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Exit Spirals in Hospital Clinics: Conceptualizing Turnover Contagion Among Nursing Staff

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Abstract

This article introduces the concept of the exit spiral to conceptualize processes in which poorly functioning hospital clinics or wards enter a phase of decline due to widespread dissatisfaction among staff, prompting turnover contagion. In describing and analyzing cases amassed during observations and interviews, the article provides tools to identify, analyze and halt exit spirals. Once a hospital ward finds itself in an exit spiral, employees experience increased workloads, loss of control and discontent. Managers may react with increased rigidity. Instability, discontinuity, and insufficient knowledge transfer are processes sparked by exit spirals. The article suggests that exit spirals can be halted if management recognizes the depth of organizational decline and directs resources to resolve it. This requires further analysis, stimulation of employee voice, innovation, and flexibility.

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Introduction

Half of all child psychiatrists have resigned from [Sahlgrenska University Hospital]: "The plug was pulled"
- When someone leaves, there is a domino effect. I have difficulties imagining us carrying on this autumn, says the union representative.[1]

In the summer of 2021, the media reported on a sudden mass exodus of psychiatrists from a major pediatric hospital in Sweden. Out of 15 psychiatrists, seven suddenly resigned, and for a considerable period, not a single person applied to fill the vacancies. The newspaper story cited above reported that the wave of resignations started with just one psychiatrist giving notice, and subsequently, "it was as if a plug had been pulled". Staff were quoted saying that the clinic had been under severe pressure for a long time, and union representatives told reporters that management had not listened to complaints about overwhelming workloads and poor working conditions.

What does "a plug being pulled" or "domino effects" signify in an organization – and how can such developments be addressed analytically? The news story describes a process that we too have identified through interviews and fieldwork observations among nurses working in Swedish hospitals: the seemingly abrupt mass exit of medical staff, which poses a threat to patients' access to care and the quality of medical services provided by clinics affected. This article introduces the concept of the *exit spiral* to conceptualize such processes, wherein poorly functioning hospital clinics or wards enter a phase of decline due to widespread dissatisfaction among staff, prompting turnover contagion. The aim of the article is to use description and analysis of cases amassed during observations and interviews to provide conceptual tools to identify, analyze and halt exit spirals – i.e., staff resignations replicating throughout the organization. It is our contention that in order to prevent and properly manage situations wherein issues of staff retention is threatening care

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provision, clinicians and management need a conceptual toolbox in order to do just that – identify, analyze and halt the process. The article further points to the strengths of qualitative, bottom-up studies of hospital organizations wherein narratives of staff and first-line managers – those working on the floor – provide the basis for interpretation and reflective understanding of organizational decline. Theoretically, the article contributes to the burgeoning field of organization studies drawing on Hirschman's (1970) EVLN model, by expanding on the concept of *exit*, and demonstrating the variety of exit processes – including collective ones – that take place in public sector organizations.

The article is based on fifty semi-structured in-depth interviews with registered nurses[2] and nurse managers[3] working or having recently worked in the Swedish public healthcare system, primarily in hospitals, as well as observations of work at four different hospital clinics.[4] Previous research has illustrated that nurses, in Sweden as well as in other countries around the world, tend to have a high turnover and turnover intention rate (De Simone, Planta and Cicotto, 2018, 131; Rudman, Gustavsson and Hultell 2014, 613). The main cause identified in research for exit and turnover intention is the psycho-social work environment, which leads nurses to experience burnout, low control and poor support systems (Karlsson et al 2019, 1364; Chiou-Fen et al 2019, 2; Wendsche and Hacker 2017, 245). The research project was initiated to study the precise factors propelling exit among ward nurses in Sweden. In interviews and observations, nurses often stressed poor working conditions and poor management as the main reason for wanting to leave a workplace, lending further support to previous research (cf Homburg, van der Heijden and Valkenburg 2013). However, through analysis of the qualitative data we also identified a pattern of quite sudden mass-exoduses of staff at clinics going through a state of organizational failure. This prompted further investigation and conceptual development.

We will begin by presenting previous research on turnover intention among nurses, which is then followed by a presentation of Hirschman's theoretical model Exit-Voice-Loyalty-Neglect (EVLN). Next, we present our data and research methods, followed by a presentation of the concept of exit spirals based on excerpts from fieldnotes and interviews. We end the article with a discussion on the strengths of the concept of exit spirals, and recommendations for halting organizational failures reproducing this process.

Why Do Nurses Leave?

The shortage of nurses is a global concern, not least since demographic changes mean that countries around the world are facing a systematic increase in the elderly population (Marc´ et al 2018), which intensifies over-all demands on healthcare systems. The World Health Organization's (2020) latest estimate suggests that there is a global shortage of 5,9 million nurses. While the problem is most acute in the Global South and exacerbated by the uneven exchange of workforce migration (ibid.), there are severe shortages in the Northern hemisphere as well, including in welfare states with relatively expansive public sectors and effective healthcare systems providing broad coverage. A report from the Swedish National Board of Health and Welfare (Socialstyrelsen 2018) suggests that there is a severe national shortage of nurses in Sweden, including

specialist nurses and midwives, which impacts adversely on patient safety procedures and standards as well as operational capacities.

Nurses provide essential care for patients and support for kin from cradle to grave, and without skilled nurses, quality healthcare provision is rendered impossible. A wealth of studies has shown that nurse-related factors such as nurse-to-patient ratio affect patient safety outcomes, for example in terms of 30-day mortality and medication errors (Alenius 2014; Aiken et al 2011; Kane et al 2007; Needleman et al 2002). The multi-center and cross-sectional study RN4CAST illustrated that all twelve involved countries – of which Sweden was one – perceived a need to address problems such as patient safety, hospital quality, dissatisfaction, and burnout among nurses; it also illustrated that patients' satisfaction with the quality of care is linked to the work environment of nursing staff (Marc´ et al 2018). Retention of nursing staff is consequently a crucial issue for healthcare providers around the world.

Why, then, do nurses leave their jobs? Linda H. Aiken, who together with colleagues published a pioneering study in 2002 on the relationship between hospital nurse staffing and patient mortality, nurse burnout and job dissatisfaction (Aiken et al 2002), has argued that "more nurses mean more nurses"; having enough nurses working in hospitals not only helps to retain staff, it attracts nurses who have left the occupation back into the workforce (Aiken 2019). Aiken's analysis rests partly on the implementation of fixed patient/nurse ratios in California in 2004 (cf Donaldson and Shapiro 2010), and posits that nurses leave because "their jobs [become] impossible", and that once hospitals ensure acceptable workloads, nurses "come back into the workforce – they come out of retirement … because they could go to work … and feel proud of their work" (ibid.). There is much evidence affirming Aiken's contention that nurses quit because of high workloads and steadily increasing and increasingly complex demands; studies have shown that nurses are laboring under austerity regimes (Willis et al 2017; Kerasidou 2019; Gea-Sánchez et al 2019) in which cost reductions and budget discipline are prioritized over sustainable working conditions (cf Hart and Warren 2013; Willis et al 2015). Furthermore, professionalization and specialization have taken place alongside technical advancements and a democratization of medical knowledge which increases professional, organizational, and patient demands on nurses, who are frontline workers positioned in a mediating role in the healthcare system (Selberg 2012). This makes nursing an increasingly complex profession, at the same time as nurses often must compensate for cutbacks in care-adjacent spheres such as cleaning and administration (Willis et al 2005; cf Willis et al 2017). Put simply, nurses need to know more, do more, and communicate more, without extra resources or support. In summation, nurses' work is *intensified*. Work intensification leads nurses to experience, among other things, incongruity between professional standards and organizational resources (Harvey et al 2020); moral stress (Thunman 2016; Morely, Ives & Bradbury-Jones 2019); exhaustion (Korunka et al 2015); inability to properly prioritize among tasks (Selberg 2013); feelings of inadequacy toward patients and anger and resentment toward management (Selberg, Sandberg & Mulinari 2021; Willis et al 2015). These are experiences and feeling states that research has shown will increase nurses' turnover intention (De Simone et al 2018), and/or lead to burnout (Woo et al

2020). Moreover, nurses' turnover intention has been linked to patient-perpetrated violence (Laeeque et al 2018), absence of managerial support (Chegini & Jafarabadi 2019) and lack of proper introduction (Schroyer et al 2020). In summation and based on the wealth of data cited in this section, lack of resources, high workloads, lack of organizational support and unfavorable psycho-social work environment are key factors in nursing staff turnover.[5]

Exit, voice, loyalty and neglect – understanding behavioral options in declining organizations

As we have demonstrated, a wealth of studies supports the contention that the global problem of nurse shortages is caused to a significant degree by unsustainable working conditions, which prompt nurses to leave workplaces or exit the occupation altogether (Drennan 2019; Oulton 2006). Unsustainable working conditions is not unique to nurses, however. Naus et al (2007, 684) argue, based on results from numerous management studies, that employees today are "expected to work longer hours, accept greater responsibility, be more flexible and to tolerate continual change and ambiguity". Contemporary organizations, they claim, demand more and provide little in return, and apply "excessive control measures aiming to discipline the workers" which can be regarded as "instruments used to colonize and affect [employees'] subjectivity" (ibid.). Employees, Naus et al argue, can be expected to "respond in sense-making ways to these changes in the work environment"; to somehow seek a new balance in the relationship with the organization by scaling down contributions and be wary of reciprocation (ibid.). They can also be expected to resist and defend their sense of self-value and dignity, perhaps by developing cynical attitudes (Naus et al 2017, 685). How, then, do we organize and conceptualize varying reactions to unfavorable working conditions? This is where we turn to A.O. Hirschman's (1970) typology of behavioral options in declining organizations – Exit, Voice, Loyalty and Neglect (EVLN) – which has been at the center of organizational- and working life research for some 45 years. It is still considered a sharp instrument in analyzing employee response mechanisms (Lee & Varon 2020; Sabino et al 2019), and it is the theoretical framework we utilize to provide conceptual tools to identify, analyze and halt exit spirals, in line with the aim of the article. There are several reasons for this choice of analytical framework. The model centers the "ability of those at work to be able to articulate their position" and views those concerns "vis-á-vis those of others in the workplace" (Holland, Teicher & Donaghey 2018, xi). Thus, the model offers a distinctive analytical approach to interests and relations in the workplace and the organizational setting, making it an optimal choice for analyzing employees' decisions to leave the workplace, as well as the dynamics propelling turnover contagion. The EVLN-model is considered especially effective in analyzing behavioral options in the public sector, wherein lock-in logics often limit clients' as well as employees' options (John 2017, 515).

The EVLN typology consists of four responses: *exit*, which represents "the painful decision to withdraw or to switch" organizations (Hirschman 1970, 83), or "any attempt being undertaken from employees in order to escape from a dissatisfying situation" such as quitting; resigning; transferring to another unit or thinking about leaving (Aravopoulou, Mitsakis & Malone 2017, 2). Intention to

leave creates a psychological distance which negatively affects commitment and performance (Chao et al 2011); some have described it as a 'psychological exit' (Naus et al 2007). Exit may be "contagious", in that "coworkers tend to imitate the withdraw behaviors they perceive in others" (Porter & Rigby 2020, 212), meaning employees use the knowledge of how others in the workplace have resolved their dissatisfaction to inform their decision about how to approach their own discontent. In contrast, *voice* describes individual and/or collective attempts to change any situation causing dissatisfaction, and can represent either constructive or destructive responses. Fundamentally, voice is about trying to "improve conditions through discussing problems with a supervisor or coworkers, taking action to solve problems, suggesting solutions, seeking help from an outside agency like a union, or whistle-blowing" (Rusbult et al 1988, 601). The notion of *loyalty* with the organization regulates the choice of behavioral option. It can be a passive response mechanism; it can prompt either exit or protest; and it can prompt a combination of exit and protest. Neglect is a destructive response representing a form of dissatisfaction channeled neither through exit nor voice but rather absenteeism, carelessness, lack of commitment, reduced work efforts and reduced productivity.

There is a negative trade-off between exit and voice (John 2017, 513); in situations wherein exit presents as a far-off option, voice tends to be the stronger alternative, and vice versa. John (2017, 513) argues that voice should be interpreted as a defense of politics over market, since voice encourages people to increase their commitment which serves to "keep [organizations] … on their toes" (ibid).

The EVLN model has been criticized for being conceptually unclear (Aravopoulou et al 2017). Researchers have continued to expand and develop the typology; Hirschman himself added concepts such as 'noisy exit', referring to customers or employees being vocal about their exit once they have a secure path out (Withey & Cooper 1989), while others have added for example cynicism (Reichers et al 1997) and compliance (Tucker & Turner 2011). Despite this, EVLN remains a go-to model for exploring behavioral options.

In this article, we do not seek to expand the model by adding concepts, or to refine it by improving definitions; rather, we explore empirically through in-depth interviews and observational data a specific form or process of exit – namely, exit in the form of turnover contagion, which creates in the organization a state of decline that we call *exit spirals*. This way, we are able to add complex organizational processes that the model may address analytically, thus strengthening the model's value to empirical research. We also contribute more generally to research on organizational decline and turnover contagion by zeroing in on exit as simultaneously a result of and mechanism for organizational decline.

Organizational decline occurs when an organization fails to "anticipate, recognize, avoid, neutralize, or adapt to external or internal pressures that threaten the organization's long-term survival" (Weitzel & Jonsson 1989, 94). Decline situations can be described as either a single major incident, or as a cumulative series of incidents resulting from action or inaction of organizational agents (Peretz 2021, 163). In the public sector, decline implies "a reduction of skills, capabilities and resources within the organization" (ibid.) and is a more

complex phenomenon than in private firms which face the risk of closure or takeover. Poorly performing public sector organizations and units "may continue indefinitely because of the greater difficulty in measuring performance and the more diffuse political imperatives to which they are subject" (Jas & Skelcher 2005, 197).

In communication research, the concept of the spiral has been used to explain how majority opinions become dominant over time; Noell-Neuman (1974) introduced the term 'spiral of silence' to analyze such processes in the domain of public opinion. Individuals assess their environment as they form opinions, according to the theory, because expressing dissent comes with the risk of social isolation. Bowen & Blackmon (2003, 1394) applied the theory to diversity management in organizations, to explain "the self-reinforcing collective dynamics of silence and voice in workgroups". Their argument holds that employees will not use voice unless they are likely to have support from co-workers (ibid.), since employees too fear isolation. Silence can become transmissible in an organization, Bowen & Blackmon argue, since "small personal silences" can be "reinforced and subsequently escalate to inhibit voice on wider organizational issues" (ibid., 1395). However, voice can also spread and be reinforced if new avenues of communication open up for employees, so that organizations may exhibit "spirals of voice" (Madsen & Johansen 2019). Whilst not engaging with Noell-Neuman's (1974) theory of avoiding isolation, Kullén Engström & Axelsson (2010) also employed the spiral metaphor to study experiences of privatizations in Swedish hospitals. They found that there is a "double spiral of change" consisting of a 'virtuous' and a 'vicious' circle of experiences and reactions. The virtuous circle starts with "positive emotions, which are strengthened by feelings of security and commitment, leading to a stage of trust" (Engström & Axelsson 2010, 166), whereas the vicious circle starts with a "lack of security and commitment leading to negative emotions and a lack of trust" (ibid., 167). They illustrate these circles with an image of the DNA molecule structure, the double helix, which represents "a tentative first step towards the construction of a theoretical model of employees' experiences of a change process" (ibid.).

Inspired by such previous research on spirals of behavioral options, and in dialogue with the expansive scholarship that has grown out of Hirschman's (1970) typology, we present in this article a deepening, rather than reformulation of, the exit category. First, though, we present the data on which our analysis builds.

Data and Research Methods

The research has been carried out in Sweden, and focuses on nurses working in hospital care. In Sweden, the healthcare system is publicly funded and mostly operated via self-governing so-called regions with independent powers of taxation; the regions are responsible for providing inpatient care as well as primary healthcare. The ways in which hospitals and clinics are organized within these regions vary, but many can be described as line organizations with varying degrees of process orientation.

This article is based on four rounds of observations (each four hours long), in four hospital wards (two ICU wards, one surgical ward and one medical ward) at three different hospitals, as well as semi-structured, in-depth interviews with 50 nurses working or having recently worked in hospitals across Sweden. The shadowed nurses were also interviewed and are thus included in the data set of 50 transcribed interviews. Participants were contacted in the period of 2017 – 2020 via hospital wards, whose managers replied to an invitation to participate in a research project on exit, voice and loyalty among nurses and social workers in the Swedish public sector. Managers were approached through emails and/or letters with information about the project. Those interested contacted the researchers and invited us to observe ward work and interview nurses at their clinics. We also connected with nurses through a Facebook group called *Sjuksköterskan* (The Nurse), which has >30 000 members, all of which identify themselves as registered nurses. Some nurses contacted us after having read about our project in the nursing union's (Vårdförbundet) member magazine. We had no exclusion criteria, and anyone willing to speak to us was included in the study. We were able to interview many nurses in their workplaces; others were interviewed over the phone. The interviewed nurses worked for both small and large hospitals across Sweden. Their ages varied between 24 and 64 years, and their work experience varied between one and 40 years. Roughly 90 percent of the interviewed nurses identified as women.

Observations in the form of shadowing is a technique of data collection particularly fitting in work environments such as hospitals, wherein work is not always spatially demarcated but rather 'on-the-move' (cf. Czarniawska 2011, 95). Eight nurses in total were shadowed at four different hospital clinics. We chose two ICU wards, wherein the nurse-patient ratio is relatively high[6] and nurses have specialist training, and two general intake wards wherein nurse-patient ratios are lower[7] and nurses seldom have specialist training. We used observations mainly as a way of gaining insight to labor processes which are difficult to capture from interviews alone. Thus, the observations served as a springboard for us to ask more detailed interview questions and help us visualize the labor processes, work tasks, task rotation systems and physical environments described by nurses during interviews.[8] The interviews served to gather descriptions of the work-world of the interviewee, with respect to interpretation of the meaning of the described phenomena (Kvale 1983, 174). Thus, the goal was to understand the research topic from the viewpoint of those interviewed, in this case registered nurses working in Swedish hospitals (King 2004, 11). We depart from a realist perspective in which "interviewees' accounts are treated as providing insight into their … organizational lives outside of the interview situation" (King 2004, 12). There was, then, an expectation of accuracy of accounts in the interviews, which was why observations were done before interviewing commenced; observations served to shore up exchanges between interviewers and interviewees regarding the organizational environment and worksite experiences described in the fifty semi-structured interviews.

We took fieldnotes during observations, and interviews were recorded. The fieldnotes and interviews were then transcribed and coded, meaning we assigned portions of the transcribed material to specific categories. The aim was to employ a "reflexive, analytical and inductive strategy" in order to "examine the

meaningful and symbolic content of the qualitative data to gather an in-depth understanding" of nurses' experiences, and the conditions and responses that shape those experiences (Chowdhury 2015, 1136). Put simply, the research team read and re-read the transcriptions while striving to recognize our active role in shaping the research process and its outcomes, and reflect critically on our own experiences and actions with the aim to improve on the quality of the analytical process.

Codes were both descriptive, reflecting the content of the material and the questions asked, and analytical, reflecting our theoretically informed processing of the data wherein certain statements were linked to theoretical concepts related to the EVLN-model. Analytic codes represent, according to Deterding & Waters (2018, 15), areas to explore further, and attempts to "integrate emergent findings with what is known from the literature". We are inspired by Leavy and Harris (2019, 95), who argue that feminist research "requires us to balance embodied standpoints, commitments to social and political justice, and respect for the dignity of all those affected by our research practice", and thus we have conducted the project according to feminist ethics as described by those authors, which includes establishing informed consent, secure confidentiality, building trust, rapport and emotional reflexivity, and "radical, active listening" which requires a responsiveness in listening for gaps and silences, pauses and patterns and putting stories into a context (ibid.).[9]

Whilst processing the data, we discovered narratives of exit, which we had not encountered in previous research. These were stories about "everybody" "suddenly" leaving a clinic. It was at first quite difficult to sort this story out, as the narrator was not always amongst those leaving the workplace; thus, we had stories about exit that seemed to be highly meaningful to the interviewee, regardless of whether they personally had exited or not. We were faced with a new kind of exit story; a collective exit, which was not always easy to pinpoint in terms of cause, and which represented something different from noisy coordinated collective exit (cf Granberg 2014). Thus, a code had to be constructed to capture what emerged from the data; that of turnover contagion in the form of resignation strings. This is how the phenomena appeared to us at first, as strings of people leaving one after the other. After having studied the accounts under this code more carefully, we realized that actually, there seemed to be a certain dynamic that reminded us of the metaphor of a downward spiral. We thus came up with a combination of Hirschman's concept of *exit* and the concept of *spiral*: the exit spiral. This concept is thus a result of a combination of inductive and theory-driven coding and analysis.

We have chosen to present this code in the form of vignettes, which are short illustrative excerpts or renditions and compilations of multiple interviews and field note extracts which we find indicative of the broader material. The reason for this is to highlight in the presentation of the data the interpretative process of coming up with a new concept (cf. Langer 2016, 735). These vignettes are based on interview transcriptions and field notes, compiled of exact or slightly abridged quotes from one or several nurses or notes taken by one of the authors during observations, and by combining various accounts we draw attention to the deliberate interpretative actions of researchers in producing concepts. Harris & Møller (2020, 2) have argued that vignettes allow for a "high

level of integration in both research problem, vignette construction, case selection, data collection, and analytical strategy". Another central point of the vignette is to present a phenomenon in a refined manner, centering the concept and process of exit spirals, rather than introducing a multitude of accounts referring to many different local organizational developments. Thus, vignettes allow us to introduce a new concept derived from an interpretative process based on qualitative data in a way that reminds the reader of the purposeful construction of concepts grounded in accounts and experiences.

Since we treat our qualitative data just so – qualitatively, we focus on the theme as relevant in and of itself, and we do not assess how common exit spirals are. In our material, many if not most nurses had either experienced the process themselves or had heard of others experiencing what we refer to as exit spirals. However, we refrain from estimating how common this is; we simply note that exit spirals exist and that from interviews and observations, we can address them analytically and construct meaning around them so that researchers and clinicians can identify them or processes like them in the future.

Within the overarching code of exit spiral, we have identified a number of themes which present below.

"People started leaving – and now, no one wants to stay" – describing the exit spiral

> *It's shaky, is what I would say to describe the ward. Really shaky. We have a problem retaining staff right now. The most senior nurse, I think she has worked here around three years. And that is what I would consider, under normal circumstances, to be a junior nurse. You don't know everything after three years, you've seen far from it all, that's for sure. You're familiar with the most common cases, you know the routines, but really, you're not that mature. But now it's like – you're one of the old ones, you supervise students and newcomers and all that. And it's too heavy a burden to be the most senior nurse after three years, so you burn out and leave and then the next one up is overwhelmed. So that is where we are and it's a struggle, it really it is. It is no fun at all, it affects everything. And I don't know what happened to be honest! People started leaving, we had some nurses who had been here for ages who retired, and now it's just – they don't want to stay. We need some very stable nurses, I'd like to hire a few who are in their early forties, they've had their kids already, they don't need to be on parental leave, they don't want to see new things, they just want to get really good at their job. If we could get a few of those, I think that would make all the difference. But it seems very difficult to find them and then make them stay.*[10]

As we started interviewing and observing nurses and nurse managers, we were introduced to workplaces, usually specific wards within otherwise functioning clinics, that could not seem to retain staff. Interviewees had different explanations for the state of decline, but all agreed that staff turnover rates were a serious problem – and, indeed, seemed to have a self-strengthening quality; the more nurses quit, the more nurses quit. Quite often, interviewees who found

themselves facing this problem would say that their workplace had worked rather well in the past, but that "something had happened" which caused several nurses to change jobs. The event setting off the decline could be leadership change; a conflict at the ward; planned retirements of older nurses; or some other event that may or may not have been considered cataclysmic at the time, but which in hindsight proved central in pushing the organization toward decline. After that, something seemed to drive the organization into a state of disarray. Scholars have argued that organizations' decline happen in steps, and that the first step is a "blindness" on behalf of management to identify challenges threatening long-term viability (Weitzel & Jonsson 1989). From our material, it is clear that management may be blind to even short-term developments. In the narrative above, a nurse manager describes the situation in unprecise terms, confessing that she doesn't know what, exactly, has caused the situation she finds herself in, other than that a few senior nurses retired a while back and things started going downhill from there. Such imprecision was the norm in narratives of staff retainment issues. What interviewees could describe was the effect of repeated resignations in the ward. Often, nurses and managers would use terms such as "shaky" or "messy", describing a sense of disorder or lack of control caused by staff turnover. They would convey that nurses quitting resulted in a great sense of uncertainty, of not knowing what the make-up of the staff would look like in a few weeks' time. Nurses expressed that it was simply not enjoyable to work at a place that so many seemed to want to leave; it created a sense of dread. It also intensified nurses' and nurse managers' workloads. As the vignette indicates, losing experienced nurses increased the responsibility of more junior nurses. They would then often feel overwhelmed by being put in the role of ward cadre. This led to feelings of inadequacy and lack of control, as well as loneliness: one nurse explained in an interview that feeling new and inexperienced but not having anyone else to turn to in difficult situations felt "scary".

Thus, what we can identify here is turnover contagion leaving nurses to experience feelings of trepidation which prompts them to follow in the path of other nurses who have left. Quitting leads to quitting – an exit spiral is in motion. How, then, can we conceptualize these experiences?

Instability, discontinuity, and insufficient knowledge transfer – explaining the exit spiral

> *They're jumping ship. That's the sense you get. So why should I stay? And now, the problem is that the doctors are made to cover for nurses so that we can keep the operating theatres open and they hate that, so now doctors are leaving too. And word spreads throughout the building, so now everyone [at the hospital] knows that this is a real shit place. The mood is not good. So, I'm leaving. The thing that made me make my mind up is that I asked for a raise since I supervise all these new nurses who come in, and they make the same as I do even as I supervise them. I show them everything. The manager said no, so that is it.*[11]

What themes appear in narratives on exit spirals? One theme is that of 'shakiness', uncertainty, loss of control. We categorize this as *instability*. Instability as an issue is related to the lack of staff, the reduced number of people available to cover shifts. Lack of staff increases the burden on those still employed, and often leads to excessive demands on remaining employees to take on extra shifts. Lack of staff makes the organization seem greedy (Selberg, Sandberg & Mulinari 2021) and has a negative effect on staff motivation and attachment to work (cf Efendi et al 2019). The instability appears as shifts are covered at the last minute, or is covered by a nurse who was not supposed to work and perhaps is reluctant to do so – or, as is the case in the narrative above, when certain tasks are covered by an unhappy physician. Instability also appears as management and staff each begins to recognize that normal absenteeism due to sick leaves or parental leaves pose a threat to the organization; simply put when the organization struggles to handle even the expected variation in staff availability. Instability is also an issue related to a sense of a general shift in the organization resulting from resignations and new compilations of staff.

To reduce instability, managers recruit new nurses, sometimes on temporary basis. Recruiting new nurses can be a challenge since there is a lack of nurses in Sweden. If positions are not filled, or filled by temporary staff, a new problem appears: that of *discontinuity*. The theme of discontinuity appeared throughout interviews with nurses and managers who had or were experiencing a workplace in decline due to high turnover rates. One concrete example of discontinuity is the problem of upholding and improving routines. Routines and quality enhancement measures and -projects are difficult to identify, launch and implement if there are only enough people to run every day (and every night) operations, and/or significant portions of the staff are not properly attached to the workplace. Discontinuity is also a problem borne out of communication problems following from instability; in work teams that often shift make-up, it is difficult to get across messages about, for example, how to organize certain work sequences. Thus, instability and discontinuity are reciprocal phenomena.

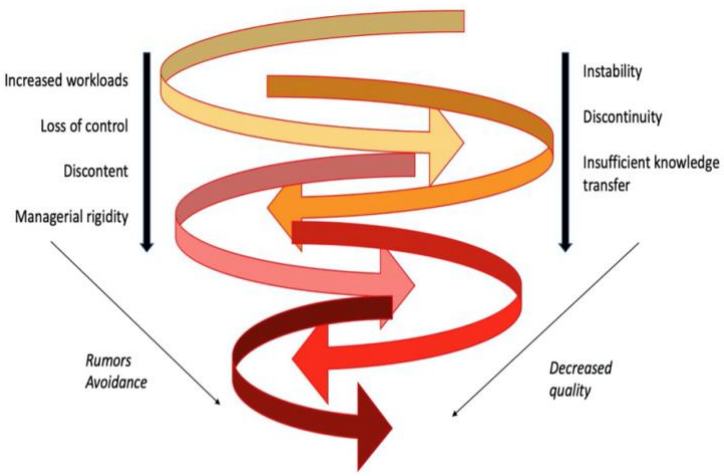
Interviews and observations suggest that once the organization has entered a phase of instability and discontinuity, management often reacts – sometimes in ways that repair the organization and stop turnover contagion, sometimes in ways that exacerbate the issues. In interviews, experienced nurses expressed, in various ways, that problems of instability and discontinuity are what prompts them to start thinking about leaving; this is likely where psychological exit happens. Often, however, nurses point to one specific thing driving them to give notice – an instance which potentially could have been prevented, had management acted differently. In the excerpt from an interview with a nurse, presented in the vignette above, we find one telling example of this: a nurse who had supervised many newly recruited nurses, at a ward where many other experienced nurses had already left and where doctors filling in were also discontent. The nurse had asked management for a raise, after having realized she earned no more than the nurses she was supervising. The manager said no to her request, and the nurse decided to exit. We have found, through interviews with nurse managers, that as they experience instability and discontinuity, they tend to become stricter with staff requests. But such austerity can also push staff to follow in the tracks of others that have resigned. Research has showed that

flexibility on behalf of management may increase retention (Reitz, Anderson & Hill 2010), and this may be especially important if turnover intention is already established. Other scholars have hypothesized that one important step toward organizational decline is the 'faulty action step' wherein leaders make inappropriate decisions due to their "misinterpretation of the gravity of the situation" (Bodolica & Spraggon 2020, 417). What our material indicates is rather that management may appreciate the gravity of the situation but take faulty actions by increasing austerity rather than flexibility in relation to remaining staff. In scholarship on organizational decline, this has been described as the "necessity is the mother of rigidity" perspective (McKinely, 1993).

As experienced nurses exit, more responsibility falls on less experienced ones. Previous research has illustrated that social support is crucial in retaining new nurses (Lavoie-Tremblay et al 2008). Poor practice environments and working conditions, Lavoie-Tremblay et al (2008, 290) argue, are "recognized as important factors contributing to global recruitment and retention in nurses", and poorly managed student-to-nurse transitions can be costly. High attrition rates have been linked to work environments which do not foster and support new nurses (Jacobsson and Cowin 2003). This was supported by our interviews, which indicate that if responsibility for maintaining routines and supervising new recruits fall on inexperienced nurses, these nurses are likely to leave. At this point, yet another problem arises: insufficient knowledge transfer. As fewer nurses remain to become experienced and properly trained in dealing with the particular patient category treated at the ward, then appropriate knowledge transfer between generations of nurses becomes more difficult. *Insufficient knowledge transfer* risks affecting the quality of care given at the ward.

Instability, discontinuity, and insufficient knowledge transfer are processes that develop within the organization as it enters an exit spiral. But there are external forces developing as well. Our material indicates that, as the vignette alludes to, rumors about a place which both experienced and newly recruited nurses readily leave may make it more difficult to attract new staff.

Fig. 1. The Exit Spiral.



The figure is an illustration of the mechanisms at play in the exit spiral. The arrows indicate the spiraling mechanism, wherein problematic features appearing in the decline phase lead to new or increased problems for staff; a downward movement of decline where each step builds on the previous one. On the left-hand side of the arrows are some key experiences we identified in interview accounts negatively affecting the staff. As nurses leave, those who remain experience increased workloads. They also experience a sense of loss of control, in their own work situation and in the ward generally, which leads them to feel discontent. As they interact with management, they may notice that managers are responding with increasing rigidity. Nurses also may find that rumors are spread about the workplace, which leads them to sense that potential recruits are avoiding the workplace. This can create, we suggest, a further psychological distance to the workplace, increasing the likelihood of remaining nurses deciding to quit. These experiences, then, create a pressure on the organization, exacerbating the downward spiral.

On the right-hand side, the figure indicates effects on the organization. There is instability as margins disappear to fulfill tasks, and as managers become increasingly busy with maintaining day-to-day operations. Discontinuity in the wake of staff changes may cause communication errors, thwart circulation of information and impede on the adherence to established routines. Insufficient knowledge transfer leads new staff to miss out on important aspects of established routines and hinders improvements of practices. All of this leads to quality decrease, which likely will affect patients as well as staff. These processes intensify the organizational decline.

As Engström & Axelsson (2010, 165) have argued, changes in the workplace often weaken social bonds, lead to conflicts and may influence the level of trust in the organization and its management. The concept of the exit spiral captures how turnover contagion may push an organization into unwanted changes – and may hinder necessary changes. Unwanted changes are major shifts in staff compilation, increased workloads, loss of control and discontent among management and staff, all of which negatively impact staff and management's experiences of the work environment. What the figure illustrates is that these problems may be exacerbated by rumors causing potential recruits to avoid the organization, and that the exit spiral thwarts stability, continuity, and proper knowledge transfer. It is likely to cause quality issues which may risk patient safety and negatively affect operational capacities. It is necessary, then, to halt the exit spiral.

Stability, continuity, and sufficient knowledge transfer – halting the exit spiral

> *They're young, they want to see new things, they want to increase their salaries, that is why they jump from one workplace to another. It's a new generation of nurses and they're very different from us, the old guard. So, they're never going to stay and really learn the craft with one category of patients. We had this word for it when I grew up, 'skipping around'. That is what we're going to have, people skipping from here to there. It can't be stopped, really.*

> *A few years ago, people left. There was a conflict of sorts, there was new management, and it wasn't a good situation. I left, actually, I went to work at [different clinic]. But I came back. That was after they changed managers. I heard from my old colleagues that things had improved, things had calmed down, it worked better. They changed the scheduling model too and people were happy about that, so I thought, I can try it, because I do appreciate working with these patients more. So, I talked to the managers, and they were happy and said that they weren't hiring but since I had all this experience that they would try to get me in. And they did. This was about ten years ago.*[12]

Through interviews with fifty nurses and on-site observations, we identified the problems associated with turnover contagion – the exit spiral. Is there a way to stop the decline? In scholarship on organizational decline and turnaround, it is suggested both that organizational decline is a catalyst for adaptation and innovation – and that it inhibits adaption and innovation (McKinley, Latham & Brown 2014). Central in our material seems to be the issue of recognition. The interviews and the observations suggest that it is possible for hospital wards to reach organizational turnaround, if management identifies and acknowledges that the organization is in fact in a downward spiral, and act purposefully to remedy the situation. Those nurses who had returned to a ward after having left during a string of resignations all suggested that they returned once they felt certain that management had recognized and addressed the problems. However, in some interviews, it is suggested rather that management sometimes react by blaming nurses for being young and therefore fickle, adventurous, or having unrealistic expectations regarding salary levels – in effect attributing organizational decline to employees and 'culture'. The quote above from a nurse manager illustrates this view, that resignations spring from a generational shift and thus are unstoppable. While there may be some truth to the idea of a new generation of nurses changing jobs more often (cf Stevanin et al 2018), it is also true that some wards are able to retain staff, including junior nurses. We suggest that defensive and deflective approaches will prolong the exit spiral and most likely result in leadership change.

Rather than deflection, then, we propose that *recognition* is key. Management should, we suggest, address the situation together with staff and create a vocabulary to name and confront the problems in the organization. We base this on interview data, that is, experiences of nurses who have in fact returned to clinics, and who talked about the important role of managerial recognition of previous failures. However, we also make this suggestion based on previous research on organizational decline, wherein the need for dialogue and experience sharing is stressed (Rockwell 2016, 18). The second step is *analysis*. We propose that management invites staff to participate in analyses of what is needed to improve working conditions within the organization. We make this contention based on research on organizational decline, wherein key steps of turnaround have been found to require a "an integrative effort of sensemaking, sense-giving, and sense-exchanging among leaders and members" (ibid.). Here, management's prerogative to identify and set the parameters of reforms can be communicated clearly in order to keep to a pragmatic and realistic agenda, but

voice should be encouraged, and management should be reflexive and *flexible* – and avoid impulses of austerity and rigidity. The agenda should focus on how to attain a sense of stability, continuity, and knowledge transfer within the organization. We argue that management should trust that nurses and physicians have expansive knowledge of the workings of the organization and are able to identify problems and remedies, even if staffing remains an issue (Selberg & Mulinari 2021). We suggest that involving staff in these analyses is a central step in organizational turnaround, since there is a negative balance between voice and exit.

Management should also make concerted efforts to recruit back staff that have resigned, including by communicating with former employees about what made them leave and what it would take for them to come back. We base this on interviews with managers and nurses who have recruited back or been recruited back to a hospital ward; the interviews illustrated that such a move is indeed possible. While employees at Swedish hospitals often are invited to so-called exit dialogues with HR officers, our interviews indicate that nurses are prone to give strategic answers to questions about why they are resigning to avoid direct conflicts with management – such as stating that they were offered a higher salary at another hospital, or that they want to learn new skills by working with a different group of patients. We argue that management should try to talk to former staff in ways that are not confrontational, but rather open to dialogue about what the unit can do to provide a sustainable position for nurses wanting to come back. In these conversations, management needs to be open to address problems at the ward, and be open to offer nurses some incentives to come back. Given that public hospital organizations often labor under strict budget restraints, management needs to exhibit *innovation* and flexibility in identifying such incentives – including measures that may demand extra funding. Management, then, should focus on recognition and distribution of efforts and resources to halt the exit spiral.

More Nurses Mean More Murses? Discussion and Conclusion

"More nurses mean more nurses", according to Linda H. Aiken (2019), suggesting a positive spiral emanating from generous staffing in hospital clinics. We have identified, through in-depth interviews with 50 nurses and nurse managers, as well as on-site observations, the constitutive elements of the exit spiral – a process of organizational decline in hospital clinics. Based on our analysis, one could argue, along with Aiken, that 'fewer nurses mean fewer nurses' – and we know, from extensive research, that understaffing among nurses has a negative impact on patient safety (Aiken et al 2018). In this article, we have provided scholars and clinicians with concepts to identify and analyze organizational decline related to nurse retention. While we were able to construct the concept from a combination of observations and interviews, as well as an engagement with previous research efforts on exit and spirals of decline in organizations, we argue that this concept offers a novel and indispensable tool to identify an existing yet under-studied pattern of employee exit. While we have used data reflecting Swedish conditions, we contend that the concept may well

be utilized by researchers studying exit processes in other countries, or in order to make cross-country comparisons. The main contribution of the article is its expansion of research on exit as well as research on organizational decline and turnaround in public sector organizations. We encourage researchers studying other organizations and types of work to engage with the concept of exit spirals, and to test its strengths, limitations, and generalizability in this way.

We recognize that managers, especially first line management, have a limited space to achieve organizational turnaround due to public sector retrenchment and austerity (Selberg 2019; Therborn 2018), but we have seen examples of successful reversals of exit spirals, and we have presented some central factors in accomplishing this. We conclude that strings of resignations – regardless of what sets them off – may create *exit spirals* that can be halted by recognition and distribution, analysis, voice, innovation, and flexibility.

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Notes

[1] Dagens Nyheter 2021-07-19.

[2] We refer to registered nurses with at least three years of tertiary education.

[3] Fifty interviews were conducted between 2017 and 2019; out of these fifty, ten interviewees held management positions or had held such a position in the past.

[4] Funding provided by Forte, grant number 2016-07146.

[5] Registered nurses work in many different areas, such as primary, secondary, and tertiary care, in public and private settings, and within a range of different specialties. While conditions vary across organizational contexts, the research referenced here is primarily focused on secondary and tertiary care, wherein patients are treated in hospitals. However, research indicates that many of the same issues facing RNs in specialized care are also present in the primary care system, with burnout being an even greater risk in primary care units (Monsalve-Reyes et al 2018.).

[6] One nurse per two patients and one assistant nurse per patient.

[7] Between six and eight patients per nurse and assistant nurse.

[8] Since we only did observations in four places, we did not gain insight in to all types of labor processes or workplace characteristics represented by the 50 interviewed nurses, whose workplace structures and experiences naturally vary. However, observations in hospital wards did aid us in the dialogue with interviewed nurses since we were able to relate interviewees' narratives to our observations, thus connecting through similarities and differences with what we had observed.

[9] The study has been reviewed and approved by the Swedish Ethical Review Board, dnr. 2017/792.

[10] This is a quote from interviewee 4, a nurse manager at a hospital.

[11] This vignette is a combination of quotes from two nurses (interviewee 48 and interviewee 16) working in different wards at two different hospitals.

[12] This vignette is based on interview quotes with one nurse manager (interviewee 3) and one nurse (interviewee 10), who both work in ICU wards, but at two different hospitals.