gave voice to the depth with which they do care about their patients and their emotional responses seemed to be indicative of the pain caused by accusations to the contrary.

8.2 Findings

There are three key findings contributed by this study to the broader knowledge of the experiences of second victims and adverse event management. First, health care providers involved in adverse events need to be given the opportunity to talk about their experience. Second, the best way to provide support is to recognize that support is needed quickly. Third, in order for an organization to appropriately support the second victims of adverse events and their subsequent patients, a systems approach -- with attention to organizational culture in its relation to power -- is required. Doing so will enable a just culture, in which organizational management and leadership are consistent and transparent in their approach to adverse event management so that staff perceive an environment that is fair and just. Here, I expand upon each of these three key findings.

1. *Health care providers involved in adverse events, from those directly involved to those involved by association, need to be given the*

opportunity to talk about the adverse event experience in a safe and supportive environment.

This study demonstrated the value of being given the opportunity to talk about the experience of an adverse event in a safe and supportive environment. Participants in the study described the relief they experienced when they were able to debrief or discuss the event with someone whom they considered supportive and understanding. The opportunity to discuss the event needs to be extended beyond those directly and obviously involved in an adverse event to those people tangentially involved. Managers and organizational leadership need to be intentional in communicating with staff about their experiences and give staff an opportunity to talk, since staff interpret silence in the context of adverse event investigation as punitive.

Most participants in this study identified their perception of the importance of having the opportunity to discuss their feelings in a timely manner following an adverse event, although some described that they themselves did not have that opportunity until they shared their feelings in the context of this study. Health care providers who had long delays in having opportunity to discuss their feelings described significant difficulty approaching the subject or finding "the right words." When health care providers are given the opportunity to share their experiences and talk about the circumstances surrounding an adverse event, some health care providers continue to struggle to communicate or explain their perspective, in particular when they have had little opportunity in the past. The challenge to express their feelings and the frustration of trying to resolve those feelings was often described by the use of metaphors.

Four metaphors used by participants were particularly representative of the sentiments that seemed to define the experience of being a second victim: "sticking like glue," "dog with a bone that won't stay buried," "we're all being tarred with the same brush", and "left holding the bag."

Sticking Like Glue

Just as glue is a very sticky substance and makes it difficult to separate two items once they are glued together, many people described, in a variety of ways, the difficulty of trying to make the traumatic memory no longer be part of their everyday lived experience. Participants described the difficulty in moving past the experience into a new reality that did not include visiting and revisiting the traumatic event in their thoughts. "Sticking like glue" was used to refer to the efforts that had been made, sometimes over several years, to try and separate oneself from the memory or recall of an event, only to find that it was stuck to them with no way to leave it behind. *Sticking like glue* was described as a frustrating reality for some participants.

Dog with a Bone That Won't Stay Buried

This metaphor is particularly powerful in capturing the sentiments of participants who were repeatedly reminded of an adverse event by the actions of the organization or the media. In particular, this experience was associated with high profile events that were revisited by the media, for example on the anniversary of the event or when another related event happened. One participant described how no matter how much she tried to bury the event by finding ways to distract herself or by taking up new activities or changing jobs, the hurtful experience would not go away but rather kept coming to the surface. Another participant recalled being reminded by a former colleague, in a grocery

store, that "today is the 10th Anniversary of ER/PR" as if that were cause for celebration. The media coverage usually happened without warning for the individuals involved, despite the organization's knowledge, and staff would be faced time and time again with the event in print and news reports. The media coverage was often followed up by other staff reminiscing about the event, with no conceptualization of how harmful these reminders were to the affected staff.

We're All Being Tarred with the Same Brush

At the time of ER/PR, as laboratory colleagues tried to cope with the public's impression that all laboratory staff were involved in the testing discrepancies, they expressed the feeling of frustration of all being identified as one entity. Similar sentiments were expressed by other participants when they described the experience of being blamed or held responsible by association with events in which they had no role or involvement. There was an overtone of blame within this metaphor, as if the staff responsible for an adverse event were causing harm to *innocent* staff.

Left Holding the Bag

The concept of being "left holding the bag" is a metaphor that describes being left to take all the responsibility for something that should be jointly shared. This metaphor also embodied the feeling of being abandoned, sometimes by colleagues and sometimes by the organization. In some instances, a person was identified as responsible for an event when in fact there were many people who were involved and responsible. Often this feeling of being "left holding the bag" occurred when an event took many months to be resolved and, by the time a resolution was reached, some people were no longer involved in a program or service or no longer involved in the follow-up of the event.

These four metaphors each speak about the meaning of being a second victim for health care providers who had never been provided the opportunity to talk about their feelings in a structured, open and safe environment. The metaphors point to the need to provide supports for health care providers in the wake of an adverse event. The value of having the opportunity to examine an adverse event from a personal perspective by talking about the feelings associated with the event at the time of the event needs to be examined for its potential to reduce the ongoing visiting and revisiting of an unresolved event by second victims.

The stories of second victims, particularly as expressed through these metaphors, also strikingly revealed the extent to which victimization may be experienced and require support by health care providers who were not at all proximate to the adverse event. There are second victims who are often only self-identified, who because of their distance from involvement in the adverse event would likely not be recognized by organizational leaders as in need of support. This group would benefit from the opportunity to talk about their feelings at the time of the event. Health care providers who are not directly involved struggle to find opportunities to talk about their feelings, both because the usual mechanisms for identifying impacted heath care providers do not extend to them and because they perceive themselves as less entitled to have feelings to express. Staff at all levels of the organization from front-line workers to organizational leaders need to have an avenue to discuss their experiences in the context of adverse events.

2. *The best way to provide support is to recognize that support is needed quickly. That support should be organized by people who are not involved*

in the event, event management or event investigation, so that the support can be provided in a timely manner.

Support is very important in the context of the adverse event experience, and in order to be effective must be prompt, respectful, voluntary and provided by someone who is not limited by conflicts of interest. Formalized and planned support mechanisms for staff provided within the structure of quality case review and investigation processes are key to ensuring that support is available to staff. It is important that staff report receiving effective support, receiving support that met their needs and receiving support at a time that made a positive difference. Organizational consistency in the manner that support is offered is key to ensuring that all who require support receive it. All people involved in an event require support from the closest to the most distant to an event.

The role of support was a central theme in participants' accounts of the second victim experience. Support and non-support were critical factors in how staff experienced and managed being second victims. The presence or absence of support was a key variable in determining whether the health care provider described the event as resolved or whether they continued to struggle to try and reach some closure. Support was sometimes sought out by the health care provider and sometimes offered by a colleague or superior. Non-support was described primarily in terms of criticism or ostracism from colleagues. Some of the most emotional and detailed recollections came from health care providers who had not received support at the time of the adverse event or felt criticized and ostracized by colleagues as a result of the event. The support provided through formal organizational structures depended in large part on the coordination of activities by managers and program leaders. The ability of a manager to provide support depended

on the manager's role in the event investigation and on whether or not the program leadership, director and clinical chief had identified the need for support as a priority.

Support can be provided by anyone irrespective of the nature of their relationship with the person or their knowledge of the event, if the person seeking the support feels supported. This study was not unique in its identification of a lack of planned and effective support within the health care environment. As described in Chapter 2, support for staff following an adverse event is understood as important and yet, in general, health care organizations have not communicated or implemented effective support mechanisms (Berlinger, 2011; Smetzer, 2012; Waterman et al., 2007), with Eastern Health being no exception. This study echoes the findings of Waterman et al. (2007) that physicians do not feel supported by the organization. The physicians interviewed in this study also reported that they do not trust the organization enough to seek support, so that even if support were offered it would unlikely be sought. Also, similarly to Denham's (2007) findings that health care leaders identify a need to support second victims, Eastern Health leadership also reported the need to support their staff following an adverse event, but did not have a plan to ensure support was provided.

Health care providers describe a number of ways that effective support could be provided at the time of an adverse event. A key finding was that it is not a specific type of support or specific personnel who provide the support that is perceived as essential; rather, it is the perception of being supported that actually counts. Support is considered effective when it is provided by someone whom the individual identifies as being genuine, non-judgemental, compassionate and knowledgeable either about the specific event or about the type of event in general. Support is most appreciated by the recipient

when it is received during the initial period of distress and again when the individual is processing the feelings associated with the experience. It is important for support to be offered at multiple junctures within the adverse event experience. That support should be provided by a person or within a process (for example a quality case review meeting or a collaborative incident analysis meeting) that the individual perceives as a supportive entity.

3. *In order for an organization to achieve a just culture, a systems approach is required with organizational management and leadership being consistent and transparent in their approach to adverse event management so that staff perceive an environment that is fair and just.*

Organizational policy regarding reporting and management of adverse events should be driven by quality and safety and a view to a *just culture*. It is important that the mission, vision and values of the organization accurately portray the concepts that the organizational leadership are prepared to embed in policy and put into practice. If an organizational policy states that the organization strives to take a systems approach[71] and to be a just culture[72], then the experience of staff should be consistent with these mission, vision and values statements. The experience of being treated differently, in the context

[71] In the systems thinking approach, the focus is placed on the conditions where the individual works i.e., the system, rather than on individual responsibility or blame (Queens University, 2016).

[72] Just Culture was first used by D. Marx (2001), a just culture recognizes that individual practitioners should not be held accountable for system failings over which they have no control.

of an adverse event, from the way organizational policy states a situation will be managed is very problematic for organizational culture.

One of the most significant problems, and one that results in experiences of disillusionment by health care providers involved in adverse events, occurs when an adverse event is described as a systemic or system problem and yet the organizational decisions include individual punitive consequences for staff. The accounts of participants in this study illuminated that when a staff member is blamed and disciplined for what is perceived to be a failure of the system rather than individual maliciousness, that information becomes very powerful and is retained within the organizational memory. Occasionally the need for punitive action related to staff activity is required when actions within an event are deemed to have been of malicious intent. In those cases, it is important that the action is consistent across programs and disciplines and that it contributes in some way to quality improvement and prevention of future incidents. In other words, if the purpose of the punitive action is primarily to achieve a perception that some action has been taken, the punitive action should be avoided.

The principal reason that staff give for being cautious about participating in a reporting process is fear of disciplinary actions, either toward themselves or toward their colleagues. One of the primary reasons why staff dissuade someone from reporting, they say, is to avoid punitive outcomes. The motivation to avoid punitive outcomes is so strong that staff are reportedly even willing for patients to undergo unnecessary procedures to avoid negative outcomes for staff.

It is important that an organization that plans to take a systems approach is consistent and transparent across the organization when adverse events happen.

Organizational leaders need to commit to the understanding that adverse events most often occur not because of individual maliciousness but because of system failure. The way that work is organized, polices are written and staff understand their responsibilities creates opportunity for system failure. When system failure is identified by the investigative process, the system should be reviewed and altered, and application of human fault should be avoided. A key ingredient to an effective system approach is being consistent within the organization, across all programs and disciplines, so that staff can predict the experience and respond with trust and confidence. A just culture requires a process of response that is predictable, so that staff feel safe within the organizational culture and know what to expect.

When events happen within an organization, the organization can use the event to inform practice and policy and learn from the event. Post-event examination of the systemic factors that may have contributed to the event is key to ensuring that change is targeted at the system. This opportunity for system learning also creates organizational memory about the event that identifies the event as a systems problem (rather than an individual failure), that is being addressed by leaders at a broad level (rather than targeting individuals for discipline), which can in turn enhance staff morale.

Avoidance of blaming and absentee blaming in the context of adverse events is also a key component of creating a just culture. Blaming can be a powerful mechanism within an organization, and absentee blaming is even more powerful than direct or indirect blaming because the individual or group of individuals (e.g., program) blamed does not have the opportunity to address and resolve the accusation. Power works most effectively when it is hidden in the norms and assumptions of everyday life. In order to

effect change, then, it is at the culture of the workplace, rather than at specific individuals, that reform must be targeted. When organizational leaders model a non-blaming culture the staff in the organization have less need to be self-protective and thereby the use of the mechanism of blame is reduced at all levels.

Involving staff in adverse event management supports two factors that contribute to the perception by staff that the organization has priorities that include staff. The first factor is the perception of timely communication to staff during and after an adverse event investigation, which would result in staff having their questions answered and feeling certain about their status within the organization. The organization can avoid staff misunderstandings of organizational decisions by prompt communication. In this study, a poignant example of the importance of direct and immediate communication was revealed in staff stories about their reaction to the *Graces Memorial* statue.[73] The second factor is the perception of tangible, organized and timely support that avoids assumptions of blame in a climate of silence. The organization can avoid staff interpreting the silence in the context of an adverse event investigation as punitive, when staff are made aware of the internal and external demands that an investigation creates. In programs where staff are an integral part of the investigation process, they do not feel disenfranchised and they feel safer to contribute to quality assurance processes.

[73] Staff who believed that the Graces Memorial statue was placed at the entrance to the Health Science Centre to punish them were not aware of the activities and negotiations of the class action lawsuit that resulted in agreements to settle the claim against the organization, decisions that in all likelihood had nothing to do with the organization's attitude toward the employees involved in ER/PR.

The Seat of Power

Eastern Health was identified and described as the seat of power, personified and portrayed as the adversary by the participants in this study. There is of course no one powerful person/adversary that is "Eastern Health"; and it is equally not the case that "Eastern Health" is a third victim. Some managers and directors have themselves been second victims, and some of these are among the key informants who were interviewed for this study. Importantly, this study revealed how those in relatively powerful positions within the organization are among the second victims of adverse events even in cases where, as leaders, they were distantly removed from the actual adverse event occurrence and were responsible for implementing the processes of investigating and managing the event and disciplining individual staff.

There are many instances of hidden power that have been described in this study. Absentee blaming, support and the absence of support, and criticism are examples of hidden power within the organization that were recognized and revealed to help define the second victim experience. When you consider blame as a form of power, it was evident in the ER/PR and Cameron Inquiry periods that there was overt blame and that this blame was powerful. Blaming in the post-Cameron organization is less overt; it happens when the person or program being blamed is not in the room, through email or other forms of indirect communication, again, a form of hidden power that is even more powerful because it is difficult to confront.

The authority of the manager coordinated by the adverse event management policy is also a form of power, exercised in the role of investigator. The power of the investigator required health care providers to answer questions and provide clarification,

with little information provided in return. The exercise of that power also included keeping silent, not communicating with staff, and having staff depending on informal pathways of communication, such as rumours, to elicit information. Staff described "immense distress" because the organization did not communicate back to staff in a timely manner or include them in any conversations.

The power of the media was paramount in the experience of several health care providers. Every participant assigned power to the media in the experience of a significant adverse event. In the case of the Cameron Inquiry, the fact that the Inquiry played out in the public arena meant that staff of the health authority were reportedly traumatized when information was misunderstood, poorly interpreted or poorly reported by the media. In addition, staff expressed powerlessness in not being able to respond to public sentiment following an event when staff felt it was poorly represented by the media.

Theorists such as Foucault (1982) and Bourdieu (1977) have shown how power is most effective when it is disguised, hidden in the norms and assumptions of everyday practice. The accounts of participants in this study, from front line staff to 'powerful' leaders within the organization, reveal how the system itself perpetuates assumptions about who can be told what, and how blame should be attributed, without any individual specifically being malicious and responsible (that is, neither the staff involved in creating an adverse event nor the managers who are disciplining individual staff). Rather, the seat of power is shown in this study to be systemic and structural. Staff feel powerless to speak up; and by resisting the oppression that they fear will result if they were to speak out, they perpetuate the relations of power by reaffirming a culture of silencing. Within

the organization, blame and responsibility are referred elsewhere (to "that" department or "that" type of staff), with resulting investigations and protocols for follow-up that both create, and are reinforced by, the culture of blame. Staff feel silenced and powerless and so they blame a constructed monolithic "Eastern Health" for the oppression, a story of responsibility and blame that is reinforced by the public via the media and then made all the more real for those who are the second victims of adverse events.

Power is hidden and implicit in the system so no one can dismantle it because it is structural, embedded in the everyday work of the organization. In this study, each informant believed that someone other than themselves held the power and would therefore be protected, but in reality no one was protected. In this web of searching for the evil person/s the real seat of power was missed – the system.

Having outlined the findings of the study, the contributions, limitations and recommendations of the study will now be described.

8.3 Contributions

1. *The second victim trauma reaches all people regardless of how proximate they are to the event and irrespective of the nature of their involvement in the event -- people at all levels of power within the organization can be traumatized and hurt.*

Health care providers who are directly involved or indirectly involved in an adverse event experience describe trauma, stress and feelings of physical illness, and report that they have difficulty providing safe and effective care or completing tasks in an effective manner following the event. Many health care providers express guilt at not

having done enough to protect a patient who had experienced harm and indicate that they exhibit protective behaviours toward subsequent patients.

The second victim trauma is described by health care providers who are at the front-line making the decisions about care to a patient, and equally by health care providers who are responsible for policy and practice decisions but not providing direct patient care. The second victim trauma reaches all providers of health care in a health care organization by virtue of contributing to the health care environment where adverse events happen. No level of involvement in health care is immune from the trauma of an adverse event if the person identifies themselves as holding some responsibility with health care delivery.

The trauma of the second victim is very real to the person involved and obvious to co-workers; it can be long-lasting and, as described in the moral distress literature, can be cumulative. The trauma of being involved in an adverse event is not easily resolved and can go on to define the person's work for many years. It contributes to an erosion of confidence and pride in the person's work, in their profession and in the organization. The trauma of being involved in an adverse event can reach those even very distantly removed from the event, if they identify with the harm.

2. *The culture of the health care system creates the opportunity for harm to the health care provider – in order to reduce the harm to second victims, system changes are imperative; these changes include increased attention to and understanding of second victims and of how organizational cultural features contribute to harm.*

An important consideration when examining a particular health care organizational culture is the narratives that get told about the organization and its staff, and how those narratives shape or reshape how staff understand and experience their work and their beliefs about themselves and the organization. The health care culture of Eastern Health has a number of narratives, past and present, some of which have had very discernible roles to play in the experience and management of adverse events. Examples include: a narrative about how staff were treated in ER/PR and the Cameron Inquiry; a narrative about the intentions of the organization in the context of the Graces Memorial statue; a narrative about how staff are supported following adverse events; and a narrative about the actions of organizational leadership compared to the policy statements about just culture. The interpretation of those narratives shape the culture of the organization, and vice versa.

Narrative works as a mechanism of power through the messages that are heard and interpreted. When the narrative is inaccurate, for example the interpretation of the staff about the reason that the Graces Memorial statue was created, the outcome is a cultural shift irrespective of the accuracy or inaccuracy of the interpretation. Staff in the laboratory medicine program interpreted the intentions of Eastern Health as punitive. The cultural shift toward distrust of organizational leadership that occurred through the narratives of laboratory staff members about the Cameron Memorial statue was as a result of a perception that was inaccurate. The inaccuracy of the staff's understanding is irrelevant, because

in the absence of communication from organizational leadership, the monument was enforcing a top down, victimization model.

Equally important to the way that narratives were shaping culture for participants in this study was the use of silence. Silence was understood to be a mechanism of power employed to manage adverse events. For example, when staff refuse to report incidents, or program leaders do not include staff in investigations about adverse events, these are instances of implementing and/or resisting power. While narrative or use of language is relatively more overt as a form of power or resistance to power, silence can be even more effective as a mechanism for the exercise of power (Bourdieu, 1977).

The transformation of a culture and in particular the creation of a just culture is not a simple task. The source of power needs to be understood; narratives (and silences) need to be attended to in order to identify what specifically is being understood, resisted, ignored or subverted. In this study, with the particular case of Eastern Health, it is my position that the "symbolic capital" that has been accumulated through the construction of a monolithic and villainized "Eastern Health" needs to be revealed as a cultural construction, identified as an ideological apparatus of power, and dismantled in order for both front line staff and upper level leaders to engage in effective change of the system itself.

8.4 Limitations of the Study

My position was a unique one in relation to this study, as discussed in Section 3.4.1, which had advantages and disadvantages in terms of my ability to capture meaning in relation to power with respect to the experiences of second victims of adverse events.

As the principal investigator I had the benefit of being an objective listener to the experiences of ER/PR and the Cameron Inquiry (since I was not present in the organization or the province at the actual time of the events). However, even though I came from a place of relative objectivity in a sense, I was also both disadvantaged and privileged due to my position as an insider to the organization, because my pre-existing values and beliefs were shaped in part by my past and (then) present working roles within the organization. I felt a sense of identity with those who suffered because of the QRM role; as well I identified simultaneously and sometimes contradictorily with upper level management who were being blamed by front line staff as not responsive enough to their concerns.

A second potential limitation of the study was the breadth of participants who informed the findings. On one hand, I was able to recruit participants from all levels of the organization, from front-line staff to organizational leadership, and the findings reported here are based on interviews at all levels of the organizational structure including the voices of upper level management (Program Directors and Clinical Chiefs). On the other hand, several features of the study necessarily limited the range of voices included. These include: (i) the study design itself, which purposefully excluded certain voices; (ii) my position as insider and manager within the organization, which may have made some reluctant to come forward; and (iii) the context of our small population which may have led some to be reluctant to come forward out of fear of being recognized.

(i) Study design. This study does not capture the voices of those who were not traumatized by second victim experiences. The focus of the study was the experiences of second victims of adverse events; the recruitment process necessarily excluded those who

did not feel trauma as a result of their experience (just as it excludes some of those who remain so extremely traumatized that they declined to talk about the experience for fear of re-living their experiences). Participants in this study are those who felt traumatized (that is, those who are "second victims").

(ii) My position. My position in management and as a Quality and Clinical Safety Leader in the QRM program (at least, at the beginning of recruitment, as I had assumed a new position elsewhere in the organization at the time of recruitment) also no doubt played a role in who participated. My position may have defined for some potential participants their own safety in participating in this study. It is difficult to know how many potential participants were dissuaded from participating by their perception of my role within the organization; however, those participants who came forward expressed feeling safe and reported no concerns given my position as an insider in a position of relative power within the organization.

(iii) Population size. Although Eastern Health as a health authority is described as large by participants, the individual health care sites are small enough that there are informal knowledge pathways that contribute to a fear of being identifiable. As a province, Newfoundland and Labrador is small from a population perspective, and the linkages in a small population between individuals as employees and partners of employees provide unique knowledge about specific events. This created limitations for the study, both in terms of recruitment (some would no doubt be reluctant to participate out of fear of being identified) and in terms of the transparency of participant accounts due to the vulnerability of being identified. Therefore, although the sample used was highly informative of the experiences of second victims of adverse events within Eastern

Health, it is possible that some potential informants did not respond for fear of being identifiable or fear of negative repercussions. For example, I was contacted by a young woman who described herself as very interested in participating in the study. I was contacted a further three times by this same young woman who expressed anxiety about participating because of a fear of being inadvertently identified and losing her job. She eventually withdrew as a potential participant.

A third limitation of this study is that it is not a report on the extent to which the adverse event experience is felt and managed by health care providers. Such a study would require quantitative measures and large scale sampling. That was not the intent of this study. This was qualitative research in search of meaning, not a scientific approach in search of laws or 'truths'. In fact, it is reasonable to expect that persons reviewing the findings will have experiences or interpretations that are different from those the participants described; but those alternative experiences or interpretations do not negate the experiences of the participants who contributed to this study. This study does provide a longitudinal account of the experience of ongoing trauma by second victims of adverse events, and how specific organizational features shape that experience.

8.5 Recommendations

Recommendations are presented in four areas for consideration: education, practice, recommended future research and policy possibilities. Leaders within the organization are aware of this study (indeed, it was funded by Eastern Health through a Quality Healthcare scholarship and was approved by its Research Proposals Approval Committee) and will receive these recommendations in the form of a report, enabling the

organization to move forward with knowledge translation. All recommendations are consistent with system change.

8.5.1 Education

Education is usually one of the prime considerations when change is identified as a necessary outcome in a study. It is important to consider the need for education with a cautionary approach, since the experience of staff had little to do with the need for more information; however, it is possible that education could help to improve processes that may have contributed to negative experiences for staff. First and foremost is the need for knowledge about how the policies and practices in Eastern Health prescribe the processes of adverse event management. If staff were more aware of the way that the processes were prescribed there may be less hurt when staff misunderstand the intentions of organizational leaders. The key to increased knowledge about adverse event processes is communication.

One of the greatest challenges of creating an environment for staff where the harm caused by adverse events is minimized is finding a way to educate without inadvertently causing further harm. The necessity for knowledge translation is well known and particularly important in quality initiatives and patient safety culture, but it is important to take examples from other organizations or make the examples used in educational endeavours that are not identifiable to prevent ongoing harm to staff.

Another consideration for education is the need to inform staff about the importance of respecting colleagues within the occurrence reporting system, to prevent the experience of blame, absentee blaming and staff feeling criticized. Managers need to receive educational support to manage the dynamic of blame and criticism that staff are

exposed to through CSRS, across programs and from patients and families. In addition, there is a need to educate managers about strategies of how to *rescue* staff in a timely manner, while balancing the expectations of adverse event management. Upper level managers, directors and executives need to receive additional education about system and human factors, so that these factors can be taken into account in the mitigation of adverse events. Directors who are expected to identify the need for support and provide support may have had no experience or been mentored to meet this demand. Education and mentorship about effective support is critical to enabling program and organizational leaders to assist effectively in the adverse event experience.

8.5.2 Practice

Removing the manager from the investigative process, allowing the manager to focus on supporting front-line staff in the Quality Case Review process eliminates the moral dilemma that managers face trying to investigate an occurrence while feeling responsible to support staff. Reassigning the roles of managers and program leaders within the investigative process will be critical; in particular freeing the manager up to be able to fulfil a support role and assigning the program leaders the investigative role. Additionally, it is very beneficial to involve staff in the investigative process. This reassignment of roles will allow staff to participate in the investigation while being supported. Involving staff in the investigative process will avoid unnecessary anxiety and harness the energy of staff in understanding the systems in which they work, to make system change a collaborative effort.

It is important for health care organizations to examine the role of human

resources departments in the management of adverse events. When a health care organization begins examining the circumstances of an adverse event and health care providers' care decisions and actions within the event, it may happen that health care providers' professional judgement and competency are also questioned. The human resources department has expertise in determining professional qualifications for particular positions, but they do not have expertise to determine the professional judgement or competency within the actions of a HCP in an adverse event. The role of the human resources department should be kept distinctly separate from the review of HCP actions within an adverse event. In keeping with this role separation, any repercussions to staff after the examination of the event would seem to be better managed by the program leadership rather than by human resources. Human resources can have a role in employee wellness, assisting staff to deal with situations that influence their wellness. The separation of human resources and management as described here is for the purpose of allowing human resources to participate in the support of staff without participating in an investigative or punitive role.

8.5.2.1 Collaborative Incident Analysis

I propose the use of a method I have entitled *Collaborative Incident Analysis* that brings together front-line staff, managers and program leaders to review and examine the details of a critical incident as soon after the incident as possible. This method provides a facilitated conversation to allow all involved parties to come to a thorough understanding of the events surrounding and contributing to an incident thereby increasing the potential for accurate interpretations. Based on the results of this research, I believe that having the first discussion of the event happen as quickly as possible can increase the confidence of

staff and prevent external forces of blame and criticism from taking hold within the staff group. During the collaborative incident analysis review, assigning or accepting blame would be actively discouraged by the facilitator in order to allow all participants a perception of equality in the process of review.

Collaborative incident analysis depends on the most-involved staff to inform the review, and as a consequence confidence is increased when staff know the details of the review and are informed of the plan regarding disclosure and next steps. This method reduces the perception of blame and powerlessness by involving front-line staff at the outset of the adverse event management process. Collaborative incident analysis would be led by someone who is not a leader within the program itself and is viewed as a neutral party who is knowledgeable about the policies and practices of the work unit. The person who leads or *chairs* the collaborative incident analysis would have expertise in group facilitation and critical incident debriefing and would be knowledgeable about a systems approach to incident analysis.

8.5.2.2 Staff Support Mechanisms

Receiving support and support-seeking behaviours presented many challenges for health care providers who participated in this study. The organizational leaders interviewed recognized that harm results from exposure to adverse events and described the need for support, and are looking for improved ways to ensure that support reaches staff in a timely and effective manner.

I recommend four types of support mechanisms. First, there is a need for a direct form of support in which the staff person involved is automatically matched with a

support process, either an individual support person or a program, of their choosing. This support would not have to be sought by the staff member but would be offered automatically with no requirement for management or the staff member to identify the need. The type of support offered here may vary according to the needs of the staff member but would not be determined by the severity of the event and would not require management approval or involvement. The importance of this approach is to ensure that all events trigger a support process and all staff will be offered support. The availability of this type of support infers that both content expert and objective non-involved support persons need to be pre-identified. Individuals who are non-involved with the program could act across several programs, whereas context experts would be required to be identified within the program. Support may be individual or group in nature depending on the needs of those individuals involved in the event, but participation in any form of support should remain the decision of the individual.

Second, I recommend paid leave be offered (in particular in the context of serious and severe incidents), twinned with the support program intervention described above, while the incident is being investigated. It is important in this type of support that the staff member is in agreement and would define this as a positive supportive intervention and not as discipline. In addition, colleagues who remain in the workplace should be briefed about this supportive intervention to reduce the chance that they may have moral distress related to an employee being on an employer-suggested leave.

Third, a staff help line would provide an opportunity for staff to reach out to a neutral third party for support. A staff help line would be focused on the individual rather than on a group as is the focus of a group debriefing or critical incident debriefing. The

service would be available to individuals immediately at any time of day or night, to enable frank discussion of personal feelings without having to make formal arrangements or involve other people. Staff who are involved in adverse events, from the closest to the event to the bystander, could equally access this support, and accessing the support would not involve program leaders or colleagues. This form of intervention does not depend on a manager recognizing the need for support or having the time to respond to staff needs.

Finally, in the context of adverse event management processes it is commonplace for a report to be provided to Senior Management and the Board, which outlines the "harm" to the patient and to the organization, especially in relation to adverse events that result in severe harm or death or result in significant media attention. I recommend including an update to Senior Management and the Board on how staff members involved in adverse events are being supported during and after the incident, along with any other relevant information regarding the well-being of the staff members. This strategy will bring this responsibility to the forefront for organizational leadership and demonstrate the commitment of the organization to the well-being of staff in the context of adverse events. Enacting this recommendation would represent a cultural shift in values and beliefs and would translate into processes to support all involved in an incident and have the organization learn and grow. The cultural shift has to come from the top (The CEO and The Board) and this needs to be made part of the regular agenda of the organization's executive meetings and processes. Attempts to enact a cultural shift will only be effective if it includes all levels of the organization and begins with the executive. If the staff are aware that the CEO and executive are talking about the well-being of staff at every meeting, staff will begin to believe that their well-being is important to the organization.

8.5.3 Recommended Future Research

There are a number of important findings in this study that beg further consideration in terms of research attention. From the participants and throughout the literature the message is clear that support is required following an adverse event. There is a paucity of research that examines support. This study goes a long way to identifying that support is needed. Now, research is needed that considers the timing and type of intervention that will make the most positive and effective outcome for health care providers. In addition, an examination of organizations that are doing well with recognizing and supporting the second victims of adverse events would be useful. Second, research is needed which examines the understanding by organizational and program leadership of the application of a system issues approach and how staff discipline factors into such an approach. Third, the question of how a respectful and collegial intervention such as Collaborative Incident Analysis could be implemented and how precisely it could change the experiences of staff and program leadership during adverse events requires further research.

8.5.4 Policy Possibilities

There are several policy options that are available to support staff in the process of adverse event investigation to create a supportive culture of managing adverse events. It seems counterintuitive to state that culture can be mandated by policy; however, the concepts of a *reporting culture* and a *just culture* are dependent on policies and practices that support them and in some ways allow them to exist. A cultural shift begins with policy and depends on the most senior people in the organization to champion for policy change.

Policies need to take a non-punitive approach to adverse event management. Policy for disclosure and adverse event management should frame all roles and responsibilities in a positive and clearly outlined manner. Disclosure policy should also outline the supports available to all people (including the patient, family and the health care provider) involved in the disclosure, during the disclosure process and after the disclosure is complete. This type of specific attention to the need for support in the context of disclosure acknowledges the stress associated with not only the event itself but also the disclosure, as families will often be distraught or angry or both. Similarly, in adverse event management, it is important in the policy to acknowledge the staff who are involved in the adverse event, to reduce the harm of the adverse event on second victims. There should be specific policy statements that plan for intervention for staff, which may take the form of counselling or talking to a colleague in a planned way.

In a reporting culture when an adverse event is reported, the role of program leadership is to investigate in order to understand as much as possible what happened and how it happened, but also to look beyond the event to the system and ask questions about how the system created the opportunity for the failure or event to happen. This type of approach, that examines the system, reduces the likelihood that the person who is informing about the occurrence will be blamed. When an adverse event is reported through a patient safety reporting system, there can be a process known as critical incident analysis (Canadian Patient Safety Institute (CPSI)) that examines the event from a systems perspective. The findings of this study indicate that in order for an organization to respond to an adverse event in a *just* manner, the investigation must focus on the system not on individual behaviour.

One of the recommendations of the Cameron Inquiry was the development of enhanced processes to manage adverse events and continued expansion of the QRM department for the purpose of adverse event management. As a result of that direction, adverse event management has become increasingly centred within the QRM program, creating separation between the event and the people involved, including the manager. It is important that program staff and program leadership are involved in adverse event management in a tangible way to avoid the perception that an event, once reported, is no longer within the purview of the program.

Communication policy is required to address the need for involved staff to be kept informed of the adverse event management process throughout the review period. In addition, the involvement of the media and the support of staff should be intentionally addressed within communication policy, to ensure that staff are informed when media become involved in an adverse event. In the case of high profile adverse events, when media outlets make requests from the organization for information or interviews, those staff most directly involved should be informed about the organizational messages that will be shared with the media.

The recommendations outlined in this chapter are intended to acknowledge that health care organizations are complex social organizations that require support to accomplish the goal of positive change.

8.6 Summary

The experience of being involved in an adverse event leaves the health care provider traumatized as a *second victim*. While the pressure to be more open and transparent with patients and their families brought about significant change, the

concomitant discipline of staff responsible in adverse events never kept pace with the changes (disclosure, support) initiated for patients and their families. This critical ethnography examined the second victim experiences of health care providers from front-line staff to organizational leaders, emphasing organizational culture in its relation to power. An important context shaping the experiences of second victims in this study was the legacy of ER/PR. That large scale adverse event, which was experienced and defined publicly as a "cover-up," was in all likelihood more a case of trying to manage an event that was too big and too overwhelming for the mechanisms that were in place, for the people who were assigned the task, in an organization that had not previously experienced an adverse event of such magnitude. The establishment of the Cameron Inquiry and the initiation of the Task Force on Adverse Events were undertaken to address the issues of ER/PR, and specific changes were instituted in various programs throughout the organization. But the legacy of ER/PR remains, not just with the patients and their families but also with the staff who continue to be second victims of the tragedy.

For the health care providers who informed this study, the term second victim is a powerful and appropriate descriptor of their experiences. As is evident in the voices of those health care providers, the experience of being involved in an adverse event – *no matter how tangentially* – can leave one traumatized as a second victim. The contributions and recommendations of the study include: being deliberate about providing opportunities for staff to talk; recognizing that all people involved in an event require support; ensuring organizational consistency so the environment is perceived as fair and just; and introducing a collaborative incident analysis method that increases

accurate interpretations of events and encourages confidence while discouraging applications of blame.

The specific organizational features that shaped the experiences of health care providers in this study are not unique to the organization which was the site of the study, but may be easily and appropriately applied to any adverse event and in any health care organization. The experiences described within the chapters of this study are an integral part of the fabric of any health care organization, and my hope is that by bringing these experiences to light, health care organizations and governments can understand how harm can happen and how patient care and patient safety can be impacted by the staff experience of being a second victim.

This study illustrates the magnitude of the trauma and the expanse of the possible experiences. It helps us to understand more fully the second victim perspective and to understand how a health care organization can mitigate the trauma to second victims. By focusing on power, particularly on the implicit or hidden ways in which power is both enacted and resisted through a culture of silencing and blame, the research highlights the need for a systemic approach to recognizing and supporting the second victims of adverse events. In doing so, it offers concrete direction about how a health care organization can better support health care providers to reduce the impact of adverse events on second victims and patients in the long term.

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Appendix A: Participant Information Letter

Research Title

Adverse Events in Health Care: examining the experience of Health Care Providers

Participant Information Letter

Dear potential participant,

My name is Sheila Marchant-Short, and I am a PhD candidate in Community Health and Humanities (Faculty of Medicine) at Memorial University. This information letter provides details about this research on the ***impact of adverse events on health care providers*** and what being a participant in this study involves.

Brief Research Project Description

Adverse events are a common and frequent event in health care. Those events can have an impact on health care providers (HCPs).

The health care system has become concerned for the unnecessary suffering of patients and families. Far less has been done for HCPs who have been involved in or have witnessed a traumatic event. Very little is known about the experience of adverse events and the impact of those events on HCPs. This study examines the impact of adverse events on HCPs.

The HCPs who will be invited to share their experiences for this research project include physicians, medical students, nurses, laboratory staff and pharmacy staff.

My Interest in Adverse Event Research

In my work within Eastern Health I have become aware of the frequency and potential impact of adverse events on HCPs. For example, some HCPs have reported feeling alone in trying to cope with their experience and feelings following an adverse event. Through my work, I have realized that we need to know more about how adverse events impact HCPs in order to create a responsive and supportive health care environment.

Being a Participant

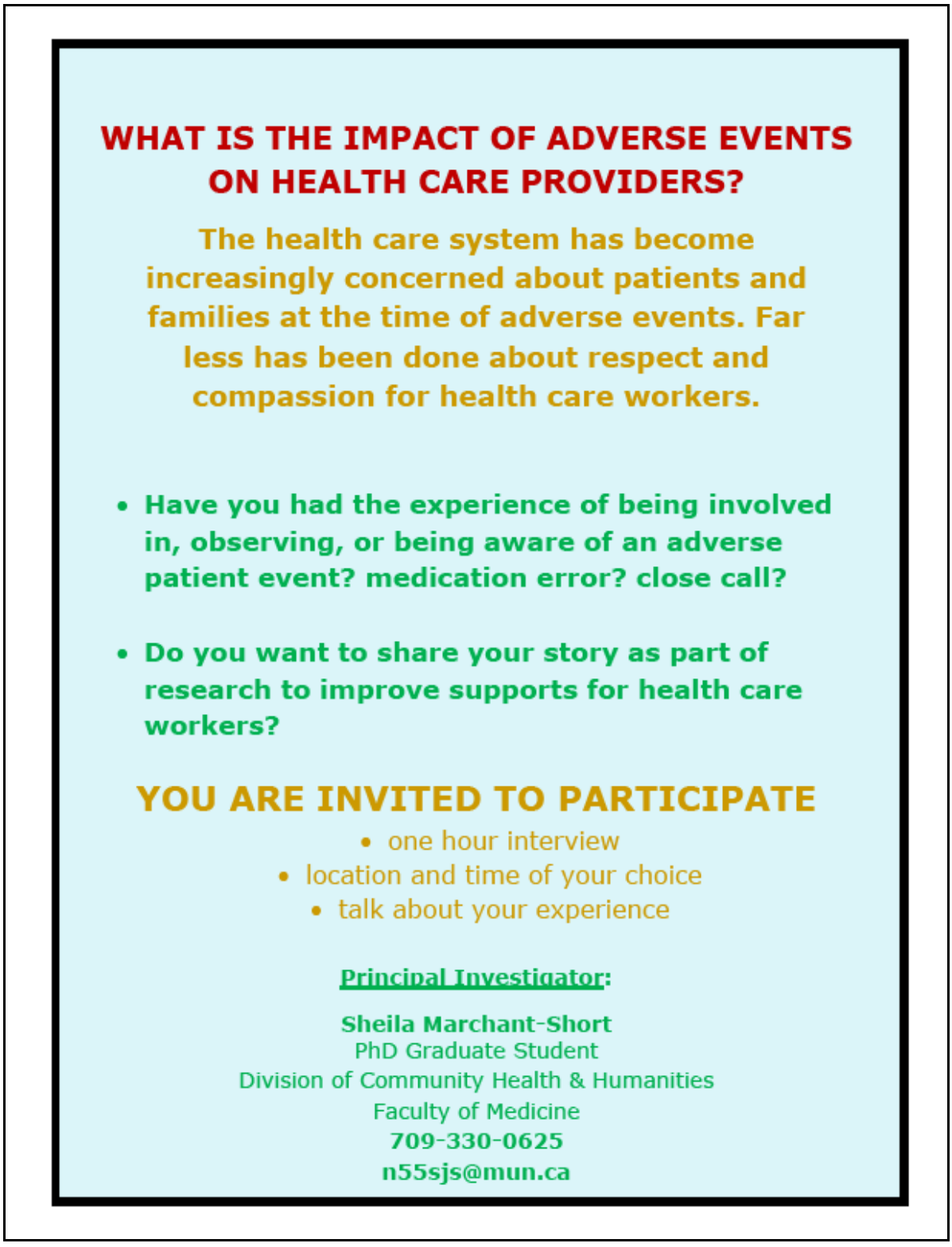
Participating in this research will involve a semi-structured interview which will take about 1 hour of your time. You will be asked to describe your experience of being involved in, observing or being aware of an adverse event in your health care setting. You will also be asked to describe the type of support you received and whether you found the support helpful.

I am happy to answer any questions about the study. If you are interested in participating please do not hesitate to contact me. **Sheila**

Sheila Marchant-Short
1 Montgomery St.,
St. John's, NL A1A 1V7
709-330-0625
n55sjs@mun.ca

Version 18/11/2013

Appendix B: Recruitment Poster



Appendix C: Presentation Script for the Recruitment of Professionals

Have you ever seen a medical mistake happen and felt helpless to do anything about it? Have you been there when we failed to rescue a patient from an adverse event?

I suspect that as a health care professional you have been increasingly aware of patient safety messages.

My name is Sheila Marchant-Short, I am a PhD student in the Faculty of Medicine, Community Health and Humanities department and an employee of Eastern Health in the Quality and Risk Management Department. I am taking a brief opportunity to talk to you about my research study, which endeavours to examine the experience of the health care provider following an adverse event. An adverse event being an event that results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition. Adverse events are a common and frequent event in health care.

The health care system has become concerned for the unnecessary suffering of patients and families, following an adverse event, often referred to as 'the first victims'. Far less has been done toward respect and compassion for health care providers who have been involved in or have witnessed a traumatic event, often referred to as 'the second victims'. This study seeks to examine the impact on health care providers.

My interest in adverse event research comes from my work with Quality and Risk Management within Eastern Health, although, this research study is not part of my role as an employee of Eastern Health. I became aware of the frequency and potential impact of adverse events on health care providers, and had some health care providers report feeling alone in trying to cope with their experience and feelings following an adverse event. Through my work, I have realized that we need to know more about how adverse events impact health care providers in order to create a responsive and supportive health care environment.

Do you want to share your experiences - things you've seen happening around you, or that you've been involved in - that are hard to talk about?

Participating in this research will involve a semi-structured interview which will take about 1 hour of your time, at a time and place of your choosing. You will be asked to describe your experience of being involved in, observing or being aware of an adverse event in your health care setting. You will also be asked to describe the type of support you received and whether you found the support helpful.

I have brought with me some information sheets and posters to describe what participation in my study would entail, with the intention of inviting you to consider participation.

I will maintain your confidentiality to the upmost of my ability.

If you feel you may be interested and would like further information, please feel free to contact me. My dissertation supervisor, Dr. Fern Brunger, will also be happy to provide any information that you would find helpful toward your decision about participation.

THANK YOU

Appendix D: Presentation Script for the Recruitment of Medical Students

Have you ever seen a medical mistake happen and felt helpless to do anything about it? Have you been there when we failed to rescue a patient from an adverse event?

I suspect that as a medical student you have been increasingly aware of patient safety messages.

My name is Sheila Marchant-Short, I am a PhD student in the Faculty of Medicine, Community Health and Humanities department and an employee of Eastern Health in the Quality and Risk Management Department. I am taking a brief opportunity to talk to you about my research study, which endeavours to examine the experience of the health care provider following an adverse event. An adverse event being an event that results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition. Adverse events are a common and frequent event in health care.

The health care system has become concerned for the unnecessary suffering of patients and families, following an adverse event, often referred to as 'the first victims'. Far less has been done toward respect and compassion for health care providers who have been involved in or have witnessed a traumatic event, often referred to as 'the second victims'. This study seeks to examine the impact on health care providers.

My interest in adverse event research comes from my work with Quality and Risk Management within Eastern Health, although, this research study is not part of my role as an employee of Eastern Health. I became aware of the frequency and potential impact of adverse events on health care providers, and had some health care providers report feeling alone in trying to cope with their experience and feelings following an adverse event. Through my work, I have realized that we need to know more about how adverse events impact health care providers in order to create a responsive and supportive health care environment.

Do you want to share your experiences - things you've seen happening around you, or that you've been involved in - that are hard to talk about?

Participating in this research will involve a semi-structured interview which will take about 1 hour of your time, at a time and place of your choosing. You will be asked to describe your experience of being involved in, observing or being aware of an adverse event in your health care setting. You will also be asked to describe the type of support you received and whether you found the support helpful.

I have brought with me some information sheets and posters to describe what participation in my study would entail, with the intention of inviting you to consider participation.

I will maintain your confidentiality to the upmost of my ability.

If you feel you may be interested and would like further information, please feel free to contact me. My dissertation supervisor, Dr. Fern Brunger, will also be happy to provide any information that you would find helpful toward your decision about participation.

THANK YOU

Appendix E: Consent

Informed Consent Form

Faculty of Medicine
Division of Community Health and Humanities
The Health Sciences Centre
St. John's, NL, Canada A1B 3V6
Tel: 709-777-6213/6652 Fax: 709-777-7382
www.med.mun.ca

Consent to Take Part in Research

TITLE: *Adverse Events in Health Care: Examining the Experience of Health Care Providers*

INVESTIGATOR: Sheila Marchant-Short, Faculty of Medicine, Memorial University

You have been invited to take part in a research study. Taking part in this study is voluntary. It is up to you to decide whether to be in the study or not. You can decide not to take part in the study. If you decide to take part, you are free to leave at any time.

Note: The researcher declares a conflict of interest in relation to her employment within Eastern Health. Involvement in this study will not negatively impact your relationship with Eastern Health.

Before you decide, you need to understand what the study is for, what risks you might take and what benefits you might receive. This consent form explains the study.

Please read this carefully. Take as much time as you like. If you like, take it home to think about it for a while. Mark anything you do not understand, or want explained better. After you have read it, please ask questions about anything that is not clear.

The researcher will:

- discuss the study with you
- answer your questions
- keep confidential any information that could identify you personally
- be available during the study to deal with problems and answer questions

1. Introduction/Background:

An adverse event[1] is a common and frequent event in health care. These events can have a major impact on health care providers. The health care system has become more aware of the unnecessary suffering

[1] an event that results in unintended harm to the patient, and is related to the care and/or services provided to the patient rather than to the patient's underlying medical condition

of patients and families. Far less progress has been made toward respect and compassion for health care providers who have been involved or have witnessed a traumatic event. Very little is known about the experience of adverse events and the impact of those events on health care providers. This study examines the impact of adverse events on health care providers.

2. Purpose of study:

- document the experience of health care providers with an adverse event; specifically, to investigate the impact of adverse events on health care providers.
- explore whether and how the culture of the health care organization shapes the experiences of adverse events.
- identify strategies and supports that can help to reduce the negative effects of adverse events on health care providers.
- determine whether, from the perspective of health care providers, there are concerns about the ability to fully provide effective health care after an adverse event.

3. Description of the study procedures:

Participating involves one interview, of about one hour, at a time and place of your choosing. I will ask you to describe your experience of having been involved directly, indirectly or by association with an adverse event. I will ask questions of clarification to explore your experience and feelings of the event as thoroughly as possible. I will audio record the interview in order to capture your description as accurately as possible. The audio tape will be transcribed.

4. Length of time:

The interview will be approximately 60 minutes in length, and will take place sometime between September 2013 and September 2014.

5. Possible risks and discomforts:

Potential risks of being in the study:

- I am an employee of Eastern Health, in a research analyst position with the Research department. However, I am conducting this research as a graduate student at Memorial University; this research is not part of my role with Eastern Health. It is not my intention to use what you tell me in my role with Eastern Health. As described below (under "privacy and confidentiality"), I will make every reasonable effort to protect your identity as a participant in this research. You may experience emotional upset as a result of sharing important adverse event experiences; I will provide contact information for counselling support. This support will be the employee assistance program.

6. Benefits:

It is not known whether this study will benefit you.

7. Liability statement:

Signing this form gives us your consent to be in this study. It tells us that you understand the information about the research study. When you sign this form, you do not give up your legal rights.

Researchers or agencies involved in this research study still have their legal and professional responsibilities.

8. What about my privacy and confidentiality?

Protecting your privacy is **an important part of this study. Every effort to protect your privacy will be made. However,** it cannot be guaranteed. For example, we may be required by law to allow access to research records.

When you sign this consent form you give us permission to:

- Collect information from you
- Share information with the people conducting the study
- Share information with the people responsible for protecting your safety

Access to records

No one except the researcher (Sheila) will know which transcript is yours. The transcriptionist and the dissertation supervisor (Dr. Brunger) will see the confidential transcript; they will not know who has said what. Other people may need to look at the study records that identify you by name. This might include the research ethics board. You may ask to see the list of these people. They can look at your records only when supervised by a member of the research team.

Use of your study information

The research team will collect and use only the information they need for this research study. This information will include the recording and transcript of your interview.

Your name and contact information will be kept secure by the research team in Newfoundland and Labrador. It will not be shared with others without your permission. Your name will not appear in any report or article published as a result of this study.

Information collected for this study will kept for five years.

If you decide to withdraw from the study, the information collected up to that time will be destroyed. This information will only be used for the purposes of this study.

Information collected and used by the research team will be stored on a password-protected laptop that will be with Sheila or locked in her home office (1 Montgomery St., St. John's). Sheila Marchant-Short is the person responsible for keeping it secure.

Your access to records

You may ask Sheila, the researcher, to see the information that has been collected about you.

9. Questions or problems:

If you have any questions about taking part in this study, you can meet with the investigator who is in charge of the study at this institution. That person is: Sheila Marchant-Short

Principal Investigator's Name and Phone Number

Sheila Marchant-Short
Principal Investigator
Graduate Student (PhD Candidate)
Division of Community Health & Humanities
Faculty of Medicine
Memorial University
(709)330-0625
n55sjs@mun.ca

Dr. Fern Brunger
Dissertation Supervisor
Professor
Division of Community Health & Humanities
Faculty of Medicine
Memorial University
(709)777-7284
fbrunger@mun.ca

Or you can talk to someone who is not involved with the study at all, but can advise you on your rights as a participant in a research study. This person can be reached through:

Ethics Office
Health Research Ethics Authority
709-777-6974 or by email at info@hrea.ca

After signing this consent you will be given a copy.

Signature Page

Study title: *Adverse Events in Health Care: Examining the Experience of Health Care Providers*

Name of principal investigator: Sheila Marchant-Short

To be filled out and signed by the participant:

	Please check as appropriate:	
I have read the consent and information sheet.	Yes { }	No { }
I have had the opportunity to ask questions/to discuss this study.	Yes { }	No { }
I have received satisfactory answers to all of my questions.	Yes { }	No { }
I have received enough information about the study.	Yes { }	No { }
I have spoken to Sheila and she has answered my questions	Yes { }	No { }
I understand that I am free to withdraw from the study • at any time • without having to give a reason	Yes { }	No { }
I understand that it is my choice to be in the study and that I may not benefit.	Yes { }	No { }
I understand how my privacy is protected and my records kept confidential.	Yes { }	No { }
I agree to be audio taped.	Yes { }	No { }
I agree to take part in this study.	Yes { }	No { }

_____ _____ _____

Signature of participant | Name printed | Year Month Day

To be signed by the investigator or person obtaining consent

I have explained this study to the best of my ability. I invited questions and gave answers. I believe that the participant fully understands what is involved in being in the study, any potential risks of the study and that he or she has freely chosen to be in the study.

_____ _____ _____

Signature of investigator | Name printed | Year Month Day

Telephone number: _____

Appendix F: Ethics Approval Certificate – Health Research Ethics Authority

Health Research Ethics Authority

Ethics Office
Suite 200, Eastern Trust Building
95 Bonaventure Avenue
St. John's, NL
A1B 2X5

April 22, 2013

Ms. Sheila Marchant-Short
1 Montgomery Street
St. John's, NL A1A 1V7

Dear Ms. Marchant-Short:

Reference # 13.089

RE: Adverse Events in Health Care: Examining the Experience of Health Care Providers

This will acknowledge receipt of your correspondence.

This correspondence has been reviewed by the Vice-Chair under the direction of the Board. ***Full board approval*** of this research study is granted for one year effective **April 18, 2013.**

This is to confirm that the Health Research Ethics Board reviewed and approved or acknowledged the following documents (as indicated):

- Revised Consent Form dated April 19, 2013, approved
- Presentation Script for Recruitment of Medical Students, approved
- Participant Information Letter, approved
- Recruitment Poster, approved
- Interview Script Direct Involvement in Adverse Event, approved
- Interview Script indirect Involvement in Adverse Event, approved
- Interview Script Involvement by Association in Adverse Event, approved
- Budget, acknowledged
- Research Proposal, approved

MARK THE DATE

This approval will lapse on **April 18, 2014**. It is your responsibility to ensure that the Ethics Renewal form is forwarded to the HREB office prior to the renewal date. *The information provided in this form must be **current to the time of submission** and submitted to HREB **not less than 30 nor more than 45 days** of the anniversary of your approval date.* The Ethics Renewal form can be downloaded from the HREB website http://www.hrea.ca.

email: info@hrea.ca Phone: 777-8949 FAX: 777-8776

The Health Research Ethics Board advises THAT IF YOU DO NOT return the completed Ethics Renewal form prior to date of renewal:

- *Your ethics approval will lapse*
- *You will be required to stop research activity immediately*
- *You may not be permitted to restart the study until you reapply for and receive approval to undertake the study again*

Lapse in ethics approval may result in interruption or termination of funding

It is **your responsibility to seek the necessary approval from the Regional Health Authority or other organization as appropriate.**

Modifications of the protocol/consent are not permitted without prior approval from the Health Research Ethics Board. Implementing changes in the protocol/consent without HREB approval may result in the approval of your research study being revoked, necessitating cessation of all related research activity. Request for modification to the protocol/consent must be outlined on an amendment form (available on the HREB website) and submitted to the HREB for review.

This research ethics board (the HREB) has reviewed and approved the research protocol and documentation as noted above for the study which is to be conducted by you as the qualified investigator named above at the specified site. This approval and the views of this Research Ethics Board have been documented in writing. In addition, please be advised that the Health Research Ethics Board currently operates according to *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*; *ICH Guidance E6: Good Clinical Practice* and applicable laws and regulations. The membership of this research ethics board is constituted in compliance with the membership requirements for research ethics boards as defined by *Health Canada Food and Drug Regulations Division 5; Part C.*

Notwithstanding the approval of the HREB, the primary responsibility for the ethical conduct of the investigation remains with you.

We wish you every success with your study.

Sincerely,

Patricia Grainger

Dr. F Brunger, PhD (Chair) Non-Clinical Trials
Ms. Patricia Grainger (Vice-Chair) Non-Clinical Trials
Health Research Ethics Board

C C VP Research c/o Office of Research, MUN
VP Research c/o Patient Research Centre, Eastern Health
HREB meeting date: May 2, 2013

email: info@hrea.ca Phone: 777-8949 FAX: 777-8776

Appendix G: Ethics Approval Certificate – Research Proposals Approval Committee of Eastern Health

Eastern Health

Department of Research
5th Floor, Janeway Hostel
Health Sciences Centre
300 Prince Philip Drive
St. John's, NL A1B 3V6
Tel: (709) 752-4636 Fax (709) 752-3501

June 11, 2013

Ms. Sheila Marchant-Short
1 Montgomery St.
St. John's, NL A1A 1V7

Dear Ms. Marchant-Short:

Your research proposal *HREA Reference # 13.089: "Adverse events in health care: Examining the experience of health care providers"*, was reviewed by the Research Proposals Approval Committee (RPAC) of Eastern Health at a meeting dated: June 11, 2013, and we are pleased to inform you that the proposal has been approved.

The approval of this project is subject to the following conditions:

- The project is conducted as outlined in the HREA approved protocol;
- Adequate funding is secured to support the project;
- In the case of Health Records, efforts will be made to accommodate requests based upon available resources. If you require access to records that cannot be accommodated, then additional fees may be levied to cover the cost;
- A progress report being provided upon request.

If you have any questions or comments, please contact Donna Bruce, Manager of the Patient Research Centre at 777-7283.

Sincerely,

Mike Doyle, PhD
Director of Research
Chair, RPAC

cc: Ms. Donna Bruce, Manager Patient Research Centre
S. Marchant-Short (n55sjs@mun.ca)

MD/jmps

Appendix H: Interview Scripts

Interview script (Direct involvement in Adverse Event)

1. Can you tell me about a time when you were involved in a medication event/medical event that you were concerned about?

2. Can you tell me how you felt about the event?

3. Can you describe how you felt physically at the time of the event and in the days following the event?

4. Can you describe how you felt emotionally at the time of the event and in the days following the event?

5. Can you tell me if your colleagues were aware of the event?

6. If your colleagues were aware, can you tell me how your colleagues felt about the event?

7. Can you tell me about how your colleagues responded to the event? and How you interacted with each other following the event?

8. Can you tell me about your interaction with the patient?

9. Can you tell me whether the event was disclosed/discussed with the patient?

10. Can you tell me about the patient's response to the event, if it was disclosed?

11. Can you tell me how you felt about the patient's response?

12. Can you describe how you felt about continuing to do this activity (event-causing) after the event?

13. What was your experience of your work environment after the event? Colleagues? Supervisor? Other patients?

14. What was your experience of how the organization responded?

15. Did you feel the need to be supported following the event? Did you seek support? Did you receive support? Who did you seek support from?

16. When you think back about the event now, how do you feel?

17. If you have been aware of events that your colleagues have been involved in, do you think your own experience impacted how you viewed those events? Did your experience impact how you responded to your colleague?

18. Can you tell me about the experience of talking about the event with me today?

Interview script (Indirect involvement in Adverse Event)

1. Can you tell me about a time when you were aware of a medication event/medical event that you were concerned about?

2. Can you tell me how you felt about the event?

3. Can you describe how you felt at the time of the event and in the days following the event?

4. Can you tell me if your colleagues were aware of the event?

5. If your colleagues were aware, can you tell me how your colleagues felt about the event?

6. Can you tell me about how your colleagues responded to the event? and How you interacted with each other following the event?

7. What was your experience of how the organization responded?

8. Did you feel the need to be supported following the event? Did you seek support? Did you receive support? Who did you seek support from?

9. When you think back about the event now, how do you feel?

10. Can you tell me about the experience of talking about the event with me today?

Interview script (Involvement by Association in Adverse Event)

1. Can you tell me about a medication event/medical event that you were concerned about but were not involved in?

2. Can you tell me how you became aware of the event?

3. Can you tell me how you felt about the event?

4. Can you describe how you feel this event impacted you?

5. Do you think that this event had an impact on your colleagues who were also not involved?

6. Can you tell me about how your colleagues responded to the event? and How you interacted with each other following the event?

7. Can you describe how you felt about the activity (event-causing) after the event?

8. What was your experience of your work environment after the event? Colleagues? Supervisor?

9. What was your experience of how the organization responded?

10. Did you feel the need to be supported following the event? Did you seek support? Did you receive support? Who did you seek support from?

11. When you think back about the event now, how do you feel?

12. Can you tell me about the experience of talking about the event with me today?