

**MAKING SENSE OF EMPLOYMENT AFTER A CARDIAC ARRHYTHMIA
DIAGNOSIS**

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DEDICATION

This thesis is dedicated to my Siamese cat, Mushroom, who has faithfully been by my side for seventeen years

ABSTRACT

The sensemaking process that employees engage in after receiving the life altering diagnosis of a cardiac arrhythmia has not been examined to date. This interpretive study uses sensemaking as a framework of data collection and analysis to examine the employment-related processes, procedures, and activities that individuals undertake after being diagnosed with a cardiac arrhythmia. Qualitative research methods are used to explore this experience from the viewpoint of the employee.

Keywords: arrhythmia, sensemaking, employment, disability

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CHAPTER 1: INTRODUCTION

As an able-bodied employee, my employment situation makes sense to me. My hours of work do not pose any particular challenges for me. My physical working space is big enough for me to comfortably complete my work. If I need to stretch my legs, grab a tea, or go to the washroom, I do not have to think twice about what that will look like. My co-workers know me and identify me based on my personality and work ethic, not my physical ability. I have never had to hide something major about myself in the workplace for fear that I would be treated differently. I have never been questioned for taking time off because I was ill or been spoken to about missing too much time at work for attending doctor's appointments. Going to work does not require me to change or adapt who I really am in any form. As such, I do not need to make sense of what is going on around me. Everything is 'typical', and I fit in well with that 'typical' environment.

But what about employees who are not able-bodied, and not part of the 'average' that I have just identified? What is the experience at work like for those who *do* have to think twice before going to the washroom, or who have to defend why they have to take extended time off for medical purposes? What is it like for those whose coworkers identify them by their disability? How does the workplace make sense to these individuals?

Taking one-step further, how do those, who once belonged to the 'normal' group, make sense of the workplace after receiving a life-altering diagnosis? How does one make sense of their surroundings when they are no longer 'Dan from Accounting', but are now instead 'Dan from Accounting who is at risk of sudden cardiac death and could collapse without notice at any minute'? Does the workplace make sense to this group of

people the same way that it makes sense to me? Does the concept of employment change after receiving a medical diagnosis?

In this study, I explore how employment makes sense for people who have received a medical diagnosis. More specifically, I look at the sensemaking process of employees who have received a medical diagnosis of cardiac arrhythmia.

Significance of the Study

As millions of Canadians deal with irregular heart rhythms (arrhythmias), it feels important that we consider this group and their personal experiences both inside and outside of the employment realm (Cardiac Arrhythmia Network of Canada [CANet], n.d.). Currently, information is available to arrhythmia patients through trusted sources such as Heart and Stroke Foundation (2018), which gives advice on how to go about daily living after being diagnosed with an arrhythmia or living with another form of heart disease. However, there appears to be little or no information available that deals with the new realities of employment that patients may experience after receiving their diagnosis. Specifically, how a patient makes sense of employment after receiving this diagnosis is not considered in detail. With the growing number of arrhythmia patients in Canada, it is important that we begin to ask these questions and explore the unknown territory of what it can mean to be an arrhythmia patient outside of the medical context.

This study begins to expose and explore an arrhythmia patient's journey within the employment sphere. More specifically, this study gains insight into the sensemaking processes used by arrhythmia patients after receiving their arrhythmia diagnosis. Using virtual interviews, arrhythmia patients were given the opportunity to share how their disability has affected their personal employment experience. The process used to make

decisions and navigate through employment was examined using a qualitative approach that allowed for the voice of the participant to be included.

As stated by Bansal, et al. (2018), “Adopting qualitative, inductive methods allows scholars to surface new insights and enable new ways of seeing.” (p. 1194). It is my intent that by using qualitative interviews, we can begin to explore how receiving an arrhythmia diagnosis can affect a patient’s employment experience. New insights about the topic as told by the patients were formed as a result of the qualitative data interpretation. Weick’s (1995) sensemaking was used to guide this study and examine the decision-making processes that employees engage in after receiving an arrhythmia diagnosis. Literature that considers organizational supports available to employees with disabilities, workplace disclosure, disability stigma, and decision-making for employees with disabilities is drawn upon and discussed.

Originally developed by Weick (1995), the qualitative social narrative process of sensemaking (Brown et al., 2008) was used as a framework in this study. Sensemaking is a process through which individuals prescribe meaning to everyday events (Aguinis & Glavas, 2019). For the purposes of this study, sensemaking was used to gain insight into how employees prescribe meaning to employment and/or employment specific situations after being diagnosed with an arrhythmia. By applying a sensemaking framework to the research, the focus shifts from organizational outcomes to the social psychological processes that contribute to organizational outcomes (Helms Mills et al., 2010).

As there is currently limited knowledge regarding the topic of my study, I suggest that sensemaking is an appropriate framework to use, which produces interesting and insightful results that explore the realities of employment for a patient who has received an arrhythmia diagnosis. Currently, we are unaware of what the sensemaking process

looks like for this employee group, and why they make the workplace decisions that they make. It is my intention that this study will provide useful information into these topics, and will spark future conversation regarding the relationship between cardiac arrhythmia and employment.

Research Question

This aims to answer the question:

How do employees make sense of their employment situation after receiving an arrhythmia diagnosis?

Thesis Structure

This study is presented in seven chapters, including the introduction. The chapters and their content will be as follows:

Chapter 1 - Introduction: This chapter introduces the study and research objectives.

Chapter 2 - Review of the Literature: Literature central to disability and employment is reviewed and discussed in this chapter. Organizational considerations for employees with disabilities are discussed, with an emphasis placed on barriers and facilitators, disclosure, and workplace stigma. To conclude the literature review, Weick's (1995) sensemaking is outlined. This is intended to provide useful insight into the study's guiding framework.

Chapter 3 - Research Methodology: This chapter discusses the design and research methodology of the study. The theoretical orientation of the study is identified.

Additionally, specific details regarding data collection and data storage are discussed.

Cardiac arrhythmia is highlighted when considering the sample population.

Chapter 4 - Data Analysis: This chapter discusses the methods chosen to analyze the data gathered. Discussions of both data validation and rigour applied to data collection, analysis, and reporting are included.

Chapter 5 - Findings: This chapter discusses and describes the findings from the data analysis in the context of organizational sensemaking (Weick, 1995).

Chapter 6 - Discussion: Key themes derived from data analysis are presented and discussed, with consideration to existing literature, and emphasis on Weick's (1995) sensemaking.

Chapter 7 - Conclusion: Study limitations are identified, implications for employees and employers are considered, and potential areas for future research are presented. Chapter Seven concludes with a summary of the research project.

CHAPTER 2: REVIEW OF THE LITERATURE

This literature review aims to expose a gap in the literature regarding the sensemaking process that an employee endures after receiving a life-altering diagnosis (in this case, cardiac arrhythmia). The experiences of this group have yet to be thoroughly examined within the context of an organization. Literature on disability and employment, including organizational supports, accommodations, barriers, and facilitators will be explored. Literature regarding invisible and episodic disabilities at work will be reviewed, and the stigma that may be attached to these disabilities in the workplace will be considered. The decision to disclose ones' disability to their employer will also be discussed and current research that studies decision-making (including disclosure) for employees with disabilities will be examined. To conclude, the sensemaking theory outlined by Weick (1995) will be discussed in detail.

Disability and Employment

When examining what work means to people with disabilities, Saunders and Nedelec (2014) found that work provides a sense of identity, a feeling of normality, self-esteem, worth, and financial stability, and was considered a natural part of life across all groups studied. Similarly, Ali et al. (2011) noted that employment provides social and psychological benefits to people with disabilities, as it increases their social networks, their sense of independence, their civic skills, and sense of self-efficacy and inclusion. Positive findings such as these provide evidence of the importance of providing employment opportunities for people with disabilities, and implementing workplace supports that allow them to meaningfully contribute to the organization.

As outlined by Rhoades and Eisenberger (2002), perceived organizational support (POS) provides employees assurance that, if needed, their workplace will provide the assistance required to execute one's job effectively and to deal with stressful situations. An example of organizational support is social support, which includes emotional, informational, instrumental, and appraisal support (Lysaght et al., 2012). Other types of supports that organizations may offer include (but are not limited to): workplace accommodations; co-worker and employer supports; and, employer-sponsored programs and policies (such as return-to-work [RTW] policies, medical/family leave policies, and disability case management) (Unger, 1999).

Workplace Accommodations

In Canada, employers and service providers have a duty to accommodate for employees with disabilities in order to prevent or reduce potential discrimination within the workplace (Canadian human rights commission, n.d.). This duty to accommodate requires employers and service providers to adjust rules, policies, or practices to allow employees with disabilities to participate fully in the workplace (Canadian human rights commission, n.d.). Job accommodations require that the employer modify the job, work environment, work process, or conditions of work to reduce physical and social barriers for the employee (Kensbock et al., 2017). However, if an accommodation is expected to cause the employer undue hardship, the employer will not be required to implement the accommodation. Examples of undue hardship include accommodations that would create health and safety hazards, or accommodations that would be financially burdensome to the employer (Canadian human rights commission, n.d.).

Workplace accommodations vary depending on the employee's needs. The accommodation may be temporary or permanent; may affect a single employee, a group of employees, or all employees; and, may include a single activity or a series of complex treatments (Williams-Whitt et al., 2015). Timely and appropriate accommodations are beneficial, as they allow the employee with the disability to remain at work rather than exiting the labour force, potentially relying on public benefits as a means of compensation (Gould-Werth et.al, 2018). Examples of workplace accommodations outlined in a study by Gould-Werth et al. (2018) include: temporary work leaves; modified workspaces, equipment, or attire; adaptation of job duties; modified work schedule; flexibility in hours worked, options to work from home; and referral to the company's employee assistance program (EAP).

Just as accommodations differ depending on an employee's needs, the experience (negative or positive) of an accommodation also differs for individual employees (Kensbock et al., 2017). While accommodations typically provide solutions to practical problems faced by employees, they may also generate new obstacles or barriers that the employee did not face prior to the implementation of the accommodation (Kensbock et al., 2017).

Barriers and Facilitators

Barriers cause workplace accommodations or the RTW process to be burdensome to the employee, while facilitators aid the accommodation or RTW process. Both are discussed below in greater detail.

Barriers

While not an exhaustive list, common barriers of accommodation that exist for employees with disabilities include: co-worker and employer negative attitudes, disbelief, and/or lack of understanding of the disability or accommodation(s) needed; customizing or learning how to use new assistive technologies; employer practices; workplace discrimination; health issues; and, difficulty adjusting to life with a disability (Nevala et al., 2015; Gould-Werth et al., 2018; Hay-Smith et al., 2013).

Managerial attitudes can also be a barrier to an employee's RTW success (Williams-Whitt, 2007). In Williams-Whitt's (2007) study, it was found that employees who required accommodations for a disability frequently felt unwelcomed by management. Additionally, it was indicated that in some cases, managers are biased towards believing that accommodations cause organizational difficulties, and are thus reluctant to accommodate for employees with disabilities (Williams-Whitt, 2007). This bias was heightened when managers questioned the legitimacy of the employee's disability (Williams-Whitt, 2007). Similarly, Gould-Werth et al. (2018) found that employees with disabilities often reported hostile behaviour from their supervisors as a result of their required accommodation. Other potential barriers identified for employee accommodations include the exclusion of the employee from the accommodation planning, accommodation investigation errors, and in the case of a unionized worksite, strained union-management relations (Williams-Whitt, 2007).

Facilitators

In comparison to barriers, facilitators can help to make the accommodation or RTW process easier for employees with disabilities. Common facilitators include: co-worker and employer's sufficient knowledge or experience with the disability; employer

and colleague support of work accommodations and the RTW process; flexibility in designing and organizing work; flexible work schedules; ability to self-manage the health condition at work; option to telecommute; freedom to take days off; reduced hours; job-sharing; altered work requirements; adapted work roles; a desire to return to work; returning to a familiar job; fostering hope in the RTW process; and, clear communication with insurance providers and supervisors (Nevala et al., 2015; Munir et al., 2009; Gould-Werth et al., 2018; Hay-Smith et al., 2013).

While discussed as a barrier above, managerial and supervisor attitudes can also be facilitators for the accommodation or RTW process. For example, O'Hagen and Thomas (2011) found that social support from employers is a significant factor in the RTW process and work adjustment for employees with cardiovascular disease. If management maintains contact with the employee (who is away from work due to their condition) and informs other employees about possible task reassignment, it can help to improve the employees' experience (Williams-Whitt, 2007; Gould-Werth et al., 2018). It has been found that employees with disabilities value managers who are responsive, fair, empathetic, and allow for shared decision-making (Williams-Whitt, 2007).

As demonstrated, there is a vast body of literature that considers workplace accommodations for employees with disabilities; however, further research is required to understand how accommodations are experienced for employees with cardiac arrhythmias.

The Impact of Invisible and Episodic Disabilities in the Workplace

An invisible disability is a physical or psychological condition that often does not include any visible manifestations or features that clearly connect it to a disability

(Santuzzi et al., 2014). Davis (2005) outlines five conditions, that if any or all are met, indicate an invisible disability. First, the presence or nature of an invisible disability is usually not able to be detected during the completion of mundane social interactions (e.g. grocery shopping). Second, invisible disabilities can place the affected individual at an increased risk for reoccurring episodes that may be painful, life threatening, or limit the activities that they are able to do. Third, invisible disabilities may severely limit the duration or circumstance in which affected individual are able to interact with others in everyday social settings. Fourth, the presence of an invisible disability can be verified by medical procedures, such as blood or microscopic evaluation, and the identification of the invisible disability is both straightforward and uncontroversial. Finally, invisible disabilities include an element of personal interpretation and judgement, beyond medical diagnosis (Davis, 2005). Examples of common invisible disabilities include sensory disabilities (e.g. hearing loss), autoimmune disorders (e.g. HIV/AIDS), diabetes, Crohn's disease, psychological disorders (e.g. post-traumatic stress disorder or depression), chronic illness or pain (e.g. fibromyalgia), and cognitive or learning challenges (e.g. attention deficit disorder) (Santuzzi et al., 2014; Davis, 2005).

Using the conditions outlined by Davis (2005), I conclude that cardiac arrhythmias meet the criteria of invisible diseases. While cardiac arrhythmia patients may appear able-bodied to the naked eye, they are living with a life-altering disability, which can, at times, be unpredictable or even fatal. While existing literature focussing on the self-management of invisible disease(s) in the workplace exists (e.g. Thompson et al., 2019), the self-management of cardiac arrhythmias as an invisible disease in the workplace has yet to be studied in-depth. Further research is required to understand how cardiac arrhythmia patients self-manage their invisible disability in the workplace, and

what self-management techniques, (such as recognizing and responding to symptoms, using medications, and managing episodes in the workplace) are used by this group (Gallant, 2003).

Episodic Disabilities

Episodic disabilities are disabilities that can be experienced in phases or ‘episodes’, in which the disability moves in and out of varying states and severity over time (Galarneau & Radulescu, 2009). Episodic disabilities include the fluctuation of mental health issues or physical health conditions in relation to different physical environments, life circumstances, and bodily experiences (Vick & Lightman, 2010). Additionally, episodic disabilities have the potential to damage a person’s health, employment stability, and overall quality of life (Vick, 2014). As it can be difficult or impossible to predict when, and to what extent, an episodic disability will affect a person and their ability to work, many people who suffer from an episodic disability encounter barriers in preparing for, finding, and maintaining employment (Vick, 2014). Difficulties in maintaining employment may arise from employers who view a person with an episodic disability as unreliable, as the person may require increased time off to deal with their health issues (Vick, 2014). Also, finding employment can be challenging for people who have episodic disabilities, as they may have gaps in their work history, which were caused because of their disability, further causing employers to be reluctant in considering that person for an interview or job (Vick, 2014).

Many arrhythmias exist as episodic disabilities. For example, a person who has recurrent syncope may faint frequently without warning. While the literature explores how episodic disabilities may affect a person’s ability to find or maintain employment, it does not consider the sensemaking process that accompanies the management of an

episodic disability in the workplace. Further, it does not consider how those with episodic disabilities, whose episodes may be fatal, self-manage their disability at work.

Stigma

Employees who have a condition or disability that differentiates them from the rest of the workforce may be subjected to stigmatization by those who do not have the condition or disability (Joachim & Acorn, 2000). Stigmatization is the process of attaching social meanings to behaviours and individuals (Joachim & Acorn, 2000). Often, this social meaning is negative, as the word ‘stigma’ indicates that something is bad or out of the ordinary about a person (Joachim & Acorn, 2000). In comparison a to person who possesses a visible stigma, whose main goal is to lessen tensions in interactions that arise as a result of their visible stigma, a person whose stigma(s) are not visible face the choice of concealing their stigma(s), or, exposing their stigma(s) and potentially facing derogation, discrimination, and/or other negative consequences (Jones & King, 2014). Previous studies have shown that individuals with stigmatizing invisible social identities (such as disability, chronic illness, sexual orientation, and race) often have interaction experiences at work that differ from the interaction experiences of people whose differences are visible (Clair, et al., 2005). However, as Jones and King (2014) acknowledge, much of the existing research regarding stigma and identity management emerges from a broader social psychological perspective. Thus, substantially less is known about concealing disability identity, such as an invisible arrhythmia, in the workplace, and how this identity management affects employees and organizations (Jones & King, 2014).

Disclosure

As disclosing disability to an employer can result in negative consequences, employees who are deciding whether to disclose their condition must consider how much information they give, and to whom they give information (Joachim & Acorn, 2000). Social and emotional dilemmas at work may affect a person's decision to disclose their disability (Thompson et al., 2019). Disclosure of the disability is likely to have implications on the employee's health, social relationships, and work performance (Santuzzi et al., 2014). Previous research has shown that employees are more likely to disclose their condition to their managers if they have felt secure enough to also tell their colleagues about their disability (Thompson et al., 2019).

Motives of disclosure include, but are not limited to, the need for workplace support, the severity of the illness, sharing to build trust with others, believing others have a right to know, and educating others to lessen stigmas (Gignac et al., 2021; Munir et al., 2005). Contrarily, motives to not disclose may include, but are not limited to, potential rejection, believing that the information is not others' business, negative past experiences, avoidance of gossip, not feeling a need to disclose, wanting to "pass as normal", believing that nothing can be done, and fear of job loss (Gignac et al., 2021; Munir et al., 2005).

Although there are both benefits and costs to disclosing disability, Santuzzi et al. (2014) argue that the benefits potentially outweigh the costs for a variety of reasons. First, disclosing the disability may reduce feelings of isolation for the worker with the disability, as they are able to facilitate social support networks with other co-workers who may have the same condition, leading to positive work and health outcomes. Second, disclosing the condition may reduce the stress that the worker feels as they try to hide their disability and identity from others. Third, if disclosure is not provided, and the

disability negatively impacts the employee's work performance, the employer is obligated to interpret the employee's performance under the assumption that disability is not a factor (Santuzzi et al., 2014).

For cardiac arrhythmia patients, the benefits and costs of disclosing their condition has yet to be given much consideration. As mentioned by Santuzzi et al. (2014), when disclosing an invisible disability that is low in social awareness, the employee may feel that they have an increased burden of proof placed upon them, as they have to convince their employer not only that they have a disability, but they also have to prove the legitimacy of their disability. Along with having to prove the legitimacy of their disability, employees may also feel that they have to prove to others that they are indeed impacted by the disability (Santuzzi et al., 2014). As arrhythmia is currently understudied in the management and employment field, there may be a lack of knowledge amongst employers and organizations about what arrhythmia is, and the different ways that it can affect employees. While Wither et al. (2015) reported that some arrhythmia patients try to 'cover up' their disability by hiding symptoms from colleagues, in fear that their condition may affect their employment, further research is still needed to discover why an arrhythmia patient does or does not choose to disclose their condition at work, and what impacts their decision of disclosure.

Employment-Related Decision-Making for Employees with Disabilities

Presently, there is limited information available in the literature that explores the decision-making process that employees with disabilities face in the workplace. Even less literature is available which explores the decision-making process outside of a formal rehabilitation or RTW plan. Studies done by Coutu et al. (2015) and Gouin et al. (2019)

explore how shared decision-making (SDM) or collective decision-making done by stakeholders in an employees' RTW process aides in the success of the plan. These studies examine how different stakeholders, including employees with disabilities, employers, healthcare professionals, union partners, and insurance companies benefit from making decisions regarding the employee's RTW as a collective effort (Coutu et al, 2015; Gouin et al., 2019). Similarly, Silverstein et al. (2014) focussed on the interactions between medical personnel and cardiac patients, and made recommendations for future collaborative decision-making processes between physicians and patients.

It is worth noting that while the study done by Coutu et al. (2015) examines the SDM model for employees' RTW process, the sample used did not include any employees with disabilities – rather, it considered the decision-making process through information given by occupational therapists and psychologists. This illustrates a need for studies that include the voice of employees with disabilities when considering employment-related decision-making.

Jans et al. (2012) considered the decision-making processes that are used by people or employees with disabilities in the context of disability disclosure, employment interviews, and job searching. Unlike the study by Coutu and colleagues (2015), Jans et al. (2012) gathered data directly from employees with disabilities. Data analysis suggested that the decision-making process and decisions made largely depend on the organization's workplace culture (how "disability-friendly" the employer is), and the employee's personal choices (Jans et al., 2012). It was found that the decision-making for these employees was a personal process, and that factors such as the visibility of the disability played a part in how decisions were made (Jans et al., 2012). Similar to Jans et al. (2012), my study considers the sensemaking and decision-making processes used by

employees with disabilities, by including the voices of these employees during data collection.

While conducting this literature review, it became apparent that research does not yet thoroughly consider the impacts that having an arrhythmia can have on an individual's employment experience, or the decisions that are made because of their arrhythmia diagnosis. While studies such as Wither et al.'s (2015) comment on the significant impact that arrhythmia can have on a person's social, family, or work life, the work sphere was not thoroughly examined. With millions of Canadians suffering from cardiac arrhythmias, it is important that we begin to explore and understand how arrhythmias can, may, and will affect these employees' experiences in the workplace. We do not yet understand how work is experienced after an arrhythmia diagnosis, and what does or does not make sense in the workplace to this group of employees. This study contributes to this gap of knowledge, using the sensemaking model as a framework to guide interpretation. The remainder of this chapter will discuss what sensemaking is, and the components of the framework that will be utilized throughout this paper.

Sensemaking

When engaging in common, everyday situations that do not create a sense of surprise, unknowingness, or shock, people use cognitive scripts to guide their decision-making processes (Louis, 1980). As defined by Abelson (1976), a cognitive script is "... a coherent sequence of events expected by the individual..." (p. 33). That is to say, when partaking in our everyday modes of operating, we do not typically use much conscious thought (Louis, 1980). Rather, we rely on established schemas, or cognitive scripts to make decisions.

In contrast, when individuals are faced with shocking experiences, or breaks from their traditional routines, they will be required to use sensemaking (Helms Mills et al., 2010). Made popular in organizational studies by Weick (1995), sensemaking literally means “the making of sense” (Weick, 1995, p. 4). When individuals face situations within or outside of an organizational context that are surprising, shocking, or confusing, they engage in a process of meaning construction to help interpret and understand such events or issues (Cornelissen, 2012). Sensemaking is process of social construction in which individuals seek to interpret and explain external environmental cues with which they are not familiar (Maitlis, 2005). Sensemaking is a primarily conversational or narrative process that involves a variety of spoken and written communication mediums, and sensemaking can be either formal or informal; occurring through verbal or non-verbal means (Balogun & Johnson, 2005). In order to infer and give meaning to unfamiliar events, individuals may engage in gossip or negotiations; seek new information; make note of physical representations, verbal, or non-verbal cues; or, engage in rumours or storytelling about past events (Balogun & Johnson, 2005). As described by Klein et al. (2006), sensemaking is unique from, yet includes elements of, creativity, curiosity, comprehension, mental modeling, and situational awareness.

Individuals retrospectively interpret and make sense of unfamiliar situations and environments in an attempt to gain understanding, order, and stability (Weick, 1995). This is done to reduce ambiguity and to return to the normal flow of activity (Weick, 1995). Drawing on the discussion of sensemaking provided by Klein et al. (2006) sensemaking serves several functions, in that it: (1) satisfies an individual’s desire to comprehend; (2) tests and improves plausibility of explanations; (3) clarifies past events; (4) anticipates future events, allowing us to gather required resources, foresee potential

difficulties, recognize problems, and realize concerns; (5) is a process of deliberation between alternative explanations; (6) guides the exploration of information; and, (7) is a social process that promotes achievement of a common understanding.

Within organizational studies, there are many specialized, distinct forms of sensemaking (Maitlis & Christianson, 2014). These include cultural sensemaking, ecological sensemaking, environmental sensemaking, constituent-minded sensemaking, future-oriented sensemaking, intercultural sensemaking, interpersonal sensemaking, market sensemaking, political sensemaking, prosocial sensemaking, prospective sensemaking, and resourceful sensemaking (Maitlis & Christianson, 2014). While various specialized forms of organizational sensemaking do exist in the literature, the majority tend to draw upon Weick's (1995) proposed theoretical framework of organizational sensemaking. For example, Kennedy (2008) describes market sensemaking as "a macro version of Weick's approach to meaning construction in organizations." (p. 272).

Weick (1995) states that it is possible for sensemaking to be a central activity within the construction of an organization and its related environments. He goes on to claim that "Both organizations and sensemaking processes are cut from the same cloth. To organize is to impose order, counteract deviations, simplify, and connect, and the same holds true when people try to make sense" (Weick, 1995, p. 82). He argues that sensemaking becomes important in organizational settings as people move from rational and understandable structures, processes, and environments to those that are more ambiguous (Weick, 1995). As such, it is suggested that social interactions between organizational members are what activates the sensemaking processes (Weick, 1995). As explained by Maitlis (2005), organizational sensemaking is a social process, in which members interpret their environment and interactions with others. It is these

interpretations that allow organizational members to comprehend the organizational world and act collectively and accordingly (Maitlis, 2005).

Maitlis and Christianson (2014) provide examples of sensemaking-related constructs, such as sensebreaking and sensehiding. One such related construct, sensegiving, is often discussed within management literature when considering sensemaking. Made popular by Gioia and Chittipeddi (1991), sensegiving refers to “attempting to influence the sensemaking and meaning construction of others toward a preferred redefinition of organizational reality.” (Gioia & Chittipeddi, 1991, p. 442). Simply put, sensegiving is a process in which individuals attempt to influence the sensemaking of others (Filstad, 2014). Sensegiving is an important activity for leaders to engage in, as it shapes employees’ understanding towards desired organizational realities and definitions (Filstad, 2014). Sensegiving can be used by leaders to communicate their thoughts to employees and gain their support during periods of change or uncertainty (Rouleau, 2005). Although much of the management literature on sensegiving focusses on how leaders use it to influence others, sensegiving is a process that can be used by other actors in an organization, including middle managers, directors, employees, and other stakeholders (Maitlis & Lawrence, 2007).

Sensemaking as a Framework

Weick (1995) identifies seven characteristics that distinguish sensemaking from other explanatory processes such as understanding or interpretation. According to Weick (1995) sensemaking is a process that is: (1) grounded in identity construction; (2) retrospective; (3) enactive of sensible environments; (4) social; (5) ongoing; (6) focused on and by extracted cues; and, (7) driven by plausibility rather than accuracy. These seven

components intend to provide a guideline for what sensemaking is, how sensemaking works, and how sensemaking can fail (Weick, 1995). These components individually contribute to our understanding of the sensemaking process, and when taken together, provide an analytical framework that can be used within organizational research. Using sensemaking as a guiding theoretical framework helps to form a description of the processes, procedures, and activities that individuals experience while navigating unfamiliar situations.

The Seven Elements of the Sensemaking Process

Grounded in Identity Construction. Sensemaking is grounded in identity construction, with the sensemaker's identity being continually shaped by interactions with others in their environment (Weick, 1995). According to Weick (1995), the sensemaker is "...an ongoing puzzle undergoing continual redefinition, coincident with presenting some self to others and trying to decide which self is appropriate." (p. 20). How individuals define themselves is often a reflection of the reactions that others display towards that individual in a particular environment (Harris, 1994). The sensemaker seeks cues from others' actions, reactions, and behaviours that either affirm or disaffirm their sense of self. If the cues received disaffirm the sensemaker's sense of self, the sensemaking process continues as the individual re-defines and re-enacts their sense of self, the environment, and the situation, to produce a more appropriate sense of self (Weick, 1995).

Retrospective. Sensemaking is a retrospective, comparative process that relies on past experiences to interpret current events (Helms Mills et al., 2010). Retrospective sensemaking draws on meaningful lived experiences (Weick, 1995). As Weick (1995) notes, 'lived' is the key word, as individuals can only know what they are doing after they have already gone through (lived) a particular experience. To give meaning to present

situations, individuals compare the current situations to a similar or familiar past event, relying on the past event to make sense of the current event (Helms Mills et al., 2010).

As Weick (1995) states, within retrospective sensemaking, ‘meaning’ becomes subject to hindsight bias. That is, meaning is both informed and influenced by any prior knowledge as well as present experiences (Weick, 1995). As such, when engaging in retrospective sensemaking, past experiences may employ multiple meanings that are contingent upon the situation (Weick, 1995).

Enactive of Sensible Environments. Sensemaking is the combination of action and cognition working together (Weick, 1995). Within the sensemaking framework, action is assumed to precede cognition, meaning that individuals often make sense of their actions only after the actions have already been carried out (Weick, 1995). Thus, it is through sensemaking that environments are created (Helms Mills et al., 2010). Helms Mills et al. (2010) note that individuals create environments that serve to reinforce their sense of credibility. The process of enactment in sensemaking is apparent when people enact environments, which enact their identities (Weick, 1995). Weick (1995) argues that as people create environments, those environments simultaneously create the people.

Social. Sensemaking is a social activity that relies on the physical and symbolic interaction between the sensemaker and others (Weick, 1995). It is not necessary for others to be physically present for an individual to engage in the sensemaking process (Helms Mills et al., 2010). Individuals may engage in mentally improvised dialogue with relevant others (whether past or present, real or imagined), to determine their thoughts and actions (Harris, 1994). Sensemaking is never a solitary process, as the conclusions that one reaches internally are reliant upon the interactions, expectations, and reactions of social others (Harris, 1994). Social cues are taken into consideration when reflecting on

past experiences that influence sensemaking decisions. Additionally, organizational rules, symbols, routines, and language affect an individual's sensemaking activities, and provide routine scripts for appropriate future conduct (Helms Mills et al., 2010). It is because of the role of social others within the environment that sensemaking is a social process (Weick, 1995).

Ongoing. According to Weick (1995), sensemaking does not have a beginning nor does it have an end. It is a sequential process that never stops, as sensemaking flows are constant (Helms Mills et al., 2010). Weick (1995) argues, "The reason it never starts is that pure duration never stops. People are always in the middle of things, which become things, only when those same people focus on the past from some point behind it." (p. 43). As individuals maneuver through their daily lives, they will on occasion be confronted with obstacles that are unfamiliar to their routine and threaten their ongoing flow of activity. In these situations, sensemaking efforts are used to restore order and resume the ongoing flow of daily activity (Weick, 1995). The sensemaker draws on similar previous experiences or emotions to then make sense of the current situation (Weick, 1995). As these interruptions are unplanned and unpredictable, sensemaking never "...starts fresh nor stops cleanly." (Weick, 1995, p. 49).

Focused on and by Extracted Cues. Individuals extract cues from interactions, events, environments, and activities that help to shape the sensemaking process. How individuals view these cues is dependent upon the context from which the cues are drawn (Weick, 1995). The context from which the cue is derived affects both what an individual extracts as a cue (through searching, scanning, and noticing), and how the cue is then interpreted (Weick, 1995). Context is critical in this stage of the sensemaking process, as without a supplied context, objects and events have ambiguous or multiple meanings.

Through the recognition of salient contextual cues and embellishment of said cues, individuals gain faith in cues and use them as reference points in the sensemaking process (Weick, 1995).

Helms Mills et al. (2010) argue that individuals choose to focus on certain cues while completely ignoring others to help strengthen and support their interpretation of an event. Cues may be interpreted in the sensemaking process in ways that support the individual's existing beliefs (Helms Mills et al., 2010). This phenomenon is sometimes referred to as a "self-fulfilling prophecy" (Weick, 1995, p. 54).

Driven by Plausibility Rather than Accuracy. Sensemaking is a highly subjective process that depends on an individual's interpretations of social situations. As such, the sensemaking process is not intended to produce an objective reality that is appropriate for all people, environments, or events. Rather than focussing on accuracy, Weick (1995) proposes that sensemaking is about "plausibility, pragmatics, coherence, reasonableness, creation, invention, and instrumentality." (p. 57). Helms Mills et al. (2010) claim that the reliance on plausibility rather than accuracy may contribute to inconsistent sensemaking among individuals who experienced the same event. Specific to organizations, different meanings of identical actions, policies, or events may become plausible for different groups within the organization (Helms Mills et al., 2010). However, whether these meanings are the same for all individuals is irrelevant, as individuals will have separate accounts of previous experiences, and will have unique interpretations of the same contextual cues. These interpretations and recollections become reality for the individual.

Weick (1995) provides eight reasons as to why sensemaking is driven by plausibility rather than accuracy. First, as people are constantly receiving new data, it is

beneficial to be able to sort and filter what information is relevant as to not be overwhelmed. Second, as a single cue can be assigned multiple meanings by multiple people, it is impossible to establish a single objective meaning of that cue. Rather than assigning an objective meaning to the cue, it is more plausible and more likely for people to individually make sense of such cues. Third, it is often necessary to sacrifice complete accuracy in favour of speed within an organization. It can be costly for organizations to strive for complete accuracy, therefore plausibility is often favoured in such situations. Fourth, in a rapidly changing world, it is more realistic to strive for circumscribed accuracy (focussing on predictions of events in limited contexts for short periods of time) than it is to strive for global accuracy (forming a widely generalizable belief). Fifth, accuracy is far less suited to studying interpersonal perceptions than it is objective perceptions. Sixth, individuals base their actions in situations on perceived consequences. The considered consequences are more likely to be derived from what makes sense, rather than what will undoubtedly happen, as that cannot be predicted. Seventh, in a constantly changing environment, plausibility will allow for forward movement, while striving for accuracy may cause stagnation. Lastly, at the time of perception, it is nearly impossible to tell whether the perception is accurate or not (Weick, 1995).

In essence, rather than striving for complete accuracy, Weick (1995) recommends striving for plausibility, coherence, and reasonableness. Information which has been filtered through the sensemaking process is often more understandable, albeit less accurate. As sensemaking is a subjective process, the need for accurate, objective descriptions does not exist (Weick, 1995).

With regards to this study, Weick's (1995) seven elements of sensemaking (grounded in identity construction, retrospective, enactive of sensible environments,

social, ongoing, focused on and by extracted cues and, driven by plausibility rather than accuracy) will be used to explore how sense is made by employees after receiving an arrhythmia diagnosis. Greater detail on the purpose of sensemaking in this study is provided in Chapter 3.

CHAPTER 3: RESEARCH METHODOLOGY

Theoretical Orientation

In this study, I used an interpretivist approach to research (Lindlof & Taylor, 2002; Eriksson & Kovalainen, 2008). An interpretivist approach to research relies on the argument that “there can be no understanding of the social world without interpretation.” (Leitch et al., 2009, p. 70). Rather than using causal relationships between variables to describe human behaviour, interpretivist research seeks to understand human behaviour by examining interpretations that are subjectively ascribed to phenomena by individuals in an attempt to describe and explain the world around them (Eriksson & Kovalainen, 2008; Leitch et.al, 2009). This strategy applies the notion that the reality of situations is not defined by acts, but rather by ongoing organized patterns and complex actions, with a focus on the human sensemaking process that accompanies these patterns and actions (Eriksson & Kovalainen, 2008). Additionally, interpretivist inquiry allows the researcher to apply a holistic view to a social research problem, enter participant realities, and interpret perceptions of these realities as appropriate. Such interpretations are formed through individual descriptions of actual events that took place, which uncover the meanings that individuals ascribe to these events (Leitch et al., 2009).

The interpretivist approach that I used in my study is an approach based in social constructivism. Using a social constructivist approach, I sought to understand and interpret how participants of the study came to make sense of employment-related events after receiving an arrhythmia diagnosis, using sensemaking as a framework. The purpose of this study was not to find one common experience or meaning that is ascribed to this phenomenon; rather, it was to uncover the unique interpretations and meanings that

individuals give to their personal experiences. As explained by Blaikie (2000), people experience multiple realities; that is, no one objective experience represents all people's experiences. Although participant interviews uncovered common themes, no two participants had identical views regarding employment after receiving their diagnosis. The same, or, similar experiences were interpreted various ways by different people (Eriksson & Kovalainen, 2008).

This study embraces the use of an abductive ontological strategy (Blaikie, 2000), which does not attempt to link theory and research through conceptual or logical ways of thinking. Instead, it allows data and theoretical ideas to respond to one another through a developmental creative process (Blaikie, 2000). As explained by Blaikie (2000);

Abduction is a process by means of which the researcher assembles lay accounts of the phenomenon in question, with all their gaps and deficiencies, and, in an iterative manner, begins to construct their own account... it involves the researcher in alternating periods of immersion in the relevant social world, and periods of withdrawal for reflection and analysis. (pg. 181)

Using an ontological lens, I assumed that how an individual made sense of employment after receiving an arrhythmia diagnosis was of a subjective nature, shaped by their lived experiences and personal perceptions. It is assumed that these individual realities are fluid, and may vary for an individual at different times or in different contexts. As Eriksson & Kovalainen (2008) discuss, ontological lenses are closely related to, and often discussed with, or, used in combination with epistemological lenses. Therefore, I also considered information gathered in this research through a subjective epistemological lens (Eriksson & Kovalainen, 2008) in combination with an ontological view. By using subjective epistemology, I assumed that participant observations and views shape their opinions and beliefs about the external world (Eriksson & Kovalainen, 2008).

Data Collection

Data were collected using qualitative methods. As described by Gould-Werth et. al (2018), “in contrast to survey methods, qualitative inquiry allows researchers to uncover nuanced differences in how individuals evaluate complex situations...” (p. 612). While it is possible to observe an arrhythmia patient at work and make assumptions based on the observational findings, we are likely to gain richer insights by gathering data directly from the employees themselves when learning about their experience(s) with employment after diagnosis. To do this, one-on-one in-depth, semi-structured interviews were conducted between myself and participants, allowing for first-hand explanations on how their arrhythmia diagnosis has affected their employment experience. This study is exploratory in nature, and as mentioned prior, does not intend to provide a single, objective experience that is shared by all participants. Rather, it aims to uncover existing themes and new knowledge related to the topic.

To ensure the integrity of data, all participant interviews were audio recorded. Audio recordings were be transcribed using the third-party transcription service Rev.com. Prior to recording interviews, participants were required to sign a waiver, agreeing to be recorded, and acknowledging that they understood that the transcriptionist would hear the recordings.

To add richness to the audio recordings, I also took notes while interviewing participants. The purpose of these notes was not to record what the participants say, but rather, to record any interesting observations (such as changes in demeanor or body language) I made during the interview.

Interviews

Data was collected using in-depth semi-structured interviews. In-depth interviews allowed me to use an inductive approach, drawing observations directly from patient narratives to explore their experiences. The purpose of these interviews was to understand the lived experiences of participants after receiving their diagnosis, and how these experiences have shaped how they made, or continue to make sense of employment. Transcripts from these interviews were used as units of analysis, which allowed me to uncover both similarities and differences between the patients' individual experiences, and draw comparisons from my findings (Gould-Werth et. al, 2018).

This study addresses three of eight distinct purposes of qualitative interviews outlined by Lindlof and Taylor (2002): 1) understanding social actors' experiences and perspectives through stories, accounts, and explanations; 2) gathering information about things or processes that cannot be observed effectively by other means; and, 3) inquiring about occurrences in the past.

Understanding Social Actors' Experiences and Perspectives through Stories, Accounts, and Explanations

Interviews were used to help understand participants' (social actors') experiences and perspectives of how an arrhythmia diagnosis altered how they made, or continue to make sense of their employment. Participants were asked to share the relationship between their disability diagnosis and their employment using personal stories, individual accounts, and explanations of behaviour (Lindlof & Taylor, 2002). Stories shared by participants provided insight into the context, action, and intentionality (Lindlof & Taylor, 2002) of their lived experience. As explained by Hunt and Manning (1991),

participants may also provide specific accounts of their lived experiences, which serve as excuses or justifications of their social conduct (as cited in Lindlof & Taylor, 2002).

Information gathered from the interviews provided explanations as to how or why participants made certain decisions regarding employment after receiving their diagnosis, as participants explained how they applied prior knowledge, negotiated issues, and interpreted social cues such as speech and text in these instances (Lindlof & Taylor, 2002).

Gathering Information about Things or Processes that cannot be Observed Effectively by Other Means

Using interviews for data collection, I was able to gather information about processes that I would not have been able to obtain through other methods of observation (Lindlof & Taylor, 2002). More specifically, the interviews were used to examine individual sensemaking processes that could not have otherwise been observed without input from those who have first-hand experience with the topic. It was through the use of interviews that I was able to “learn about physically unbounded social realities... [and] identities and meanings that cut across, lie outside, or transcend settings” (Kleinman et al., 1994, as cited in Lindlof & Taylor, 2002) that would not have been otherwise observable to an outsider.

Inquiring About Occurrences in the Past

Participants were asked to reflect upon past events during the interview process. Inquiring about past events allowed me to interpret any critical events or memories (Lindlof & Taylor, 2002) that may have directly or indirectly affected the sensemaking process used by the participant after being diagnosed with an arrhythmia.

Interview Structure

All interviews were guided and semi-structured (Eriksson & Kovalainen, 2008), and followed the same interview guide (see Appendix A). The purpose of using semi-structured interviews was to allow for flexibility in the way I asked questions, the order in which questions were asked, and to allow for the use of additional probes or questions as the conversation unfolded. The prepared interview guide is systematic, in that it outlines the topics, themes, and issues that were to be addressed throughout the conversations, yet it still allowed for the interview to take a conversational, informal structure when appropriate (Eriksson & Kovalainen, 2008).

A set of established questions were used as a conversation guide during all interviews (see Appendix B). These questions were formulated in a way that encouraged organic, open conversation, between the interviewer and interviewee. Additional questions that were not prepared in advance were also asked in response to information shared by the participant. The questions that I asked were guided by a sensemaking framework, and aided me in understanding the participant's individual experience. For example, participants were asked '*Who did you discuss your disability with after receiving your diagnosis?*' to gain insight into the social aspect of sensemaking. '*How "disability-friendly" would you consider your job at the time?*' was asked when exploring the cues extracted and focussed on component of sensemaking. Appendix B organizes the list of interview questions into the seven components of the sensemaking framework of the study.

When conducting interviews, I used a 'constructionist' approach (Eriksson & Kovalainen, 2008) that focussed on the interaction between the interviewer and interviewee, resembling an everyday conversation. This approach allows the interviewer

(in this case, me) to fully submerge themselves in the discussion with the interviewee, acting as a party of a conversation, rather than an external observer (Eriksson & Kovalainen, 2008). Eriksson & Kovalainen (2008) explain that when using a constructionist interview approach, the pre-prepared interview guide and questions serve to initiate conversation, allowing for flow in many different directions, depending on how the interaction proceeds. This was true to the interviews conducted for this research, as all interviews had a unique ‘flow’, as participants offered information specific to their experience, with interpretations of these experiences that were distinctive to the participants.

All interviews conducted were one-on-one between me and the participant, using Zoom Video Communications, Inc. (Zoom). While designing the study, in-person interviews were listed as the preferred method of interview; however, this was not possible due to the unforeseen circumstances of COVID-19. As interviews were conducted during the COVID-19 Pandemic, they were done virtually using Zoom in compliance with temporary provincial mandates.

Interviews followed McCracken’s (1988) “long interview” approach. Each interview was between approximately 45 to 120 minutes in length. By using the long interview approach, time allowed me to simultaneously learn about participant views, perspectives, and lived experiences while exploring emerging key themes (McCracken, 1988).

Data Storage

To protect the participant’s information, all transcripts have been stored in locked digital files. Those with access to the file were identified to the participant via the consent

form. Only those directly involved with the study have access to the data collected, with the exception of an external transcriber. As previously outlined, participants were informed about, and required to agree to, the use of an external transcriptionist before their interviews were submitted for transcription

Sensemaking Framework

Sensemaking played a leading role in this study, as it is the framework on which interview questions were centered. Additionally, sensemaking was used during data analysis and in the presentation of findings.

Sensemaking seeks to understand how individuals assign different meanings to the same event (Helms Mills et al., 2010). This aligns with the theoretical orientation of the study, which utilizes an ontological, social constructivist lens. The objective of studying individual sensemaking in my research was not to produce one reality that was shared by all individuals. Rather, the use of the sensemaking framework allowed me to uncover the unique individual realities that are formed through the conscious or unconscious engagement in sensemaking. This method of inquiry allowed me to capture how employees individually make sense of their employment situation after they receive an arrhythmia diagnosis. As previously mentioned, the intent of my research is not to find a shared-meaning of the experience by all participants.

Sensemaking can be used to examine both individual experiences and organizational outcomes (Helms Mills et al., 2010). For the purposes of my research, sensemaking is used solely to understand individual experiences, within an organizational setting. The use of sensemaking in my study is not to examine organizational outcomes or efficiencies. Instead, it is used to understand the unique, lived-experience of cardiac

arrhythmia patients within an organization, and examine how the context of the organization affected the individual sensemaking process.

Sample Selection and Recruitment

Sampling Strategy

The sampling units for this study are individual participants who have received a medical diagnosis of cardiac arrhythmia, and are either currently employed, or were previously employed with knowledge of their diagnosis. This group of people were chosen as the sampling unit as they could provide first-hand knowledge and share personal experiences that directly relate to the research topic (Lindlof & Taylor, 2002). Purposive, non-probability sampling methods (Lindlof & Taylor, 2002; Eriksson & Kovalainen, 2008) were used to recruit participants to volunteer in the research.

Recruitment

This study relied on purposive sampling methods to recruit participants. My own knowledge of people who have been diagnosed with an arrhythmia was used, and those people were invited to participate in the research. Through both previous research I have been involved in, and through personal relationships, I have made connections with arrhythmia patients who were eager to share their stories. As interviews were completed, I asked these connections to help identify and recruit others who fit the requirements of the study and were able to participate. My recruitment efforts primarily consisted of criterion sampling, opportunistic sampling, and snowball sampling.

Criterion Sampling. All participants were required to meet three specific criteria: 1) they must have received a medical diagnosis for a cardiac arrhythmia; 2) they must currently be employed, or have been previously employed with an arrhythmia diagnosis; and, 3) they must have been employed in Canada at the time. As a part of a larger study

examining arrhythmia patients' journeys, preliminary focus groups had been conducted with numerous participants that met the sample criteria for this study. Participants from the focus groups who met the above criteria and expressed interest in partaking in further research were contacted with the opportunity to be interviewed in-depth about their employment experience as an arrhythmia patient. Additionally, any personal connections that I had with people who fit the study criteria were asked to participate. In total, seven participants were recruited using criterion sampling.

Opportunistic and Snowball Sampling. I also made use of opportunistic sampling and snowball sampling. Participants who had been identified through criterion sampling were asked if they knew of any other potential participants who met the necessary criteria that would be willing to be contacted (snowball sampling). Additionally, if through chance encounter I identified a potential participant who met the necessary criteria, they were asked if they were interested in participating (opportunistic sampling). In total, eight participants were recruited using opportunistic and snowball sampling.

Participants

The preference for this study was to include participants with varied demographic information; however, the criteria that participants were required to meet to qualify for the study limited who I was able to include. Demographic information for all participants is further discussed in Chapter 5.

All participants in my study are Canadian citizens. The purpose of only including Canadians within this study was to ensure consistency across federal legislation that may have affected their employment experience as an arrhythmia patient.

Arrhythmia Diagnosis

All participants in this research have received a medical diagnosis of a cardiac arrhythmia. A person is said to have a cardiac arrhythmia if their heart rate or heart rhythm is irregular; arrhythmia may cause a person's heart to beat too quickly, too slowly, or irregularly in comparison to a healthy heart (National Heart, Lung, and Blood Institute [NHLI], 2019; Heart and Stroke Foundation, 2018). The various types of arrhythmias are classified by whether the heart beats too slowly (bradycardia), or too quickly (tachycardia) (Heart & Stroke Foundation, 2018). Multiple forms of cardiac arrhythmias have been identified, including the most common type of arrhythmia, atrial fibrillation (also known as Afib or AF) (Lip et al., 2012). For this study, it was not required for participants to have received a specific type of arrhythmia diagnosis (for example, it did not matter if the patient was diagnosed with Long QT Syndrome or Afib; as long as their diagnosis fell under the umbrella of an arrhythmia, they were qualified to participate).

Sample Size

Sample size was not determined until later in the study, as recommended by Lindlof and Taylor (2002). Similarly, Eriksson and Kovalainen (2008) suggest that decisions regarding sample size evolve as interviews are completed. When considering if more interviews were required, I took a variety of factors into consideration. Specifically, I assessed the quality of data that had been received to that point, and the presence of data saturation (that is, was I still learning things that had not already been discussed in previous interviews?) (Lindlof & Taylor, 2002). Additionally, I considered the accessibility of available participants, the time needed to conduct more interviews, and the resources available to me to conduct such interviews (Lindlof & Taylor, 2002; Eriksson & Kovalainen, 2008). My initial intent was to interview between ten to fifteen

participants. In total, I was able to interview fifteen participants. I began to encounter data saturation after approximately ten interviews, but continued with five additional interviews to confirm saturation. These five interviews were possible due to the accessibility of participants. Due to continued data saturation and time constraints, I stopped recruiting and interviewing participants after fifteen interviews were completed.

CHAPTER 4: DATA ANALYSIS

During data analysis, I used the “data analysis spiral” described by Creswell and Poth (2018). The spiral consists of five steps that occur in the period between data collection and reporting findings: managing and organizing data; reading and memoing emergent ideas; describing and classifying codes into themes; developing and assessing interpretations; and, representing and visualizing the data. Each step will be briefly described below, with an explanation of how the steps were applied in this study.

At the onset of analysis, collected data were organized in a way that allowed for ease of access. Data were managed using separate digital files for each participant. The computer software Quirkos was used to store and analyze all data in one central location.

Once data had been managed, organized, and stored in the electronic database, I read and listened to all transcripts. As Agar (1980) suggests, each transcript was read more than once, to gain an understanding of each interview as a whole, before dissecting the data into separate codes and themes.

To aid in the formation of codes, I made memo of all thoughts, ideas, and interpretations as I read each transcript. Three levels of memos were utilized throughout this stage of analysis: segment memos, document memos, and project memos (Creswell & Poth, 2018). Segment memos were used to capture ideas that were born from reading particular phrases, paragraphs, or words in the transcripts. Document memos were used to capture ideas that formed after reviewing an entire transcript. Finally, I used project memos to link ideas from multiple transcripts, demonstrating how these concepts fit together across the entirety of the project. These memos were then used to aid in the building of codes and themes.

My third step of analysis, describing and classifying codes into themes, required me to make sense of data collected from interviews. Using my own sensemaking process during analysis, I constructed detailed descriptions of the data, created and applied codes, and developed overarching themes that allowed me to provide an in situ interpretation of the collected data.

While developing codes that later became themes, I also “winnowed” the data (Wolcott, 1994). Through the process of winnowing my data, I identified what information was not needed within the final interpretation. As such, only data that were relevant to my research question were coded and later sorted into themes.

While coding, I used an emergent strategy, creating new codes as I sorted through the data. At the conclusion of data analysis, I had created 23 separate codes (see Appendix C). Suited to this particular study, I coded information was relevant to the experience of the employee, and the processes, actions, and interactions that they engaged in specific to the research questions. At the conclusion of the coding process, I identified overarching themes that were derived from the list of codes. These themes are discussed in detail in Chapter 6.

As described by Patton (2015), the interpretive process requires creatively and critically making judgements about what is meaningful in the patterns, themes, and categories that have been identified through analysis. I used Weick’s (1995) sensemaking framework to develop and assess interpretations. The emergent themes, patterns, and categories were considered within the seven steps of the sensemaking process. It is worth noting that while the sensemaking framework was used to guide the interview process, my final interpretations from the data may vary from another person’s interpretations who used an identical framework.

During this step of data analysis, I performed member checks to ensure that the interpretations that I had developed were true to the stories told by participants. To ensure that participants were in agreement with assisting in member checks, I asked during the interview process if I had permission to contact them during the data analysis stage to ensure that the themes presented were accurate representations of the employment experience of an arrhythmia patient, in their opinion.

As my final step in the data analysis process, data were presented using detailed descriptions. These descriptions can be found in Chapters 5 and 6.

Quality of Data Collection and Analysis

Steps were taken to demonstrate the rigor applied to the data collection, analysis, and reporting of this study. Guba and Lincoln (1989) discuss a ‘Parallel Criteria’ (trustworthiness) that can be applied to assess the adequacy of qualitative research. The Parallel Criteria contains four components (credibility, transferability, dependability, and confirmability) of assessing the adequacy of qualitative research, which are considered to be parallel to the criteria used to judge the quality of quantitative or ‘conventional’ research (internal validity, external validity, reliability, and objectivity) (Guba & Lincoln, 1989). Each of the four criteria used for assessing the adequacy of qualitative research is explained below, along with a description of how these criteria were applied throughout this study. In addition to using the Parallel Criteria, I bracket myself out of this study, outlining the researcher’s voice, by discussing my personal position and experience with the topic. By doing so, I establish rigor in my research by exposing my personal biases that may present themselves throughout the study.

Credibility

Guba and Lincoln (1989) consider the credibility criterion parallel to the concept of internal validity. Whereas internal validity is used to describe the similarity between research findings and objective reality, credibility is used to describe the similarity between a participant's constructed reality, and the reconstructions that are attributed to those realities (Guba & Lincoln, 1989).

To demonstrate credibility in my research, I conducted member checks with willing research participants. As stated by Guba and Lincoln, member checks are the "single most crucial technique for establishing credibility" (Guba & Lincoln, 1989, p. 239). To conduct member checks, I brought back information collected from interviews to members, as well as the key themes that were formed through analysis. Members were then able to confirm whether I had accurately captured the information that they had shared with me, and if the key themes were relevant to their personal experience.

Transferability

Transferability is considered parallel to external validity or generalizability (Guba & Lincoln, 1989). More specifically, transferability refers to the degree in which the results of qualitative research can be applied to other contexts or settings.

To demonstrate and create transferability with this research, I include all pertinent information to this study in the final report, increasing the opportunity of transferability to others who may wish to apply this study, or facets of this study, to their own situations or situations of interest (Guba & Lincoln, 1989).

Dependability

Similar to the criterion of reliability, dependability is concerned with the stability of the data over time (Guba & Lincoln, 1989). Compared to conventional inquiry, which views alterations in methodology or design of the study as a weakness in reliability or dependability, qualitative inquiry views methodological shifts and changes as the hallmarks of a maturing, successful study (Guba & Lincoln, 1989).

To demonstrate dependability in my study, I noted the few changes in methodology that arose throughout the process. All changes made were specific to the interview protocol script or blueprint. First, changes were made to the wording in paragraph eight of the interview protocol script. No new information was added as a result of these changes; rather, words were rearranged to create a natural flow within the script.

Second, two questions were added to the demographic questions in the interview blueprint. The questions added were: “*What gender do you identify with?*” and, “*What city/province do you currently reside in?*” For those who were not asked these questions in their initial interview, I followed up with them later to gather their responses.

Confirmability

Guba and Lincoln (1989) describe confirmability as a parallel process to objectivity. To achieve confirmability, the data, interpretations, and outcomes of the inquiries must be rooted in contexts and persons apart from the researcher (Guba & Lincoln, 1989).

To attain confirmability, I have ensured that all data collected can be traced back to its original source, and that the processes in which the data were converted to research findings were rooted in the information provided by interview participants.

Researcher's Voice

Throughout this qualitative study, my voice and position within the research topic may become apparent. As such, I wish to explain how this research topic relates to me personally, and expose any potential biases that may surface throughout the study.

When I was first introduced to the topic of an arrhythmia patient's journey (not just in employment settings, but in other areas of daily living as well), I was immediately fascinated by the subject. While my interest in the topic was strong, I did not initially believe that an arrhythmia patient's journey was something that I had any personal connection with. I was motivated to partake in this research to gain insight into a field that I had little knowledge in; my motivation did not stem from a personal connection to the topic.

As I began to tell people about the research that I was involved in, it quickly became apparent that I was more connected to this topic than I had initially thought. For example, my grandmother, who is now 83, was diagnosed with atrial fibrillation when she was in her fifties. My father, who had his first of two heart attacks when he was 39 years old and I was five years old, has an implantable cardioverter-defibrillator (ICD) device that helps to regulate his heartbeat, should there be any further complications. Talking with an acquaintance (whom I regularly see) about this research led her to share her story of her arrhythmia that she has dealt with since she was a child. My thesis supervisor, who not only leads patient-perspective arrhythmia research, but also has an arrhythmia herself, has shared stories with me about the negative consequences that having an arrhythmia can have on daily living. Even our beloved family Chihuahua, Ella, passed away during the course of this study from complications with a cardiac arrhythmia. I realized that I was more connected to arrhythmia than I had ever noticed before.

As I became more aware of the struggles and triumphs that people in my life have experienced due to their cardiac arrhythmias, I grew a stronger sense of personal connection to the topic. The stories shared by those I know opened my eyes to the undiscussed difficulties that result from being an arrhythmia patient. These invisible disabilities can create hardships, stigma, and feelings of helplessness in daily living for some patients. The more stories that I heard, the more I became confident that this is an area of study that has not been properly examined, and that deserves attention.

CHAPTER 5: FINDINGS

Participants

The following table provides demographic information of all participants from this study:

Table 1: Participant Demographic Information

Name	Gender	Age Range	Industry of Employment
Anne	Female	55-64	Educational services
Samantha	Female	25-34	Health care and social assistance
Peter	Male	25-34	Agriculture, forestry, fishing and hunting
Bella	Female	55-64	Other services (except public administration)
Vicky	Female	35-44	Health care and social assistance
Jane	Female	35-44	Professional, scientific, and technical services
Christina	Female	55-64	Educational services
Thomas	Male	25-34	Real estate and rental and leasing
Richard	Male	55-64	Retail trade
Laura	Female	25-34	Information and cultural industries
Jeffrey	Male	55-64	Manufacturing
Donna	Female	45-54	Finance and insurance
Jennifer	Female	55-64	Health care and social assistance
Evan	Male	65+	Public administration
John	Male	45-54	Health care and social assistance

In total, fifteen participants were interviewed for this study. This included nine females and six males. The most prevalent age category of participants was 55-64 years old, with six total participants. Participants were located in British Columbia, Alberta, and Nova Scotia. A variety of industries were reflected in this study. Industry information listed above was determined by comparing the description of the industry that the person is or was employed in, and matching it to the appropriate industry defined in Canadian Industry Statistics (Government of Canada, 2021). Since the time of their diagnosis, nine participants had changed jobs (some due to cardiac arrhythmia complications), and among those nine, two have now retired. Not all participants who changed position since

their diagnosis changed organizations or employment industries. For example, since her cardiac arrhythmia diagnosis, Vicky moved into a promotional position within the same organization.

A variety of cardiac arrhythmias were reflected in the participant pool (please note that the specific cardiac arrhythmia diagnosis is not listed with participant demographics in an attempt to protect anonymity). Cardiac arrhythmias represented in this study included, but were not limited to, hypertrophic cardiomyopathy, supraventricular tachycardia (SVT), premature atrial contractions (PACs), long QT syndrome, recurrent syncope, unsustained ventricular tachycardia, arrhythmogenic right ventricle dysplasia, and atrial fibrillation. At the time of interviews, one participant, who had been previously diagnosed with a cardiac arrhythmia, was awaiting test results to determine if their cardiac arrhythmia had further progressed.

Organizational Sensemaking

Weick's (1995) conceptualization of organizational sensemaking was used as an analytical tool during the data analysis phase of this study. As previously mentioned, organizational sensemaking is comprised of seven key components: grounded in identity construction, retrospective, enactive of sensible environments, social, ongoing, focused on and extracted by cues, and driven by plausibility rather than accuracy (Weick, 1995). All 15 participants demonstrated that they have undergone, or may still be undergoing, a sensemaking process that considers the relationship between their cardiac arrhythmia diagnosis and their individual employment experience. The remainder of this chapter will illustrate how the sensemaking process affected individual participants as they navigated the employment-arrhythmia relationship. First, each of the seven elements of sensemaking will be discussed, using direct quotes from participants. Next, I will provide

an example of an integrated sensemaking process that incorporates all seven elements of sensemaking as it relates to one participant. Please note that all names have been changed to protect participant anonymity. Select quotes may be edited to protect anonymity.

Grounded in Identity Construction

During the interview process, I asked participants open-ended questions that centered around their identity construction. Questions asked included, but were not limited to, “How would you describe yourself?”; “How important is work to you?”; “How do you think your co-workers would describe you?” and, “Can you tell me if you consider your cardiac arrhythmia diagnosis to be a main component of your self-identity?”

The purpose of asking these questions was to understand how participants viewed themselves; whether employment was a central piece of their self-identity; whether their cardiac arrhythmia was a central piece of their self-identity; how employment and cardiac arrhythmia were different/similar in identity construction; and, how others’ opinions of them impacted their personal identity construction.

The following interview excerpts demonstrate the existence of the sensemaking component, grounded in identity construction, within the data collected for this study. Specifically, the three examples provided aim to illustrate how the participants view or viewed themselves, and how their cardiac arrhythmia diagnosis influenced or threatened their constructed sense of identity.

Example 1 (Jane)

I've always been a career person. That has been my biggest dream since being tiny is that career. Yeah. I always pictured myself fancy car, fancy place, nice purses, nice clothes...

No. I don't really like bringing it up only because people get very uncomfortable about it. Well, because they see me, and then they talk to me, and I'm a very powerful person, I'm very educated. I've done a lot. I started up, actually, another

company in [location]. And so, they hear all of this stuff, and then it's very difficult to them, then, check the box of also has cardiac arrhythmia and [diagnosis], and and and ...

As demonstrated above, Jane's self-identity is strongly influenced by her image of herself as a "career person". In Jane's experience, this sense of identity is threatened when she tells others about her cardiac arrhythmia. To Jane, the image of a successful career person, who is educated and powerful, is incongruent with the image of someone who has a cardiac arrhythmia diagnosis. This disconnect between her self-identity and her cardiac arrhythmia is further confirmed by the reactions of others, as they struggle to comprehend that Jane is both a "very powerful person" while simultaneously living with a cardiac arrhythmia.

As part of Jane's identity construction process, she seeks cues that confirm the image that she holds of herself (Weick, 1995). By purposefully choosing not to discuss her cardiac arrhythmias, she confirms her self-image of a powerful businessperson, rather than person with a disability.

Example 2 (Jeffrey)

Freedom 50. And I kept telling everybody and myself that I was retired, which isn't true. I'm disabled. There's a difference. Big difference. And I did work for two summers as an [employee] at the [organization]. And that was the best job I ever had two days a week. But a little different, you show up at seven go home at two.

In this example, Jeffrey recounts an instance in which his sense of self was redefined. As suggested by Weick (1995), if an individual's selective cues disaffirm their sense of self, they will undergo the sensemaking process as they re-define and re-enact their sense of self, the environment, and the situation in an attempt to produce a more appropriate sense of self. For Jeffrey, this was the difference between identifying as someone who retired in their fifties, joining the "freedom 50" club, to identifying as

someone with a disability. Jeffrey's decision to leave his full-time position in manufacturing was driven by his cardiac arrhythmia diagnosis and complications. Although Jeffrey now recognizes that this was done because of his disability, at the time, he chose to tell others that this was a choice driven by early retirement and "freedom 50". Throughout time, Jeffrey's continuous sensemaking process led him to redefine himself as 'disabled'; a sense of identity that had directly contributed to prior decisions, such as leaving his long-term career. As someone who admittedly experienced denial at the time of his diagnosis and throughout the sensemaking process, this change in self-identity was not immediate for Jeffrey. Rather, it occurred years after his diagnosis, as Jeffrey attempted to construct his self-identity in a manner that was consistent with his situation.

Example 3 (Anne)

I was discussing with the [boss] about my work over the past year in particular and it was a very strained and unpleasant conversation in that he was starting to reprimand me for not being productive during that year while I was being assessed and diagnosed and on six weeks of medical leave. And I pointed back to my [resume], because my [resume] of course was part of this and it was in front. And I was going, look this is who I was. This is who I will be again and direct quote from him was, "Yeah, but what have you done for us lately?" And that moment broke me and I will never actually probably move past that feeling when it comes to my employer, even though now I've got a different [boss].

Anne describes a situation in which she was defending her constructed identity to her employer. The combination of Anne's cardiac arrhythmia diagnosis and the time that she required away from work to manage her diagnosis created a threat to her constructed identity, as her employer began to question her productivity at work. During this conversation, Anne aimed to reaffirm to her employer that she was a capable, productive employee, making statements such as "this is who I was. This is who I will be again." The threat to Anne's constructed identity was further heightened when her employer questioned, "what have you done for us lately". As a successful, high-performing

employee prior to her diagnosis, this comment was damaging to Anne's ongoing identity construction. Although Anne now has a new boss, and is able to work in the capacity that she was working prior to her diagnosis, this conversation and perceived conflict between Anne's identity construction and her employer's perception of Anne has created irreversible damage to Anne's perception of her employer.

Retrospective

During the interview process, I asked participants to "walk me through" their arrhythmia diagnosis, in an effort to understand the past events that have influenced their sensemaking processes. In addition, I also posed multiple open-ended questions to participants that required them to reflect on their experience prior to answering, such as, but not limited to, "What thoughts of your employment situation, if any, did you have when you received your diagnosis?" and, often in response to individual narratives, "Why did you choose to do that?". By focussing on and analyzing individual retrospective interpretations, I was able to gain an understanding of the meaning that participants ascribed to their prior experiences (Weick, 1995).

The following examples represent retrospective sensemaking undertaken by participants.

Example 1 (Christina)

I didn't have any thoughts [of employment at time of diagnosis]. Honestly, again, I think in part because my mother had [a cardiac arrhythmia], and she kept working, and it was never something that she acted like was a big deal or anything, that I had already thought, "Oh yeah, [cardiac arrhythmia]." I didn't think about it as something that was going to impinge, or have a profound impact. Even as I'm being driven to emergency and having that done on a frequent basis, I still did not expect it to impact my work. And I didn't actually think about what it meant if it happened during [job duties]. I think at one point I thought, if it does happen over [job duties], I'll just have to [stop working], and explain that I'm not feeling well,

and then reschedule, or have [other work tasks arranged]. I just felt that I could work around it, like it wasn't going to permanently impact my work life.

In this example, Christina compares her cardiac arrhythmia diagnosis and the impact that it could have on her employment to her mother's experience with the same cardiac arrhythmia diagnosis. Although Christina had not been diagnosed with a cardiac arrhythmia prior, she was able to draw conclusions and make sense from her mother's lived experience, which she witnessed. When determining how cardiac arrhythmia could affect her employment situation, Christina reflected upon her mother's previous lived experience, to help her make sense of her current situation. Because Christina's mother's cardiac arrhythmia did not negatively affect her employment situation, Christina concluded that her experience would likely be the same or similar to her mother's. Had Christina's mother's arrhythmia negatively affected her employment situation, it is likely that Christina would have then perceived that her own cardiac arrhythmia would negatively affect her personal employment experience.

Example 2 (Bella)

Like to me, I've never lost a job or had a job threatened due to my heart condition. Because like I said, any job I ever took, I was always up and forefront with any employment I ever had and said, "Hey, at this time I have a pacemaker that lasts three years. I have to have surgery. I have to take two to three weeks off after surgery." I've never experienced problems because I've never not disclosed it.

Bella provided a retrospective account when discussing her decision to disclose her arrhythmia to prior employers. In Bella's experience, all prior instances of disclosure had no negative effect to her employment, so it made sense for her to continue to disclose her disability to new employers. Bella has ascribed a positive meaning to this experience that is formed by both her knowledge and experiences (Weick, 1995). If, in the future,

Bella had a negative experience with disclosure, it is likely that she would draw on these past experiences to try to make sense of the new phenomena.

Example 3 (John)

Well at the time, didn't want anybody to ... there's a supervisor that sits in the same building as me, two doors down. And I just said, "I'm going home sick." He said, okay. And I went home and I didn't even tell my significant other that I was doing that, and she works on the same shift. She texted me and said, "Did you [leave work] for the night?" I'm like, "Ah, crap, now I'm going to have to tell her." I just wanted to get through it, thinking I was going to get through it without having to be concerning people. In hindsight, bad choice, for sure, especially knowing that [it] could've stopped my heart just as easily, and that could have been it. So better choices next time.

John's excerpt illustrates both retrospective sensemaking, as he reflects on his prior experience, and ongoing sensemaking, and he continues to make sense of his actions, and what he would change in the future. In this example, John was reflecting on a cardiac arrhythmia episode that he was having in the workplace. Rather than seeking help or telling his co-workers what was going on, he decided not to tell anyone and to drive himself to the hospital. While at the time, these actions made sense to John, when a retrospective lens was applied, he analyzed his decisions and determined that he would not repeat these actions in the future. Likely, if John ever has another episode at work, he will use this lived experience as a comparator to the ongoing situation to make sense of the current event (Weick, 1995).

Enactive of Sensible Environments

Sensemaking relies on the give and take between an individual's ability to enact their current environment through appropriate actions and interpretations, and the constraints that the environment places on the individual. To gain an understanding of the sensible environment(s) that participants were faced with, I asked them to describe the organization that they worked in at the time of diagnosis, as well as the specifics of their

position (e.g., full-time vs. part-time; manager vs. employee). I also asked questions such as, but not limited to “How disability-friendly would you consider the organization to be?” in an attempt to understand potential constraints that were placed upon them in the environment(s).

The two examples below illustrate interpretations of sensible environments, as well as restraints that affected the sensemaking process.

Example 1 (Jane):

And so, it really impacted my work because I worked now as a consultant at [organization], in a very very professional setting. I wore a suit to work. And you can't exactly be [having cardiac arrhythmia episodes] at your client site.

At the time of her diagnosis, Jane was employed at a reputable professional services organization. Jane describes the organization's environment to be “very very professional”. Cues such as attire (“I wore a suit to work.”) contribute to Jane's interpretation of the environment. In her position, Jane was required to visit client sites outside of her workplace. As a representative of her organization, Jane felt it necessary to display the same level of professionalism at client sites as she did in her regular workplace.

During this time, Jane was having regular, visible, arrhythmic episodes at work. In Jane's interpretation of her environment, the visible cardiac episodes did not appropriately match the perceived professionalism of the environment. The level of professionalism at work required of Jane acted as a restraint, such that Jane's visible health complications did not appropriately match the environment that she was placed in.

Example 2 (Laura):

So in this industry, the people have been there the longest and kind of the best are morning. So they would start at 4:00 AM. And then as the day goes on, it's kind of like when you get into the evenings or overnights, that's when your newer people

come in. I firmly believe that if I had gone to my boss very early on and said, "This is what's going on," he would accommodate. But again, he wouldn't sort of do everything he can. He'd be like, "Well, let's just put you on weekend evenings." And I think going to [head office] is not an option just because they're such a big company, so they own so many little guys. But it's not approachable to go to this corporate place and say, "Hey, look, this is what's going on. What's your policy like?"

Laura describes that her work environment has perceived benefits specific for long-term and high performing staff. As a fairly new employee, this creates a restraint for Laura, as she is left to work evenings and overnight. Although she feels that her boss would be willing to accommodate her if needed, within the current environment, she believes that this would still require her to work overnights. At times, overnight shifts were a barrier for Laura, as she would often have to continue working, even if she was feeling unwell. There was little to no coverage available for last minute overnight shift changes, so she would have to manage arrhythmia episodes while at work. This lack of coverage was an additional restraint for Laura, as at times she felt that she had no option but to work when she was feeling unwell.

Additionally, Laura perceives the size of the company that she works for as a restraint. As an employee of a large organization, Laura did not feel that she was able to reach out to head office to speak about disability policies and procedures. Laura felt that it was most appropriate to deal with questions and concerns with her direct manager, who she indicates "wouldn't sort of do everything he can."

Social

Throughout the interview process, I asked participants questions around social interactions that were about, or were impacted by their cardiac arrhythmia and employment relationship. Questions included, but were not limited to, "Who did you talk to about your employment when you received your diagnosis?" "Did you disclose your

diagnosis to your co-workers? Why or why not?” and, “Whose advice did you really listen to?”

These questions were intended to gain insight into the various interactions, between the sensemaker and others, that affected their sensemaking process (Weick, 1995). Social considerations were not always drawn from a physical interaction between parties; in some cases, social considerations were given to assumptions and dialogues that were mentally improvised in the sensemaker’s mind (Weick, 1995).

The following examples illustrate how the social element of sensemaking influenced three participants’ experiences.

Example 1 (Christina)

No. No one ever talked to me about that at all. Well my parents passed away, and I don't remember if I spoke to my ... I mean I did talk to my brothers, who don't live locally, but no one ever ... And my spouse clearly. No one actually said, "How's that going to impact ..." I think we're really fortunate in [education], that there's a lot of flexibility, and so it's not a ... If it was a 9:00 to 5:00 job, where suddenly getting up and walking out and going to the emergency, or I had to use a punch card, those sorts of things. But with [education], there's a lot of flexibility in how one works. And as a result, no one ever said to me, "How is this going to impact your work life?"

In this example, Christina discusses the social interactions, or lack-of, specific to her employment at the time of her diagnosis. As a result of the organization rules and routines described by Christina, she did not engage in social interactions with others about the impact to her work situation at the time of diagnosis. Christina has a high degree of autonomy in her employment situation, which she considers “fortunate” for her situation, as it allows flexibility when self-managing her cardiac arrhythmia. Although Christina’s sensemaking of the situation still included other social processes, in this specific example, the expectations of her in her employment situation reduced the need

for social interactions between herself and social others when considering the impact of her diagnosis on her employment.

Example 2 (Jane)

"Ah, I have to explain this to you, great." And she didn't have kids, either. And so, there was no maternal instinct, and a [job title], and it was just really awkward, and then she was just very worried about how I would be able to handle it, and then almost overreacted to the point of being overly cautious. I'm like, "I'm not going to die."

Jane recounts her experience of disclosing her arrhythmia diagnosis to her boss. Prior to disclosing to her boss, Jane has made assumptions of the social interaction given her observations of her boss. These assumptions made by Jane affected the manner in which she spoke about her diagnosis to her boss. Due to Jane's preliminary conclusions about her boss, Jane approached the situation with the expectation that the interaction would be uncomfortable. Jane relied on the social cues that her boss had "no maternal instinct", and assumptions about her boss's area of expertise when entering the social interaction. Jane's predetermination of the situation was confirmed, as she describes the situation as "really awkward".

Example 3 (Richard)

I know what goes on in the workforce and my job is not probably any different than any other job, but there's a lot of talking amongst them. I know it because I hear it in other situations that have nothing to do with me, but I hear it. The thing is, is that I know there's probably chit chat going on back and forth about, like I said earlier. Look at [Richard] and he's going like a stallion did it. How the heck can he have a heart condition. What's going on here. But then it's almost like, I feel sometimes I need to have another episode to happen just to remind them.

Richard describes a social sensemaking process that does not involve physical interactions with others. As Weick (1995) states, individuals may engage in mentally improvised dialogue with relevant other social beings to determine their thoughts and actions. For Richard, he has assumed that there is social dialogue among his peers

regarding the legitimacy of his cardiac arrhythmia. This social sensemaking process has been influenced by the social cues observed: “there’s a lot of talking amongst them. I know because I hear it in other situations that have nothing to do with me, but I hear it.”

Through these social cues and mentally improvised dialogue, Richard has concluded that some of his coworkers are in disbelief that he is impacted by a cardiac arrhythmia. Although others at work are either aware of Richard’s cardiac arrhythmia, or have witnessed an episode of Richard’s cardiac arrhythmia, he feels as though his credibility would increase if his co-workers witnessed him having another episode, as it would remind them that his arrhythmia is still an ongoing concern, despite his ability to continue working.

Ongoing

During the interview process, I asked participants questions such as “What were you doing when you received your diagnosis?”, and “What emotions did you feel when you received your diagnosis?”, and other questions that allowed them to reflect on the early stages of their cardiac arrhythmia journey. The intent of these questions was to understand how the diagnosis created an interruption to the participants regular routine, and, the emotional responses and emotional depth that was felt at the time of the diagnosis.

According to Weick (1995), individuals engage in sensemaking when they are confronted with obstacles that threaten their regular routines. In these instances, the sensemaking situation is intended to restore the ongoing flow of activities. Previous emotions or experiences are drawn on to make sense of the interruption of the routine (Weick, 1995).

The following examples demonstrate the ongoing sensemaking of participants.

Example 1 (Jeffrey)

I was on my way to the Christmas party and I got the diagnosis...I drank a lot. It's a good party. And I continue to sort of just sort of live in denial for four or five years just. And then the cardiologist asked me if I had a favorite suit... And I said, "Really?". He goes "yeah". It's okay, that was it. Next day, another lunch you go to lunch, do you want to be alive or dead? Pick?

In this example, Jeffrey relays two instances of ongoing sensemaking. The first is when Jeffrey received his diagnosis while on the way to the company Christmas party. This created a disruption, which he chose to ignore and continually deny for years to follow. The second instance of ongoing sensemaking in this excerpt is illustrated when Jeffrey's doctor asked him if he had a "favorite suit". When speaking with Jeffrey, he explained that this was his doctor's way of telling him that his denial of his arrhythmia diagnosis would lead to his death. At that moment, Jeffrey experienced another interruption as he was faced with his own mortality. This caused Jeffrey to engage in further sensemaking, as he now had to interpret this new information and determine how to restore order to his now interrupted routine.

Example 2 (Christina)

Well I was literally just walking down the hall to a meeting in the [boss's] office, and I was really light-headed, and my heart was like ... I could feel that it was pounding, just pounding really, really hard, and I'm like, this is not normal, and I think I need to get immediate attention. The episode was so ... It was just really dramatic. And I was even having difficulty catching my breath. It came on suddenly, and there wasn't anything that precipitated, and I was really calm, and it wasn't stress related. It was just something that suddenly happened. And I walked to the [boss's] office, said "I can't make this meeting, I need to be driven to emergency, something's happening." Then I went downstairs to a colleague and said, "Could you drive me to emergency?" Apparently I was violating a number of [organizational] rules, but at the time I didn't actually realize that.

Christina's excerpt demonstrates a moment of interruption at work, where she had an unexpected and unfamiliar arrhythmic episode on the way to her boss's office. At the time, Christina had yet to be diagnosed with her cardiac arrhythmia, so the interruption

was foreign, and she did not have a plan in place to manage the episode. This episode created an obstacle in Christina's daily routine that affected her work obligations. Due to the intensity of the episode, Christina chose to seek medical help in an attempt to deal with the interruption and return to her regular routine.

Further in the interview, Christina spoke about how she self-managed arrhythmic events at work after this event, and after receiving her medical diagnosis. Because she was familiar with the interruption, she was able to self-manage it in a way that quickly allowed her to get back to her normal routine. The concept of self-management resulting from sensemaking is discussed in further detail in Chapter 6.

Focused on and Extracted by Cues

During the interview process, I asked participants questions about the organization that they were employed at when they received their diagnosis. For those who had changed careers, I also inquired about the environment of their current organization. Questions asked included, but were not limited to, "How disability-friendly do you consider the organization to be?" and, "Does your organization have formal supports, such as policies and procedures that guide disability/accommodation/return-to-work processes?" By asking such questions, I was attempting to learn about the participants' perceived context of the organization. As suggested by Weick (1995), the perception of cues is dependent upon the context from which such cues are drawn.

Throughout the interview and data analysis process, I paid attention to the cues that participants extracted from employment interactions, events, environments, and activities, that were subsequently focussed on.

The following quotes demonstrate cues that participants either knowingly or unknowingly noticed and focussed further sensemaking processes on.

Example 1 (John)

But I'd rather not use anything medical as a crutch, because I think there is a bit of a stigma for certain people that are off for long periods of time, or come back for a little bit and then go off. I'm not trying to milk the system to get myself to retirement, I just want to be healthy enough to do my job.

John discusses cues that he has extracted regarding the negative perception surrounding employees who take extended time away from work. John perceives that there is a “stigma” assigned to people that “are off for long periods of time, or come back for a little bit and then go off”. Because John has ascribed a negative meaning to these cues, he makes decisions at work that will not be perceived in the same manner. John mentions that he is not trying to “milk the system” until he retires. This statement is influenced by the cues he has extracted that are directed towards others who take repeated time off until they retire or exit the workplace for other reasons.

Example 2 (Anne)

The same [time period] that I became ill, two of my colleagues had heart issues and they were, I know what they were but they were obstructive. So, consider it the equivalent of a heart attack... And they were accommodated instantly. And I think it's they had their [job duties] covered and they were given the time and they were given the space that they needed. And I think it was because people can relate to heart attack. It's sudden, it's known, it's scary. It's something that everybody fears. It's like a cancer diagnosis, that's something that people fear. And actually, at the same time people had that as well and they were accommodated. When you have something that's unusual, atypical, weird not, as you said, not understood... And I think it's even worse when you have something that is not easily related to and the accommodation isn't straight forward. So somebody has a heart attack or they have to have chemotherapy, people understand that and they go, "Okay, so you need time off work or you're not able to [perform job duties], of course." But if you have something that's weird, you appear otherwise healthy, they need you to tell them everything that needs to be done and then there's that pause as in, do you really need that? Do I really need somebody to [perform job duties] with me because I'm scared I'm going to die in [the work environment]? Do you really need that? Is what would be asked, and they wouldn't ask that of the others.

In this example, Anne has extracted cues related to the struggles of her accommodation process in relation to the accommodation processes of her peers. From her observations, Anne has determined that her peers who have well-known or well-understood medical impairments are quickly accommodated with little to no pushback from the organization. On the contrary, Anne's accommodation process was met with questions and continued complications from the employer. From this experience, Anne has determined that accommodations in the workplace are met with more understanding and willingness from the employer when the reason for accommodation is well understood. The cues extracted that led to this conclusion include the willingness and speed of the employer to accommodate her colleagues in comparison to her own accommodation experience.

Example 3 (Christina)

When that happened, I was walking in the [building], and my heart was racing and I felt odd. I was near the medical unit at the [building], and I just said, "I'm feeling really weird," and they let me see someone. They asked me what was happening. I saw a nurse, they took blood pressure, and they took my heart and my heart rate, and they were like, "Your heart rate's really high." But they didn't say anything like, "Go see a doctor, this is significant." And they didn't say anything else, so I honestly was like, it finished quickly, and so I just went to my office and kept working. Then the subsequent week, then it happened again, and that's when I asked my colleague, my friend, to drive me to the hospital.

As demonstrated, Christina extracted cues that were influenced by the medical setting that she had attended during an arrhythmic episode at work. Because she was in the presence of medical professionals, and they did not appear to be worried or overly concerned about her racing heart, she interpreted that as a cue to return to her office and continue working. Had there been more urgency from the medical staff who were assisting her, it is likely that she would have interpreted the same situation as a serious episode that required immediate attention, and taken alternate actions as a result.

Driven by Plausibility Rather than Accuracy

Sensemaking is not intended to produce an objective reality that is appropriate for all people, situations, or environments (Weick, 1995). The focus of sensemaking is not on accuracy; rather, it strives for reasonableness and plausibility. My analysis of the data considered the plausible, reasonable sense that was made by participants in various situations, rather than the accuracy of individual accounts and assumptions.

While interviewing participants and analyzing data, I focused on arguments or statements made by participants that defended their reasoning. Whether or not these arguments or statements were objectively true was not relevant.

The below examples show two situations in which participants made decisions based on what they believed to be plausible outcomes.

Example 1 (Vicky)

I think that was part of my reluctance is because I had new people that I really felt responsible for, and I didn't want to freak them out. So I did not want them to worry about me, because I wanted to make sure that I was being a support for them.

This response was given by Vicky when she was asked why she chose not to tell her direct reports about her cardiac arrhythmia diagnosis. Vicky holds a leadership position within her place of work, which in turn, has various consequences to her sensemaking process.

In this example, Vicky is justifying her decision not to disclose her arrhythmia to certain co-workers, by providing plausible reactions she expects that she would receive. As a leader, she does not want to “freak [her employees] out”, and does not want them to “worry about her”. This reaction from employees is based on an assumption made by Vicky, that to her, is a reasonable and likely response. Vicky likely perceives these

reactions from her employees as a negative consequence that would threaten her identity construction as a leader. As such, her actions are based on perceived consequences that will maintain her identity as a leader.

Example 2 (Jane)

And so, I just realized I had to start and work for myself basically. I had to go out on my own because that was the only way I would be fully in control of my own hours, the amount I worked, where I worked, how often I worked, all of that stuff. Because my heart issue seemed to sort of be running the day.

At the time of her diagnosis, Jane was an employee within a professional services organization. Jane's cardiac arrhythmia caused her to have frequent, visible episodes at work. Depending on the magnitude of the episode, Jane would sometimes require time off after the fact to care for her health. As a result, there were changes made to Jane's employment situation by her employer. For example, in an effort to support Jane, her working hours were reduced, and she was allowed to work from home on certain days. Although these changes may have been made with good intentions, they were not what Jane felt she needed. As such, Jane decided to eventually leave the organization, and in time, start her own business. Jane assumed that this change would allow her to have more control over her employment-related decisions while still being able to manage her cardiac arrhythmia. Jane based her actions on perceived consequences, rather than what would undoubtedly happen, which cannot be predicted (Weick 1995). This decision was not guaranteed to produce Jane's desired outcome; however, it made sense to Jane to make a decision that was focussed on circumscribed accuracy, rather than global accuracy (Weick, 1995).

Sensemaking as an Integrated Process: Anne

As demonstrated above, all seven elements of organizational sensemaking (Weick, 1995) were discovered within my data analysis. So far, this chapter has provided an in-depth look into the individual sensemaking components and how these components presented in various interviews; the remainder aims to provide a comprehensive example of an integrated sensemaking process that demonstrates how one participant experienced all seven elements of sensemaking after receiving their arrhythmia diagnosis. The remainder of the chapter will focus on an integrated sensemaking example, using information provided in Anne's transcript.

The following passages were chosen from Anne's transcript as they represent the complexity and integration of the sensemaking process. It is important to note that passages are presented in the same order that they appear in Anne's transcript, but interview questions and prompts have been removed to present the information as a comprehensive narrative to the reader. The potential influence of questions and prompts was, however, taken into consideration during the data analysis phase. Additionally, any identifying details were stripped from the passages, or were modified, to protect Anne's anonymity. For the purposes of the discussion following the narrative passage, line numbers have been added so that specific sections of text can be easily identified by the reader.

Anne provided multiple examples throughout her interview that highlighted her integrated sensemaking process. As new situations arose, Anne would reengage in prior sensemaking processes, or undergo new sensemaking processes, in an effort to comprehend how to appropriately respond to challenges in her work environment as a cardiac arrhythmia patient. Further discussion regarding the reengagement of and/or new sensemaking processes for participants is included in Chapter 6. For the purposes of this

chapter, I chose to provide an example that focussed on Anne's sensemaking process around accommodations and disclosure in the workplace after receiving her diagnosis and learning how to navigate in the workplace as a person with an arrhythmia.

Anne:

(01) I received the diagnosis shortly after I had had the [injury]. And so, I was
(02) receiving a bit of support and accommodation for that, although minimal. I
(03) had to cancel [job duties on one occasion]. But, the [boss] at the time was
(04) the one that was supposed to provide me with accommodations and it's not
(05) that he didn't believe me, because he absolutely did. It's that he didn't do
(06) anything, even with specific requests. So, when things in the path of
(07) getting diagnosed and treated reached the point where I actually needed, I
(08) guess it was just I ended up only taking I think it was six weeks off of
(09) work, he never found anyone to cover [my job duties] for me in that time.
(10) So, it was pretty much an abandoned to the wolves situation. I had to call
(11) on personal favors to get somebody to take my [job duties] from me and
(12) stuff...

(13) I would put it under accommodation, but really what I was asking for was
(14) understanding. And that's an accommodation, but not one that falls into a
(15) list as in covering [job duties] would have been. What I wanted them to
(16) understand was that I wouldn't be me for a while and that it wasn't that I
(17) was a bad employee. That I just needed their understanding that added
(18) stress right now I can't go to those meetings. I can't engage in these ways
(19) and with these people and so just to trust me, back off and let me have
(20) time to come back to being me again...

(21) The same [time period] that I became ill, two of my colleagues had heart
(22) issues. And they were, I know what they were but they were obstructive.
(23) So, consider it the equivalent of a heart attack... And they were
(24) accommodated instantly. And I think it's they had their [job duties]
(25) covered and they were given the time and they were given the space that
(26) they needed. And I think it was because people can relate to heart attack.
(27) It's sudden, it's known, it's scary. It's something that everybody fears. It's
(28) like a cancer diagnosis, that's something that people fear. And actually, at
(29) the same time people had that as well and they were accommodated. When
(30) you have something that's unusual, atypical, weird, not, as you said, not
(31) understood...

(32) And I think it's even worse when you have something that is
(33) not easily related to and the accommodation isn't straight forward. So
(34) somebody has a heart attack or they have to have chemotherapy, people
(35) understand that and they go, "Okay, so you need time off work or you're
(36) not able to [perform job duties], of course."... But if you have something

- (37) that's weird, you appear otherwise healthy, they need you to tell them
(38) everything that needs to be done and then there's that pause as in,
(39) do you really need that? Do I really need somebody to [perform job duties]
(40) with me because I'm scared I'm going to die in [the work environment]. Do
(41) you really need that? Is what would be asked, and they wouldn't ask that of
(42) the others.

Grounded in Identity Construction

Anne's sensemaking process is affected by her personal identity construction and how she wishes others in the work place to identify her. As a high-achieving employee, Anne's identity construction is threatened by others viewing her as a "bad employee" (line 17) as she requires time to adjust after her diagnosis. To protect her prior identity construction, and assure others that her identity has not been permanently and negatively altered by her diagnosis, Anne asks that others at work "trust" her (line 19), and allow her time to restore her prior projected identity. Anne reinforces that her identity has not changed as she asks for "time to come back to being me again..." (line 20), attempting to assure others that she is still the same person that she was prior to her diagnosis.

Retrospective

In lines 1-42, Anne describes how she made sense of the accommodation process in her workplace after receiving her cardiac arrhythmia diagnosis. The above passage is classified as retrospective, as Anne is describing a situation that occurred in the past. Through retrospective reflection, the meaning that Anne ascribed to the situation during her interview is likely different than that meaning that Anne assigned to the experience at the time of occurrence (Weick, 1995).

Line 10 provides insight into the meaning that Anne retroactively assigns to the experience, as she describes it as "an abandoned to the wolves situation". Although this is

how Anne describes the experience in hindsight, it is possible that at the time, the meaning she ascribed to the experience would have differed (Weick, 1995).

Enactive of Sensible Environments

Anne's sensemaking process is enactive of sensible environments as it relies on the interplay between her ability to enact her current work environment, post-arrhythmia diagnosis, and the constraints and expectations that work environment places upon her (Weick, 1995). In this example, Anne discusses the constraints of her personal accommodation process in her work environment. In lines 05-06, Anne expresses that her boss "didn't do anything" to assist with her specific accommodation requests. Further, during her struggles with the accommodation process, she witnesses that two of her co-workers in the same environment were "accommodated instantly" (line 24) as they had heart issues that were "sudden", "known" and "scary" (line 27), compared to her diagnosis, which "unusual, atypical, weird" (line 30). In response to the constraints of the environment and Anne's needs as an employee, she calls on "personal favors" (line 11) from co-workers in an attempt to balance her needs as an arrhythmia patient, and the expectations of the work environment.

Social

Anne's experience is both informed by and influenced by the meaning that she assigns to various social interactions she has had with relevant others about the influence of her cardiac arrhythmia on her work experience, and vice versa (Weick, 1995). Anne recounts social interactions that involve both actual and perceived interactions with others (Weick, 1995). In lines 03-06, Anne recalls that her boss believed her about her cardiac arrhythmia and accommodation needs, yet that her boss took no action. Additionally, in

lines 10-11, Anne describes calling on personal favors with co-workers to cover her job duties as needed. Both of these illustrate actual social situations that Anne experienced.

Lines 36-42 demonstrate perceived social interactions that Anne has mentally formulated. In Anne's situation, these are questions that she anticipates that others would ask her during an accommodation process, as she has an arrhythmia diagnosis which is not widely known or understood in her workplace. She compares these constructed social interactions to what she has witnessed, and what she believes to occur when others with more commonly known disabilities/impairments (such as heart attacks or cancer) seek accommodations in her work environment.

Ongoing

Anne provides an account of an ongoing sensemaking process. In line 01, Anne refers to the time of her diagnosis, when the particular sensemaking process began. In lines 13-15, Anne discusses the type of accommodation she was seeking at the time from her employer, and how it differed from the standard accommodation of job duties. Additionally, lines 21-26 demonstrate an ongoing sensemaking process, as Anne sees others in the workplace receive accommodations, and attempts to make sense of the different experiences. As Anne continues to describe her experience, it is apparent that the sensemaking process was ongoing throughout, and is still ongoing as she retrospectively reflects on her lived reality.

Focused on and Extracted by Cues

Anne extracted and responded to several cues as she sought accommodation after receiving her arrhythmia diagnosis. For example, in lines 05-06, Anne describes that her boss 'didn't do anything' when she sought accommodation. In line 09 she explains that "he never found anyone to cover [my job duties] for me in that time". In response to these

cues, Anne “had to call on personal favors to get somebody to take my [job duties] from me and stuff...” (lines 10-12). Additionally, in lines 21-22, Anne recalls that “the same [time period] that I became ill, two of my colleagues had heart issues”... “and they were accommodated instantly” (lines 23-24). Responding to these cues, Anne reflects on the different experiences of her and her co-workers, and concludes that these differences arose from the relatability of the diagnosis. Anne responds to these cues by concluding that her cardiac arrhythmia diagnosis is something “weird” (line 37) compared to those co-workers with understood disabilities, and as such, she will be subjected to questions during her accommodation process that others would not be asked.

Driven by Plausibility Rather than Accuracy

Anne demonstrates in lines 15-20 that her sensemaking process in this instance was driven by plausibility rather than accuracy. In lines 15-17, Anne expresses “what I wanted them to understand was that I wouldn’t be me for a while and that it wasn’t that I was a bad employee”. In lines 19-20, Anne adds, “so just to trust me, back off, and let me have time to come back to being me again”. In this example, Anne demonstrates a thought process driven by plausibility rather than accuracy, as she is making assumptions on the responses of others in the workplace, implying that they may now view her as a “bad employee” (line 17). Additionally, she mentions that they need to “trust” (line 19) her, and give her “time to come back to being me again...” (line 20). Anne has concluded that her disability and accommodation requirement may result in others seeing her as a bad employee, which threatens her identity construction (Weick, 1995). Additionally, Anne implies that her employer does not trust her in the process, and that there is doubt that she will be able to return to her pre-diagnosis performance at work. While Anne has drawn these conclusions from cues and social interactions with others at work, these are

based on what Anne feels others are *likely* to be thinking of her post-diagnosis, and do not necessarily reflect the *accurate* perceptions that others held of her (Weick, 1995).

CHAPTER 6: DISCUSSION

The purpose of this chapter is to introduce and discuss themes that emerged from the findings presented in Chapter 5. To begin, I review the research objective. Next, I examine the emerging themes in relation to existing literature, with a focus on Weick's (1995) organizational sensemaking.

The current state of the literature on cardiac arrhythmia is centered on medical research into the various types of arrhythmias. Numerous studies have been conducted that examine medical treatments or medication efficacy related to cardiac arrhythmias. Although the medical research is abundant, there is a lack of understanding on how a cardiac arrhythmia diagnosis can affect the everyday situations that patients face, such as employment or social challenges. This research aimed to contribute to a larger study, *Mapping the Arrhythmia Patient Journey* (Runté, 2022) which uses arrhythmia patients' first-hand accounts of the impact(s) that their diagnosis has had on the social, financial, emotional, and employment facets of their lives. This research focussed solely on the impacts that a cardiac arrhythmia diagnosis has to the patient's employment experience. Using Weick's (1995) sensemaking in organizations, the relationship between a cardiac arrhythmia diagnosis and the patient's employment experience was explored using the seven elements of organizational sensemaking: grounded in identity construction; retrospective; enactive of sensible environments; social; ongoing; focused on and extracted by cues; and, driven by plausibility rather than accuracy. All data were gathered through one-on-one interviews between myself and fifteen voluntary participants who have received arrhythmia diagnoses. The findings of the interviews were presented in Chapter 5, with a focus on how organizational sensemaking (Weick, 1995) contributed to participants' experiences.

Although this study was intended to examine the sensemaking process that patients undergo at the time of diagnosis, I found that participants were continuously reengaging in this sensemaking process as they came across new situations in the workplace that were impacted by, or caused by, their cardiac arrhythmia diagnosis. This finding supports that sensemaking is an ongoing process (Weick, 1995) that does not have a defined ‘start’ or ‘stop’. For example, as demonstrated in Chapter 5, Anne reengaged in her sensemaking process when facing the (lack of) workplace accommodation after her cardiac arrhythmia diagnosis. At the time of her diagnosis, although Anne may have considered whether she needed a workplace accommodation, she did not partake in an in-depth sensemaking process around what that meant. Later, when she required a workplace accommodation, she became reengaged in her ongoing sensemaking process, to assist her in navigating the new situation.

My findings suggest that this continuous reengagement of their initial sensemaking process was common for all participants. All participants embarked on a sensemaking process that considered the relationship between their employment and cardiac arrhythmia at the time of diagnosis; however, as new and unfamiliar situations arose in the workplace that were impacted by or involved their cardiac arrhythmia, participants would reengage in their sensemaking process in an attempt to successfully manoeuvre through the new situation as both a cardiac arrhythmia patient and an employee.

In this study, there were three dominant workplace situations in which participants reengaged in their initial sensemaking process. These situations, which I refer to as the key themes from the findings, are: (1) *reasonable disclosure*; (2) *self-management of an arrhythmia episode at work*; and (3) *real and anticipated reactions from others in the*

work sphere. The first theme, *reasonable disclosure* was further broken down into two subthemes: (1) safety and (2) visibility. The third theme, *real and anticipated reactions from others in the work sphere* considered both real and anticipated positive and negative responses from relevant others at work (e.g., co-workers, clients, bosses, customers, etc.).

The remainder of this chapter will further discuss these key themes, and consider how these themes relate to existing literature and organizational sensemaking (Weick, 1995).

Key Themes within the Data

Reasonable Disclosure

The theme of *reasonable disclosure* addresses the individuals' decision to disclose their arrhythmia at work and the factors considered when making that decision, such as whom to disclose to and what/how much information to disclose (Joachim & Acorn, 2000). The decision to disclose their arrhythmia diagnosis to their employer was often made after considering potential positive and negative consequences. Participants chose to disclose their disability to all others, select others, or no others in the work sphere.

Prior research suggests that number of factors, including the need for workplace support(s), sharing to build trust, feeling that others have a right to know, educating others, or gaining legislative protection (Gignac et al., 2021) act as motivators for disability disclosure. My findings suggested that there were two main reasons that an arrhythmia patient would choose to disclose their disability to others in the workplace: 1) safety; or, 2) visibility of the disability in the workplace. Visibility was further broken down into two subthemes: visibility of cardiac arrhythmia episodes, and visible absences from the workplace.

Safety

A primary consideration with disclosure of their disability was the participants' personal safety. More specifically, if the participant thought that they may need assistance from others during an episode of cardiac arrhythmia in the workplace (e.g., CPR or calling 911), they would disclose their disability to others in the work sphere to ensure that others were aware of their potential role in the arrhythmia episode.

When speaking with Donna, who has an implantable device that helps to manage her arrhythmia, she expressed:

I remember being very forthcoming. And it's only because if anything were to happen to me, as an emergency, I would want somebody to be either on it or giving me CPR or whatever. So yes. I always was... I still am. I'll even tell people. That's why I wear my watch with my medical alert, just to make sure. Yeah.

As someone who had been shocked by her device in the past, Donna was aware of the impact a shock could have on her body. Donna's sensemaking process led her to the decision of telling others at work about her condition so that they would know what steps to take in the event that she had a serious shock at work. This decision was driven by plausibility rather than accuracy (Weick, 1995), as Donna could not guarantee that she would face this situation at work. Additionally, it was a social process that was enactive of the work environment and the potential constraints that the environment could have on her safety, should she choose not to disclose (Weick, 1995).

Another example of disclosure driven by personal safety was provided by Richard:

That's what I did, so I just decided, just made the decision that my type of work, I work in an area where I'm by myself a lot. People pass by and everything so of course in my employment, I had to warn them of what was going on. They knew something was going on because I had to be taken away in an ambulance one time at work. So I basically told them I have a heart condition and I'm going to be having some medication, and I'm deciding to just try not to panic and each time I have an episode, to take another pill and sit down and relax and make sure that

you guys know that I'm having an episode so somebody can check up on me from time to time.

Richard's sensemaking process considered his safety in the workplace. Often working alone, Richard wanted to ensure that his safety was not compromised by his arrhythmia, demonstrating that his sensemaking process was enactive of sensible environments (Weick, 1995). In addition to disclosing his cardiac arrhythmia diagnosis to his employer and co-workers, Richard also chose to disclose when he was having a cardiac arrhythmia episode in the workplace. The rationale was to ensure his safety by tasking others to check on him until the episode had passed.

Donna, Richard, and others discussed personal safety as a reason for disability disclosure at work. This safety-driven employee disclosure is not widely acknowledged, however, in the existing literature. Research has examined the disability disclosure and employee's safety as a consideration of the employer, rather than of the individual worker who has a disability. For the employer, an employee's decision to disclose a disability is relevant when the disability could have an impact on the safety of others in the workplace (Santuzzi et al., 2014). Depending on the industry or the type of work being performed, lack of disability disclosure can be viewed as harmful by the employer, as there may be negative safety implications for the employee with the disability, as well as coworkers, clients, customers, and others in the work sphere (Santuzzi et al., 2014). Further research is needed to examine how personal and co-worker safety affects an employee with a disability's decision to disclose.

Visibility

Santuzzi et al. (2014) discuss three benefits of workplace disability disclosure: first, disclosure can reduce the feeling of isolation for the worker with a disability;

second, in the absence of disclosure, employers cannot attribute poor work performance to the employee's disability; and third, disclosure reduces stress for the worker, as they do not have to hide their disability from others in the work sphere. Additionally, when studying workplace decision-making for employees with disabilities, Jans et al. (2012) found that the visibility of the employee's disability often contributed to decisions made. Similarly, my study found that visibility was a key component in the participant's decision to disclose their arrhythmia diagnosis in the workplace. There were two categories of visibility that were present in this study: visible episodes, and visible absences from work.

Visible episodes

Participants at risk of having visible episodes of cardiac arrhythmia at work, or who had already had visible episodes at work (e.g., fainting, requiring defibrillation, leaving in an ambulance) often considered this when deciding whether to disclose their arrhythmia to their employer or with others at work. For example, Jane, who was often required to visit client sites while at work, chose to tell her clients about her condition, as demonstrated in the two excerpts below:

And I do have to, whenever I go on site at a client's, I usually do warn them. I'm like, "By the way, this can happen. So, you should be aware."...

I would do what I did, which was write that standard operating procedure up, and talk to the people around you, and just have a meeting and be like, "Listen, this is odd, actually. But I'm not going to die." Well, mine, I'm not going to die.

Jane's sensemaking around disability disclosure led her to make the decision to tell clients about her arrhythmia diagnosis and was driven by the probability of having an episode in their presence (Weick, 1995). For Jane, who, at the time was having frequent episodes at work, it made sense to let those around her know that there was a possibility

of her having an episode, and what the reason for the episode was. This decision also provided Jane the opportunity to inform others what assistance, if any, she required from them during or after her cardiac arrhythmia episode.

Unlike Jane, Vicky has never had a visible episode of arrhythmia at work. While she has admittedly had arrhythmia episodes in the workplace, she has been able to manage or hide her episodes by isolating herself from others during the episode. Thus, Vicky engaged in a sensemaking process to determine whether it was necessary to disclose her disability to her employer, with a focus on visibility. As Vicky stated:

And I think having a boss virtual has made a difference, because I think if my boss was onsite, I would be more likely to go, "Hey, I'm not feeling well right now, and I might seem a little bit off, but I want to let you know," because there's a higher chance that you're going to cross paths and they may notice some signs, so you feel like you want to give that heads up...

There's a practicality component where it's like, well, I didn't feel like it was at the level of an FYI. Now I think if I was having episodes at work that were more noticeable, or I needed to take a break, at that point I would have a conversation.

The lack of visibility of Vicky's arrhythmia in the workplace led her to decide that she did not need to actively disclose her condition to others. Vicky considered the likelihood that others would "notice some signs", and because she considered it unlikely, she did not feel the need to disclose her arrhythmia. However, Vicky mentions that "if I was having episodes at work that were more noticeable", that she would likely have a conversation with her employer about her arrhythmia. This demonstrates the importance that Vicky places on the visibility of her arrhythmia at work when choosing whether to disclose. Additionally, it demonstrates that Vicky's sensemaking process is ongoing (Weick, 1995), as she considers how her decisions may change if her arrhythmia becomes visible in the workplace.

Visible absences

My findings suggest that disability disclosure driven by visibility is not limited only to visible episodes or symptoms of disability in the workplace. The decision to disclose based on visibility also includes visible absences from the workplace that are caused by, or related to, the employee's disability. In essence, when considering whether to disclose to their employer or others at work, many participants considered the likelihood that they would be absent from the workplace because of their cardiac arrhythmia. Similarly, Gignac et. al (2021) and Munir et. al (2005) suggest that one of the reasons that workers disclosed information about episodic disabilities to others at work was to manage absenteeism. For example, while discussing disclosure with Christina, she expressed "So it was either those with whom I worked quite closely, or if I had to reschedule meetings or things, I would explain." Others in my study often did as Christina outlined: disclosing their disability to others in the work sphere to explain visible absences (e.g., taking time off after surgery, leaving for a specialist appointment, or rescheduling prior commitments to manage their cardiac arrhythmia). These decisions were often made in response to work environments where the expectation was that employees not be absent (Weick, 1995).

In Bella's interview, she revealed that she has had approximately twenty-four surgeries related to her cardiac arrhythmia since her initial diagnosis. With the high number of surgeries, and required time off post-op, Bella has determined that it is to her benefit to disclose her arrhythmia to her employer at the time of hire. By disclosing her arrhythmia during job interviews, Bella has attempted to mitigate the risk that the employer would later consider her unreliable as she took time off to manage her disability (Vick, 2014):

Yeah. Like to me, I've never lost a job or had a job threatened due to my heart condition. Because like I said, any job I ever took, I was always up and forefront with any employment I ever had said, "Hey, at this time I have a pacemaker that lasts three years. I have to have surgery. I have to take two to three weeks off after surgery." I've never experienced problems because I've never not disclosed it...

Be honest, be forefront with your condition, don't hide anything. Bosses don't like to hire someone and then find out, well, by the way, I'm going in for open heart surgery every six months in six months, and I'm going to need a month off work.

Bella proactively discloses her cardiac arrhythmia to her employer at time of hire, rather than reactively disclosing after she is visibly absent from the workplace. However, not all participants felt it necessary to proactively disclose, prior to taking time off work, as demonstrated below in an excerpt from the interview with Laura:

Yeah, in terms of, I don't know how everyone else is with this, but it's not like I feel shameful of it. I don't feel the need to bring stuff up unless it gets brought up itself. Do you know what I mean? I'm not going to say I broke my leg until they see that I broke my leg. So unless it can directly affect maybe them or the workplace. Then I would. I have, a couple of times, told a couple coworkers. "I didn't come in because I used to have a heart problem and it arose, I think, again," and stuff. But it's not something that I bring up in casual conversation, just kind of when I need to, I think, is the biggest thing.

Laura demonstrates the decision to disclose her arrhythmia to her co-workers after she has been visibly absent from the workplace. Laura's sensemaking process aided her in deciding that it is more appropriate to share this information only after there has been a visible consequence, such as a workplace absence.

Reasonable Disclosure and Sensemaking

As previously mentioned, when faced with the decision to disclose their arrhythmia diagnosis in the workplace, participants re-engaged in their initial sensemaking process. To illustrate, I provide an excerpt from Vicky's interview, and briefly discuss the presence of the seven components of sensemaking:

And it then happened a couple of times at work and just for a couple moments, so, I sat there and I'm like, Do I need to say anything? Because I was trying to sit

there and because I'm in [department name], it's like, do I need an accommodation? I don't. So, I don't know that I need to say anything ... I just didn't feel that it was relevant...

There's a practicality component where it's like, well, I didn't feel like it was at the level of an FYI. Now I think if I was having episodes at work that were more noticeable, or I needed to take a break, at that point I would have a conversation.

In this example, Vicky demonstrates that her decision was influenced by, and *grounded in identity construction* (Weick, 1995) as she considers her identity and need for an accommodation as it relates to her specific department. Her decision to disclose is also *enactive of sensible environments* (Weick, 1995) as she considers the potential constraints that would be placed upon her as an employee in a specific department. Additionally, she considers the visibility and frequency of the episodes in the environment. This process is *social* (Weick, 1995), as Vicky considers if she needs to inform others of her diagnosis. Vicky's sensemaking process is *focused on and extracted by cues* (Weick, 1995), as she considers whether her disability requires a workplace accommodation, and ultimately determines that because she does not need an accommodation, she does not need to disclose. This sensemaking process is also *driven by plausibility rather than accuracy* (Weick, 1995), as Vicky's decision is influenced by the likelihood of others witnessing a visible episode at work. Vicky demonstrates that this process is *ongoing* (Weick, 1995), as she reengages in the sensemaking process when deciding whether to disclose. Additionally, she also illustrates that her decision to disclose may change in the future, should her arrhythmia episodes become noticeable in the workplace. Finally, this example is *retrospective* (Weick, 1995), as Vicky is recalling a past lived-experience, and the decisions made at that time.

Self-Management of an Arrhythmia Episode at Work

The second theme that emerged during data analysis was the participants' *self-management of an arrhythmia episode at work*. This theme describes the sensemaking process that participants underwent when deciding what actions to take, should they have an arrhythmia episode while working. Self-management includes recognising and responding to symptoms, managing acute episodes, use of medication, managing the impact of the illness on daily functioning, managing relations and obtaining support from significant others, and is influenced by contextual factors such as social networks, family support, healthcare providers, and the physical environment (Gallant, 2003; Munir et al., 2005; Munir et al., 2009).

As discussed by Gallant (2003), some self-management tasks are condition specific (such as a person with diabetes measuring blood glucose levels), and other self-management tasks are applicable to, and used by, people with a wide-range of disabilities. In this study, the self-management techniques used by participants were typically techniques that are used by people with varying disabilities (e.g., taking medication at work). The techniques that were described by participants in my study included medication management, isolating themselves during an episode in the workplace, informing others in the work sphere of their disability, drinking water, sitting down, consuming salt, elevating their feet, working from home, and managing their schedules. Self-management techniques were often fluid, with different techniques being used depending on the work environment and the severity of the episode. As with *reasonable disclosure*, individuals reengaged in sensemaking when determining how to self-manage

their arrhythmia in the workplace, or, if they needed to self-manage their arrhythmia while at work.

For example, as Jane often experienced frequent, visible episodes at work, her sensemaking decisions around self-management considered managing relations and obtaining support from others, and considered social networks and the physical environment (Munir et al., 2005; Munir et al., 2009). To assist in self-management, she created a plan that she proactively shared with others in the workplace, which explained what was happening during an episode, and what they needed to do if they were present during an episode:

I actually have, it's called [Jane's cardiac arrhythmia] SOP, so standard operating procedure. And it literally walks them through it, like, "This is what you need to happen, this is completely normal for me, and these are my cardiologists."

Jane's plan was a formal document that she gave to others in the workplace, to assist with episode management. Co-workers, clients and others who Jane dealt with at work may have received a printed copy or been aware of Jane's "SOP", but this document was not created in conjunction with her employer. Although Jane's employer did offer and provide accommodation (e.g., reduced hours), they did not contribute to her personal arrhythmia management plan.

My findings suggest that those participants who have more autonomy in the workplace, or who are their own boss, are better suited to self-manage their arrhythmia at work than those who work for organizations under heteronomous expectations. Those who had job autonomy often had the freedom to choose when they worked, where they worked, and how their job was performed, which allowed them to self-manage their arrhythmia on their own terms. In comparison, those with lower job autonomy felt either that they were unable to self-manage their arrhythmia at work or were concerned that

there would be consequences for their self-management actions. Below I provide an example from three participants who discussed self-management.

The first example arises from Jane's interview. Jane works for herself, and discusses the benefits to her self-management of her arrhythmia that result from her autonomy:

I'm my own boss, right? So, it's like, if I need the extra sleep, then I'm going to take the extra sleep. Or if I need a nap in the middle of the day, because I am feeling very overwhelmed or whatever, I can go do that... It's just offered me so much more control and freedom, and once I got that all up and running, everything sort of seemed to level off. That control and the flexibility allowed me to be healthier basically, and not experience ... I still [have episodes], and as my cardiologist will say, "You're going to [have episodes] again, it's a guarantee."

The second example is taken from the interview with Samantha, who has low autonomy in the workplace, and, although allowed to self-manage when needed, considers potential consequences of the self-management actions:

I sat down for like a good 20 minutes, and they were supportive of that. But then I know I remember feeling a lot of guilt myself, like about now can I still take a break at break time or was that my break?

The final example is an excerpt from the interview with Jeffrey. Unlike Jane and Samantha, Jeffrey does not feel that he is able to self-manage his arrhythmia while at work. As stated by Jeffrey, "I ignored [arrhythmia episodes that happened at work]... There's nothing you can do except drink water, elevate your feet and rest. How do you do that when you're working?"

The three examples above demonstrate the outcomes of sensemaking that three participants had when considering self-management. The decisions made appear to be influenced by the level of job autonomy that each participant had. Those who have high levels of autonomy, such as Jane, are better able to self-manage their arrhythmias at work, as compared to those with lower levels of autonomy, who in some instances, may choose

not to self-manage at work, as they do not feel that they are able to. As suggested by Jans et al. (2012), the organization's workplace culture ("disability-friendliness") often impacts the decision-making of an employee with a disability. In this key theme, the decision and ability to self-manage was impacted by the workplace culture, specific to levels of autonomy. As such, I suggest that job autonomy was a consideration in participant disability self-management in the workplace as participants underwent a sensemaking process of how to manage their arrhythmia while at work.

Self-Management of an Arrhythmia Episode at Work and Sensemaking

When required to self-manage an arrhythmia episode at work, participants would reengage in sensemaking to determine what they felt was the best way to do so while in the workplace. Factors such as how to self-manage, who to involve, and where to go were often considered in the sensemaking process. Below is an excerpt from Christina's transcript, in which she discusses how she self-manages arrhythmia episodes in the workplace. Following this quote, I describe how the seven elements of sensemaking influence Christina's self-management:

I would see where it was at, like how quickly, and when it first started, I was trying to, again ... I'd walk to the bathroom and throw water on my face, I would do these things in my office where I was upside down, trying to get it to stop on its own, and then when I couldn't get it to stop, I would ... Well once I drove myself, which, I was chastised, and a couple other times I went [with a colleague] before I was told in no uncertain terms that was not protocol. Then there was the time that I went to the health unit and they called the ambulance. And sometimes, quite frankly, after I had it done in the health unit, I would just drive myself, even though I knew I wasn't supposed to. Just to get it over with, because I didn't want to walk over to the health unit, and I didn't necessarily want to scare my colleagues, who were already pretty freaked out that this was happening. So I would just drive myself to the hospital, and park and walk into emergency.

Christina's self-management of arrhythmia episodes at work is *ongoing* (Weick, 1995), as she adjusts her self-management process after receiving negative feedback and

being ‘chastised’ for not following ‘protocol’. Christina’s process is *social* (Weick, 1995), as she considers how she may ‘scare’ her colleagues by seeking assistance during an arrhythmia episode. This also demonstrates that Christina’s self-management is *focused on and extracted by cues* (Weick, 1995), as she makes decisions focused on the cues that suggest her colleagues are ‘already pretty freaked out that this is happening’.

Additionally, this suggests that Christina’s sensemaking is *grounded in identity construction*, as she attempts to conceal episodes that may ‘freak out’ others, as they are abnormal to Christina’s typical workplace identity. She does so by either managing episodes alone in her office, or driving herself offsite to seek medical attention. This also demonstrates that Christina’s self-management is *enactive of sensible environments* (Weick, 1995), as she considers environmental constraints, and chooses to self-manage in private spaces. Christina demonstrates that her self-management process is also *driven by plausibility rather than accuracy* (Weick, 1995), as she does not immediately choose to go to the hospital each time she has an episode at work. Given that it is more likely that she will be able to manage the episode without medical assistance, she will try other techniques to alleviate her arrhythmia episode. It is only when these techniques fail that she will then seek medical help. Finally, this account is *retrospective* (Weick, 1995), as Christina reflects on how she has previously managed arrhythmias while in the workplace.

Real and Anticipated Reactions from Others in the Work Sphere

The third emerging theme in my research, *real and anticipated interactions with others in the work sphere* evolved as participants spoke about the impact that social interactions (both real and imagined) with relevant others in the work sphere had on their

sensemaking process. For the purposes of this study, *others in the work sphere* refers to bosses, managers, co-workers, direct reports, clients, customers, students, and any other relationships specific to the participants' employment.

The remainder of this chapter will discuss the real and anticipated reactions from others in the work sphere that were experienced by participants, and consider how sensemaking influenced these experiences.

Real Interactions

Participants who chose to disclose their arrhythmia diagnosis to others in the work sphere often received reactions and comments from those that they told. In some situations, they received supportive feedback from others; conversely, in other situations, participants felt as though others in the workplace were unsupportive of their situation. As such, participant's sensemaking processes regarding their cardiac arrhythmia diagnosis in the workplace were influenced by whether they felt that these interactions were supportive or unsupportive of their arrhythmia diagnosis and needs.

Supportive interactions

During their interviews, some participants spoke about the support that they received from others at work specific to their cardiac arrhythmia. For a few participants, they felt that the support they received was expressed by all others in the work sphere. Other participants felt that select others showed support at work, but that this support was not expressed by all. Consistent with the findings of Abma et al. (2013), participants in this study placed importance on the support from co-workers and supervisors regarding their disability in the workplace.

For example, Jennifer was a participant who felt supported by all of those in her organization. The excerpt below reflects how Jennifer felt others reacted when they learned of her cardiac arrhythmia.

Yeah. They were always really good, and people would be, of course, horrified by the story and then they would be very supportive. I think they were just glad to see when I came back, I was still normal. You know?

Being employed in the healthcare and social assistance industry, Jennifer felt that the support and understanding that she received in the workplace might have been influenced by others' knowledge of her disability. Although others may not have been personally diagnosed with a cardiac arrhythmia, their exposure to others with arrhythmias in the workplace, combined with their educational knowledge of cardiac arrhythmias was assumed to have contributed to the support and understanding they showed Jennifer. Had Jennifer been employed in a different industry, she may not have received the same level of support. Further research that focusses on the similarities and/or differences of co-worker support across employment industries is needed to confirm these assumptions.

In Anne's employment situation, she did not feel support from all others in the work sphere. More specifically, she had negative experiences involving reactions from her boss, students, and had difficulties securing an appropriate workplace accommodation. Despite these challenges, Anne received support from one co-worker that positively influenced her experience:

The other person I told, I told because I needed help and this was her area of expertise in terms of accommodations and stuff. And so I told her because I didn't know what else to do. I needed somebody to tell me that I wasn't wrong, that I wasn't crazy. That what I was asking for was on the very minimal side of things and I needed somebody to fight on my side and she did...

It made a difference, that one in particular who fought at my side, that made a huge difference and I actually probably would have quit my job if it wasn't for that

one individual. Because she believed me. Because she, that she honored that my need was real and thought I was worth fighting for.

Anne's example illustrates how powerful and influential the support from others in the work sphere can be on a person's employment experience. Without the support from the one individual, Anne states she "probably would have quit my job".

The findings from my research study related to positive social interactions aligned with prior research that examine the barriers and facilitators in the workplace for employees with disabilities, that suggest that the support and/or understanding from others in the workplace positively impacts the employee with a disability (e.g. Nevala et al., 2015; Gould-Werth et al., 2018; Hay-Smith et al., 2013; Medin et al., 2006). However, in comparison to the studies listed, my research did not focus on social support as a facilitator solely for return-to-work and/or accommodation processes. Instead, my findings suggest that for cardiac arrhythmia patients, social support acts as an ongoing facilitator that positively affects their employment experience after receiving their diagnosis.

Unsupportive interactions

In contrast to the above examples, some participants received unsupportive interactions specific to their cardiac arrhythmia from others in the work sphere. These unsupportive interactions were primarily doubt, panic, and lack of understanding from others.

Due to the episodic nature, and at times, invisible symptoms of a cardiac arrhythmia, many participants received doubt from others in the work sphere. This was often influenced by the otherwise 'healthy' appearance of the participant.

For example, although Richard had previously had visible episodes at work, he still felt as though others in the work sphere doubted his cardiac arrhythmia, as it was often invisible:

And then again, honestly, I've got some coworkers that kind of just blow it off and think, well, it's probably not that serious. Look at him, he's working away. I can have days where I don't have to stop all day long, no problem. Then all of a sudden, bang, there'll be a day where I'll have a bad day and I'll have a couple of small little episodes. And they go, "Well, how can that be? If you had a heart condition, then you shouldn't be able to do half the work that you do." The rest of me is nice and healthy.

In this example, Richard speaks about co-workers who “blow it off” and think that his cardiac arrhythmia is “probably not that serious”. As Richard is still able to perform his pre-diagnosis duties with limited restrictions, he appears as a healthy, able-bodied worker to others. Richard illustrates that when he does have a visible episode, this has not meant that the doubt then shifts to understanding or belief. Rather, the doubt remains, with questions arising around his ability to perform his work.

For Jane, others in the work sphere were vocal about their doubt surrounding her diagnosis. When discussing the reactions of others surrounding her cardiac arrhythmia diagnosis in her interview, Jane stated, “And they're like, "Is it really a real thing?" "Yes."... Oh yes, all the time. "Oh, just trying to get out of work." Yeah.” Additionally, as Jane had to miss work at time to attend specialist appointments, and had her work hours modified by her employer, others often joked to her that her cardiac arrhythmia was an excuse to “get out of work”, ignoring the legitimacy and significance of her situation.

The doubt that Richard and Jane received from co-workers is consistent with the findings and discussions in prior studies. For example, Santuzzi et al. (2014) discussed that when an employee with an invisible disability discloses to others in the workplace, the disability is sometimes viewed as suspicious or illegitimate. The employee who

disclosed may be questioned about the legitimacy of their disability, or, others may assume that the employee is falsely claiming the disability in an effort to receive special privileges (Santuzzi et al., 2014), as shown in the two examples above.

Further to doubt and lack of understanding, some participants also shared experiences where others in the work sphere became panicked or stressed when they learned about the participants' diagnosis. Although the panicked person may not have intended their reaction to be unsupportive, the data from this study shows that this reaction was often a negative experience for the participant, as it was for Jane:

And of course, anything to do with your heart, you only have one, and it's like your lifeline. So, it is very scary to certain people, especially when they don't have ... They've never had any health issues, and they're like, "Oh, this is a big fucking deal, god." ... Yeah, it was always mass panic. So, just not my style. I don't want this attention.

Similarly, Richard spoke about one specific person in the work sphere, who “freaks out” about Richard’s cardiac arrhythmia:

Well, I have the one lady who does that with me all the time. Every time I put my hand on my chest, she kind of freaks out. She's the one that called my wife the day of the ambulance ride. She called my wife first. My wife told her call 911 right now. So she called 911 and she's saying, "Do I get the defibrillator out or what?" She was like freaking out.

Other studies have reported employees with episodic disabilities having similar experiences to Jane and Richard. For example, a participant in Gignac et al. (2021) reported, “There is a lot of stress that goes along with telling people because, first of all, they look at you like you’ve got two heads, and then they treat you like you’re very fragile...” (p 157). Generally, participants in my study did not feel that these panicked reactions from others in the work sphere came from a place of intentional wrongdoing; however, these reactions were not positively received. Participants showed more appreciation to those who reacted to their cardiac arrhythmia diagnosis or episodes

rationally, by asking questions, offering workplace supports, offering emotional support, and displaying empathy.

Anticipated Reactions

Along with real interactions, participants were also influenced by anticipated perceptions of others in the work sphere. As explained by Helms Mills et al. (2010), physical presence is not a necessary component to social sensemaking. Individuals may mentally improvise interactions with others and act based on these assumptions. For example, as discussed by Santuzzi et al. (2014), if participants expected that co-workers would negatively react to their diagnosis, it influenced their decision to conceal their disability at work, in an effort to avoid stigmatization and stereotyping from others.

When deciding whether to seek help from a colleague while having a cardiac arrhythmia episode at work, Vicky considered how she thought the colleague would react to the information. Vicky explains the thought process that she had when deciding whether to involve her colleague:

"Is this the day that I go and ask [my colleague], I need you to take me to the hospital because I've got this heart thing going on?" So I think if... It's just like the eye over the shoulder. So what I was rolling around in my head, I'm like, so I've never told anyone and then if I messaged her to come into this [room I'm in] to be like, "Hey, so by the way, I've got this going on. And I think I need you to take me to the hospital." I feel like she would have been really stressed.

In this instance, after concluding that her colleague would be "really stressed" by this information, Vicky chose not to seek help from the colleague. Although Vicky could not be certain that this would be the outcome, she wanted to avoid the possibility. Had Vicky concluded that her co-worker would have been calm when presented with the information, she may have been more likely to share, as the anticipated perception would be closer aligned to her preferred experience.

In comparison to Vicky, who made decisions based on anticipated reactions from colleagues who were unaware of her diagnosis, Samantha reflected on prior conversations that she has heard in the workplace, and assumed that others had similar conversations about her and her diagnosis:

I have a huge fear people's judgment and I don't know what they're thinking - even if they don't tell me, they're judging. And so I think just the idea of people... Because I've heard people talk about other people behind their back, saying like, "Oh, so-and-so misses so many days. So-and-so's sick all the time." I'm just sure it happens about me when I'm not there too.

Although at the time of the interview Samantha could not be certain that these types of comments were made about her in the workplace, she assumed, based on extracted cues (Weick, 1995) and social conversations (Weick, 1995) that these comments were also made about her. Samantha anticipates that when she needs to leave work early or miss a day due to her cardiac arrhythmia, that others make comments about her absences. Because she has seen this negative perception around others, she anticipates that it will also apply to herself.

Real and Anticipated Reactions from Others in the Work Sphere and Sensemaking

As with the prior two themes, participants reengaged in sensemaking when considering the reactions of others to their arrhythmia diagnosis in the workplace. Below is an excerpt from Thomas's transcript, in which he discusses how others at work may react to his diagnosis. Following, I provide an outline of how the seven components of sensemaking were present in this quote:

And this is going to sound really bad, but I think that goes back to hockey, and just, if you're hurt, you don't tell anyone, because someone could replace you the next day. Right? So you just bear through it as much as possible, and go with it.

Thomas describes a sensemaking process that is *driven by plausibility rather than accuracy* (Weick, 1995) as he explains how he expects others to react to his diagnosis.

His expectations are *focused on and extracted by cues* (Weick, 1995), as he draws cues from his experience playing hockey, and applies them to the context of the workplace. This account is *retrospective* (Weick, 1995), as Thomas draws and reflects on previous lived experiences both within the workplace and sports. *Social* (Weick, 1995) factors are given consideration as Thomas decides to “not tell anyone” about his diagnosis. This process is *enactive of sensible environments* (Weick, 1995), as Thomas considers the workplace culture and the risk of being “replaced” if he tells others about his diagnosis. Additionally, Thomas demonstrates that these decisions are *grounded in identity construction* (Weick, 1995), as he tries to prevent others from viewing him as “hurt”. Finally, Thomas explains an *ongoing* (Weick, 1995) sensemaking process that he has reengaged in when determining whether to discuss his arrhythmia diagnosis with others.

CHAPTER 7: CONCLUSION

This chapter provides a summary of my research, theoretical and practical implications of the findings, and a discussion on the limitations of this study. Suggestions for future research are provided at the end of this chapter as a conclusion to this thesis.

Research Summary

This qualitative research study has provided insights into the experiences and considerations of cardiac arrhythmia patients in the workplace. I used an interpretivist approach to research when conducting participant interviews and performing data analysis. The intent of this research was not to find a universal truth that is shared by all employees with cardiac arrhythmias; rather, this exploratory study served to understand how arrhythmia patients experience work after receiving their diagnosis.

Organizational sensemaking (Weick, 1995) was used as an analytical framework in this study. Sensemaking (Weick, 1995) served as a tool for data collection and analysis, and guided the overall research process. This approach unveiled three key themes during data analysis: (1) *reasonable disclosure*; (2) *self-management of an arrhythmia episode at work*; and (3) *real and anticipated reactions from others in the work sphere*. The first theme, *reasonable disclosure* was further broken down into two subthemes: (1) safety and (2) visibility. The third theme, *real and anticipated reactions from others in the work sphere* considered both real and anticipated positive and negative responses from relevant others at work.

The information shared by participants and found during data analysis suggests that after receiving a cardiac arrhythmia diagnosis, employees continually engage and reengage in a complex sensemaking process in an attempt to successfully navigate the ever-changing workplace as a person with a disability.

Implications

The findings of my study provide both theoretical and practical implications not only to the employment sector, but to the medical sector as well.

Theoretical Implications

Although a large body of research exists that examines both disability in the workplace and the medical implications of cardiac arrhythmia diagnoses, the impacts of a cardiac arrhythmia on a patient's life outside of the medical context is largely understudied. More specifically, literature that examines the impacts that a cardiac arrhythmia may have on a patient's employment experience is sparse. This study has addresses this gap in cardiac arrhythmia research by considering the effects of a diagnosis on the patient's daily life. This information can benefit employers, as they support employees with arrhythmia in the workplace. To ensure that employers are appropriately responding to and accommodating for employee disabilities, it is important to understand the individual needs of the employee. Additionally, it is important for employers to understand that there is no "one-size-fits-all" accommodation for employees with cardiac arrhythmia, as this diagnosis is an umbrella term used for a variety of heart arrhythmias.

This information is also useful to medical practitioners, as it addresses the patient's quality of life outside of the medical setting, and how this needs to be considered when working with arrhythmia patients.

Additionally, while significant research exists that discusses disability in the workplace, studies have not been conducted that specifically address cardiac arrhythmia as a disability in the workplace. In addition, many studies on disability in the workplace, focus on a single event or point in time, such as an accommodation/rehabilitation program

or return-to-work process for employees with disabilities (e.g., Gouin et al., 2019; Coutu et al., 2015; Hay-Smith et al., 2012; Medin et al., 2009). This study offers a unique perspective of disability in the workplace, as it considers the daily events that employees with disabilities experience in the workplace, in comparison to a single event, such as a return-to-work process.

Prior research on disability in the workplace has largely focused on observers' (e.g., human resources professionals or co-workers) roles in the disability schema, or attitudes towards the employee with a disability (Santuzzi & Waltz, 2016). This study provides further insight into the experience of the employee with the disability, rather than the observer. All participants in this study were currently experiencing, or had previously experienced, what it meant to have a disability as an employee. This research contributes to and extends the existing body of literature that focuses on the patient's voice and first-hand experience.

This study also adds a unique contribution to the growing body of organizational sensemaking literature, as it integrates organizational sensemaking and disability research. The results of this study suggest that participants engage in ongoing sensemaking as they are faced with new situations in the workplace that they are required to navigate with an arrhythmia diagnosis. While the sensemaking process that considers the arrhythmia and employment relationship often starts at the time of diagnosis, it continues as new challenges, questions, and interactions arise in the workplace. Participants must constantly reengage in sensemaking to determine how to most appropriately respond to new situations.

Finally, this study directly contributes to the ongoing research funded by CANet, *Mapping the Arrhythmia Patient's Journey* (Runté, 2022), which examines the social

implications that a cardiac arrhythmia diagnosis has on a patient's life. More specifically, the research uses a qualitative approach to examine the impact of a cardiac arrhythmia diagnosis on a patient's social, financial, emotional, and employment situation. This study provides additional information that can be used within the employment focus of the mapping research. Of note, the mapping research is part of a larger CANet initiative, which seeks to understand the quality of life for arrhythmia patients, and how the quality of life needs to be considered by medical practitioners and integrated into their practice.

Practical Implications

This study provides several practical implications for both employees with cardiac arrhythmia diagnoses and employers. First, employees with arrhythmias have identified a need to self-manage their disability in the workplace. Additionally, they have expressed that the employer is seldom involved in the self-management planning or process. This identifies an opportunity for employers to work with employees who have cardiac arrhythmias (or other disabilities) to understand how they can provide continued support in the self-management of the disability at work. Working collaboratively with employees, employers have the opportunity to identify what their role is in the self-management process, and the degree of involvement that the employee is seeking. This employer involvement and support could potentially have positive impacts for employees such as Jeff, who, as discussed in Chapter 6, felt that he was unable to manage his diagnosis and health in the workplace.

Second, this research has shown that in many situations, employees with unfamiliar episodic disabilities receive mixed reactions, including unsupportive interactions, from others in the workplace. In this study, unsupportive interactions were expressed as doubt, panic, and a lack of understanding from others. These findings imply

that there is further need for employers to educate all staff on disability diversity and inclusion in the workplace. Educating employees on episodic disabilities, invisible disabilities, and how to respond to a health crisis may promote an inclusive culture for employees with lesser-known or understood disabilities, such as arrhythmia. It should be noted that while disability diversity and inclusion education is a potential implication of this study, employers who wish to further educate staff must ensure to protect the privacy of the health information of employees with disabilities.

Next, the findings of this research suggest that there is no “one-size-fits-all” experience for employees after receiving a cardiac arrhythmia diagnosis. Although this study found common themes that require ongoing sensemaking, the experiences, considerations, and decisions of employees because of the sensemaking were varied. This is likely due to the different arrhythmia types and complexities, and the personal preferences of the employees. It is important that employers do not assume that all employees with cardiac arrhythmias require the same degree of workplace support or modification. Each employee that discloses a cardiac arrhythmia requires separate consideration to ensure that his or her disability is supported in the workplace.

Finally, my study provides information that clinicians can use when assessing an arrhythmia patients’ quality of life, as well as what to share with the patient’s employer in the event that there is an accommodation required. Prior clinical observation and research has shown that what matters most to arrhythmia patients is their subjective quality of life, rather than objective measures of disease burden. This knowledge surrounding the employment experience can be used when considering the subjective quality of life for patients with cardiac arrhythmia.

Research Limitations

While all research undoubtedly experiences numerous limitations, there were three prominent limitations in my study that should be addressed.

The first limitation is the number of participants included in this study. This research is limited to the opinions of fifteen individuals, who voluntarily shared how their arrhythmia diagnosis affected, or continues to affect, their employment experience. This information was analyzed using an interpretivist, sensemaking lens (Lindlof & Taylor, 2002; Eriksson & Kovalainen, 2008; Weick, 1995) to derive sense from and ascribe meaning to this arrhythmia diagnosis and employment relationship. Participant claims do not necessarily represent an objective reality, and therefore, the findings of this study do not reflect a universal experience shared by all arrhythmia patients. Therefore, the results of this study are not likely generalizable to all currently or previously employed arrhythmia patients. However, previous research suggests that when attempting to understand the common perceptions and experiences among a similar situation or relatively homogenous individuals, twelve qualitative interviews are sufficient (Guest et al., 2006). This study surpasses that recommendation with fifteen interviews used.

The second limitation relates to participant diversity. While the study included the voices of both male and female arrhythmia patients, patients with various cardiac arrhythmias, and patients of various age ranges, it did not include the voices of ethnically diverse patients. All participants in the study identified as, and presented as Caucasian and/or Canadian. While the parameters of the study required participants to be living in Canada at the time of employment, it was not necessary that participants be of Caucasian or Canadian descent. No volunteers identified or presented as an ethnic minority. The experience of those who are an ethnic visible minority in the workplace, who then receive

a cardiac arrhythmia diagnosis, furthering their status as a visible minority is not represented in this research.

The final limitation to address is the timing of the research. All interviews were conducted during the ongoing global COVID-19 Pandemic. As a result, some participants' work environments were altered (i.e., working remotely) which likely affected their employment experience as an arrhythmia patient, and may have resulted in findings that were specific to the COVID-19 reality, and did not reflect their employment situation pre-pandemic. While I suggest that this is a limitation, I also argue that it is simultaneously a strength as it allowed some participants to compare how working from home versus working from the office influenced their sensemaking regarding their arrhythmia diagnosis.

Future Research

Purposive, non-probability sampling methods (Lindlof & Taylor, 2002; Eriksson & Kovalainen, 2008) were used to recruit participants for this study. While fifteen participants of varying age ranges and from varying industries were interviewed, as mentioned above, the sample population lacked ethnic diversity. I suggest that future research is needed that examines the experience of ethnically diverse employees with cardiac arrhythmias in the workplace. Further research is needed to examine the experience of employees with cardiac arrhythmias who belong to marginalized groups in the workplace.

Additionally, I propose that future research is needed that considers the industry of the organization that the cardiac arrhythmia patient is employed at. While a variety of industries were reflected among this study's participants, the influence of the specific

industry on the cardiac arrhythmia sensemaking process was not discussed in detail. As discussed in Chapter 5, a participant of this study who worked in the healthcare and social assistance industry assumed that the acceptance she received from her co-workers was related to their advanced healthcare knowledge. Future research is needed to establish if and how the industry of employment affects the cardiac arrhythmia patient's employment experience.

I also suggest that future research focus not only on one single point-in-time when examining disability in the workplace, but rather, focus on the ongoing, day-to-day experiences and challenges of employees with disabilities. This suggestion spans beyond the research of employees with cardiac arrhythmias, and includes the experiences of employees with all types of disabilities.

Finally, I propose that future research examine the employers' and medical practitioners' sensemaking process regarding cardiac arrhythmia patients' employment experiences. By examining the sensemaking process of these two stakeholder groups, we will gain a better understanding of where further education and action is needed to support arrhythmia patients in the workplace.

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APPENDIX A: INTERVIEW PROTOCOL SCRIPT

Good morning / afternoon / evening,

Thank you for taking the time to be interviewed today. Prior to starting I need to ask for your permission to audio record this interview. Do I have your permission to record this interview?

(Y)

Thank you. Once I have begun recording I will need to ask you again if I have your permission to record.

[start recording]

Do I have your permission to record this interview?

(Y)

Thank you.

Before we begin the interview, I would like to introduce myself and explain my role in this research, as well as give you some information on the study that is being conducted. My name is Shannon Jarvie, and I am a Master's student at the University of Lethbridge. My educational and professional background is in Human Resource Management and Labour Relations, and Social Responsibility - specifically in the healthcare industry. My Master's thesis uses an HR lens to study the sensemaking relationship between an arrhythmia diagnosis and employment.

The purpose of this research is to explore the sensemaking process that employees go through after receiving a medical diagnosis of cardiac arrhythmia. I'm hoping to explore how you made sense of your employment situation after you received the news that you have an arrhythmia. The research will require approximately 60 to 90 minutes of your time today. During this time, an in-depth, semi-structured interview will be conducted, in which I will pose to you questions about your thoughts and actions towards your employment situation when you received your diagnosis. The questions will focus on the sense and meaning that you ascribed to organizational experiences that were impacted or caused by your cardiac arrhythmia.

This research is being conducted in accordance with the University of Lethbridge policies for ethical research. There is a possibility that discussing your experience today may cause you discomfort or be emotionally distressing. If you do find that this process leaves you feeling uncomfortable, please let me know so that I can assist you in finding resources or counselling in your area to assist you. On the contrary, you may find that talking about your experience with a nonjudgmental interviewer to be an enjoyable, personally rewarding experience.

Your participation in this research is completely voluntary. During the interview, you have the right to refuse to respond to any questions that you are asked. As well, you have the right to withdraw yourself from the study at any time during the research, until the point that the final thesis document is completed. There is no consequence for withdrawing from the research if you choose to do so.

The interview will be digitally audio recorded, and the recording will be professionally transcribed, using the transcription service Rev.com. As such, this means that there will be one external party who will hear the content of the interview, strictly for the purposes of transcription. Do you understand and agree to this?

(Y)

The interview information that you provide for this research will be held in the highest confidence, and several steps will be taken to protect your anonymity and identity. During the data analysis phase, and in the final thesis document, you will be identified by a pseudonym in place of your real name. A code sheet will be kept that will match your pseudonym with your real name; however, access to this code sheet as well as to your interview data will be restricted to only myself and the three faculty members of my thesis committee.

You are encouraged to respond to the interview questions in an open, honest, and frank manner. Your answers will in no way be judged; there is no “right” or “wrong” way to answer the questions that I will ask you.

Only the information that you provide me during your interview will be used in my research and reported in my final thesis document. The findings of my research THAT ARE REPORTED IN MY final thesis document may also be published in an academic and/or professional peer-reviewed journal or presented at an academic and/or professional conference, so that others may gain a better understanding about how arrhythmia patients make employment-related decisions.

After the interview, should you have any questions regarding the study or should you wish to obtain a copy of the study results, please feel free to contact me by email at shannon.jarvie@uleth.ca or telephone at (403) 330-2908. You may direct questions regarding this study to my thesis supervisor, Dr. Mary Runté, who may be reached by email at mary.runte@uleth.ca or telephone at (403) 329-2367. Questions regarding your rights as a research participant may be addressed to the Office of Research and Innovation Services, University of Lethbridge by email at oris@uleth.ca or by telephone at (403) 329-2431.

Do I have your permission to begin the interview?

APPENDIX B: INTERVIEW BLUEPRINT

RESEARCH OBJECTIVE	RESEARCH QUESTION	PROBING QUESTIONS
CARDIAC ARRHYTHMIA		
To understand their personal arrhythmia story	Can you start by telling me about your arrhythmia diagnosis?	What events led up to you receiving your diagnosis? How old were you when you received this diagnosis? Have there been any changes or developments in your diagnosis over the years? What type of impacts or symptoms do you experience? How frequent are these symptoms?
SENSEMAKING: Self-referential Identity Construction		
Role of work and disability in the identity construction of the participant	How important is work to you?	Tell me more about that.
Self-embodied identity (identity projected to others)	How would you describe yourself?	Do you use work when defining yourself? Do you use your disability when defining yourself?
Observed identity (identity obtained from others)	How do you think your coworkers would describe you?	Do you think your coworkers who know about your arrhythmia describe you differently than your coworkers who don't know about your arrhythmia?
SENSEMAKING: Retrospective		
Personal account of employment at the time of diagnosis.	Can you provide me with detail about what your employment situation was at the time of your diagnosis?	Title? How long in that position? What were your responsibilities? How many individuals reported to you? Who did you report to? Is this still where you work? What industry was your organization part of? Same position as now? Different? Was your diagnosis part of the reason that you are no longer at this job/organization? FT? PT?
SENSEMAKING: Enactive		
Role participant played in making the decision.	When you received your diagnosis, what thoughts did you have about your job?	Options considered? Decision(s)/choice(s) made? Constraints faced with? Look for assumptions made.
SENSEMAKING: Social		
Role of others	Who did you discuss your disability with after receiving your diagnosis?	Coworkers? Managers? Family? Friends? How did these people react? Did they influence your thoughts on employment at the time?
Influence of others	Who did you 'really' listen to when deciding what to do about your job?	Why? How did you feel about work after talking with these particular individuals? Who did you ignore? Why?
SENSEMAKING: Ongoing		
Gain understanding of the interruption	What were you doing when you received your diagnosis?	Were you at work? At home? Elsewhere? What were the first actions taken? Continue what you were doing? Immediate stop?
Emotions involved	Do you recall what your emotions were when you received your diagnosis?	What were your initial thoughts/feelings/actions? Did you think about your employment right away? Was it an afterthought?
SENSEMAKING: Cues Extracted and Focused on		

What is/ was the organization's orientation towards disability?	How "disability-friendly" would you consider your job at the time?	The job itself? The organization? Formal/information policies? Uniform throughout or depends on the individual with the needs and responsibilities?
What cues did the participant focus on and extract from their experience	<i>(Cues salient in the account provided in answers to the other questions.)</i>	<i>(Look for indication that the cues were perceived to be novel, unusual, extreme, negative, goal relevant, particularly influential, figurative, etc.)</i>
Self-fulfilling prophecy. Acting on assumptions and expectations.	<i>(Within the account provided in answers to the other questions.)</i>	<i>(Look for explanation of the presentation of the cues ... whether the participant anticipated or expected them.)</i>
SENSEMAKING: Plausibility Driven		
	<i>(The situation as presented is a filtered account complied in hindsight and therefore the account is about making plausible reason sense of the situation and involves ordering distinct events/episodes and creating clarity; as well as, creation, invention and instrumentality)</i>	<i>(Look for explanations, assumptions made and meaning derived. Narrated order of events. Arguments, provided by participant, in support of accuracy and credibility of their account. Feelings of autonomy and control over situation.)</i>
CONSEQUENCE OF SENSEMAKING		
Effect of the decision & participants sensemaking processes on organizational commitment	Prior to your diagnosis, committed were you to you organization? To your manager?	
	After your diagnosis, how committed were you to your organization? To your manager?	
	When talking through this now with me, how would you describe your current level of commitment to your organization and manager?	
What was learned. Meaning of experience.	Say a co-worker of yours recently discovered that they have a disability that may affect how they can function/perform in the workplace. What advice would you provide them?	Would your advice be the same for all disabilities? Specifics to arrhythmia?
DEMOGRAPHIC INFORMATION		
Age	How old are you as of today's date?	
Gender identity	What gender do you identify with?	
Marital Status	What is your current marital status?	Married? Common-Law? Divorced? Separated? Widowed? Single?
Ethnic origin	What is your ethnic origin?	
Location	What city/province do you currently reside in?	Was this different at the time of employment?

Education Level	What is the highest level of Education that you have obtained?	High school? Some college? College Diploma? Some University? Bachelor's Degree? Master's Degree? PhD Degree?
Dependents	Do you have any other dependents?	Children? Adult dependents? What are their ages? Do they reside with you?
Personal level of health	How would you describe your level of personal health?	Very poor, poor, fair, good, very good
Current occupational status	Do you still have the same job we talked about? If no, what are you doing now?	Retired? FT? PT? Industry? Title?
FUTURE CONTACT		
Interest in participating in future research	Would you be interested in participating in future research?	May I contact you by phone? Email?
Member checks	I will be conducting member checks as I analyze data to ensure that I am correctly capturing individual stories. Would you be willing to provide a member check if needed?	May I contact you by phone? Email?
Knowledge of potential interview participants	Do you know of anyone else in a similar situation that may be interested in participating in this research? If yes, would you mind passing on my information to this individual?	

APPENDIX C: FINAL CODE LIST

Quirk Title	Description	Author	Total Codes
Disclosure	Decisions around whether Employer and/or others about the cardiac arrhythmia diagnosis	Shannon Jarvie	58
“No big deal”	Arrhythmia diagnosis was “no big deal” to participant	Shannon Jarvie	29
Workplace benefits	Employer provided benefits, pension, etc. that were considered and/or used	Shannon Jarvie	8
Accommodation	Thoughts and need for accommodation, and consideration as to whether the Employer would be willing to accommodate	Shannon Jarvie	26
Support and/or reactions from ER	How the Employer reacted to the information of, or witnessing of cardiac arrhythmia events, OR, how the participant predicts they would react. Level of support that was provided	Shannon Jarvie	40
Support and/or reactions from others	How others (e.g., coworkers, customers, clients, etc.) at work reacted to the information of, or witnessing of cardiac arrhythmia events, OR, how the participant predicts they would react. Level of support that was provided	Shannon Jarvie	34
Job autonomy and flexibility	Ability to work from home, make own schedule, plan own day and tasks, etc.	Shannon Jarvie	7
Visibility	Degree to which others could see the cardiac arrhythmia or consequences of the arrhythmia	Shannon Jarvie	36

Time-off work	Time-off work to manage arrhythmia, such as doctor's appointments, surgery, recovery time, sick days, etc.	Shannon Jarvie	23
Disability-friendliness of org	How disability friendly the participant felt that the organization was	Shannon Jarvie	22
Isolation during episode	Participants who purposefully chose to isolate themselves from others when having an episode in the workplace	Shannon Jarvie	14
Pay implications	Lost wages due to arrhythmia complications	Shannon Jarvie	12
Uncertainty	Ongoing uncertainty of how participant will deal with an episode in the workplace	Shannon Jarvie	9
Job Commitment	Changes to job commitment after receiving diagnosis	Shannon Jarvie	22
"Normal"	Participants wanting to be viewed as "normal" by others in the workplace	Shannon Jarvie	13
Job change or retirement	Change to participants job or decision to retire, driven by cardiac arrhythmia diagnosis	Shannon Jarvie	27
Replaceable	Viewing themselves as replaceable if others find out about their arrhythmia	Shannon Jarvie	3
Limit job growth	Opportunities in the workplace limited due to arrhythmia and consequences of arrhythmia	Shannon Jarvie	10
Caused by work	Participants felt that work activities or tasks caused cardiac arrhythmia episodes	Shannon Jarvie	20
New tasks	Participant kept same job, but was forced to do new tasks/job duties because of arrhythmia	Shannon Jarvie	10

Identify with work	Degree to which participants felt that work was part of their central identity	Shannon Jarvie	22
Identify with arrhythmia	Degree to which participants felt that their arrhythmia was part of their central identity	Shannon Jarvie	16
Participant negative emotions	Includes negative feelings that participants had (e.g., guilt, fear, isolation, anger) toward the employment-arrhythmia relationship	Shannon Jarvie	33