

CRITICAL CARE NURSES AS COWORKERS ARE OUR INTERACTIONS NICE OR NASTY?

In a recent paper¹ published by the American Association of Critical-Care Nurses (AACN) describing the environment where critical care nurses work, the authors targeted numerous issues that warrant further attention to improve and maintain the milieu necessary for optimal patient care. Although many of these issues such as leadership, staffing, and support for professional development relate to multifaceted features typically viewed at the clinical unit and/or organization level, others such as communication, collaboration, and respect point to indicators that can be viewed at more of an individual, interpersonal level. At this level, some findings that particularly intrigued me pertained to the quality of interactions between and among registered nurses (RNs) who work in critical care areas:

- When asked to rate the quality of communication between RNs in their work units, only 14% rated this as excellent, 58% as good, 25% as fair, and 3% as poor.
- When asked to rate the quality of collaboration between RNs in their work units, only 17% rated this as excellent, 58% as good, 23% as fair, and 2% as poor.
- When asked to rate respect for RNs by other RNs in their work units, only 21% rated this as excellent, 57% as good, 19% as fair, and 3% as poor.
- When asked whether they had personally experienced verbal abuse from another RN while working as a nurse during the past year, 18% (representing 709 instances) indicated that they had.

Before proceeding with this discussion, it should be noted that in all these instances, critical care RNs overwhelmingly rated their interactions

with other RNs highest when compared to interactions with physicians, nurse managers, and administrators. Ratings of interactions with other RNs were either excellent or good in 72% of cases for communication, 75% for collaboration, and 68% for respect. In the vast majority of instances, critical care RNs report working well with each other in a supportive, respectful manner.

Although this professional glass is clearly more than half full, the nagging precipitated by those 25% to 32% of instances in which critical care RNs reported only fair or poor quality of interactions with peers would not subside. Especially in relation to respect and verbal abuse, I wanted to know more about the specific situations critical care nurses experienced that underlie those less than stellar quality ratings. What is going on that we might improve upon? Because the survey report did not address these details, I would like to examine this issue more fully via its more inclusive umbrella term from the nursing literature of lateral hostility.

Lateral Hostility Between Nurses

Lateral (or horizontal) hostility refers to a variety of unkind, discourteous, antagonistic interactions that occur between persons at the same organizational hierarchy level and are commonly described as divisive, infighting, backbiting, and off-putting. The phenomenon of lateral hostility between nurses who are peers has received considerable attention for many years, particularly throughout Great Britain and Australia. In these countries the issue is characterized as “bullying” and is considered both a serious and per-

Help us identify the situations in which critical care nurses experience lateral hostility—take our online survey!

vasive problem throughout each country's national healthcare system.

The recent publication of a monograph titled *National Overview of Violence in the Workplace*² by the Royal College of Nursing in Australia attests to the importance of this issue addressing not only the many victims of this behavior who are still practicing nursing, but extending to wider concerns for the effects of this problem on the ability to recruit and retain nurses in the midst of a severe shortage of nurses.

Nurses in the United States,^{3,6} Canada,^{7,8} and Hong Kong⁹ have added their voices to the international outcry against this insidious problem within the profession. Only last year, when one nursing journal Web site¹⁰ asked visitors, "In the last 6 months, have you witnessed any nurse treating another nurse inappropriately (horizontal violence)?" 55% of respondents said yes.

The elements and behaviors that comprise the phenomenon of lateral hostility have spawned a number of terms used throughout the lexicon of this literature, making its precise and consistent definition difficult. Some of those terms include the following:

- *Verbal abuse.* "Communication perceived by a person to be a harsh, condemnatory attack, either professional or personal. Language intended to cause distress to a target."^{11(p148)} Verbal abuse can be blatant or subtle and consist of communication through words, tone, or manner that disparages, intimidates, patronizes, threatens, accuses, or disrespects another person.¹

- *Bullying.* "Workplace bullying is coercive and persecutory ... may be covert or subtle ... [and includes] ... the gaggle of individuals who ... ignore one of their co-workers [when they enter the room] ... [and] ... the saboteur who undermines another's success, who engages in the silent treatment, or spreads rumours."^{12(p23)}

- *Horizontal hostility* is "a consistent pattern of behavior designed to control, diminish, or devalue a peer (or group)...."^{13(p26)}

- *Horizontal violence.* "Sabotage directed at coworkers who are on the same level within an organization's hierarchy."^{14(p977)} Horizontal violence is nonphysical intergroup conflict, manifested overtly and/or covertly in hostile behaviors.^{15,16} Horizontal violence refers to hostile and aggressive behavior by individuals or group members toward other members or groups of members within larger group. The behavior may be conscious or unconscious and is typically nonphysical.¹⁷

- *Interactive work place trauma* is "ugly, mean, destructive, demoralizing, and counterproductive to efficient, effective patient care and positive staff performance."^{8(p24)}

Origins of Lateral Hostility

A number of different mechanisms have been proposed to explain the origin of lateral or horizontal hostility, although the most commonly identified source is via oppressed group behavior. According to Duffy,¹⁶ "Oppression exists when a powerful and prestigious group controls and exploits a less powerful group." At this point, the oppressor controls others out of self-interest¹⁵ to achieve his or her goals. The purpose of the oppressor's behavior is to control, humiliate, and/or denigrate the dignity of his or her colleagues.¹⁶

Within this interpretation, the ugly interpersonal behaviors manifested by one RN toward another represent system and cultural issues, symptoms of an emotionally, spiritually, and psychologically toxic and oppressive environment. It is one way that staff who themselves feel oppressed can release built-up anger, frustration, and tension attributable to their own inability to resolve issues with others (such as administration or management).¹⁷ Unable to effectively retaliate against their own oppressors, they redirect their negative behaviors toward other members of their peer group.

Not everyone subscribes to the oppression mechanism as an explanation of how these inappropriate and disrespectful behaviors germinate. Some view the oppression etiology as denigrating to nurses, making them appear as helpless victims.¹⁸

Another viewpoint regarding the origin of bullying in public service sector workplaces proposes that this type of bullying behavior is preceded by long-standing struggles for power that emerge from organizational conditions and conflicting work values and leadership styles.¹⁹ Still other interpretations of these dynamics emphasize that this form of bullying is a learned behavior within a given workplace, rather than a personality or behavioral deficit contained within one or more individual perpetrators.²⁰ In reality, the individual versus organizational contributions to this problem may be deeply interwoven and nearly impossible to distinguish. As Hastie^{17(p2)} suggests, "Horizontal violence is not a symptom of individual pathology, although individual pathology flourishes in a climate that supports and condones aggressive behaviour." Hutchinson²¹ echoes this point, proposing that a focus

on oppressed group behavior fosters only a partial understanding of the phenomenon because it neglects its broader organizational context related to how power operates within the organization.

Manifestations of Lateral Hostility

Lateral hostility, bullying, horizontal violence, and the like may be conveyed in a nearly endless variety of forms that denigrate a nurse's professional dignity. Some of those expressions identified in the literature include the following^{3,14,17}:

- Backstabbing, gossiping
- Belittling gestures (deliberate rolling of eyes, folding arms, staring straight ahead or "through" when communication is attempted)
 - Constant criticism, scapegoating, fault-finding
 - Elitist attitudes regarding work area, education, experience
- Humiliation
- Ignoring, isolation, segregation, silent treatment
- Inequitable assignments
- Inflammatory angry outbursts, impatience
- Insults, ridicule; patronizing, or condescending language or gestures
 - Intimidation, threats
 - Judging a person's work unjustly or in an offending manner
- Making excessive demands
- Sabotage, undermining
- Unfair evaluations of work
- Unwarranted criticism sarcasm
- Withholding information or support

Your Experiences With Lateral Hostility

Because the most recent AACN survey was not designed to reveal the specific forms of hostility that critical care nurses experience, we would like to solicit that information by asking you to visit our Web site at ccn.aacnjournals.org between June 16 and September 15, 2007, to complete our brief survey.

Effects of Lateral Hostility

As the AACN policy statement³ related to this problem summarizes, the adverse effects of lateral hostility include threats to the delivery of safe, quality patient care as well as violations of the critical care nurse's individual rights to personal dignity, integrity, and freedom from

harm. At the individual, unit, and organizational levels, the ill effects of this problem can be pervasive, sapping the life from team spirit, collaboration, cooperation, and professional satisfaction. Hastie¹⁴ identifies the following manifestations of lateral hostility in nurses: sleep disorders, low self-esteem, low morale, apathy, feelings of disconnectedness, depression, and intentional or unintentional work absences.

Prevention and Management of Lateral Hostility

AACN's position statement related to abuse³ of staff constitutes a clear and strongly worded mandate for a zero tolerance policy for any form of verbal abuse or disrespectful behavior directed at critical care nurses from peers, coworkers, or colleagues. This document includes 2 Calls to Action—that is, one for healthcare institutions and the other for critical care nurses.

The Call to Action for institutions relates that all healthcare organizations must:

- adopt and implement clear zero tolerance policies and procedures for all abusive behavior with multidisciplinary guidelines for reporting, enforcement, and progress measurement;
 - encourage employees to promptly report incidents and ensure that no employee who experiences and reports workplace abuse faces reprisal;
 - establish multidisciplinary evidence-based educational interventions to ensure skill development in preventing and responding to abuse—the program should include a system for documenting incidents, procedures to be taken in the event of incidents, and forums for open communication between employers and staff; and
 - take action following an incident of abusive behavior including disciplining offenders, counseling victims and other employees, providing a follow-up mechanism for analysis of incidents and imposing corrective measures to prevent recurrence of similar incidents.
- The Call to Action for nurses says that all nurses must:
- communicate respectfully, honestly, and openly;
 - hold self and each other accountable for unacceptable behavior;
 - seek solutions as a team—investigate and analyze occurrences of abuse just like other incidents such as medication errors;
 - develop a mentoring system among peers, supervisors, physicians, and other providers to build on strengths and enhance personal skills;

- change negative cultures—establish a standard for collaboration and communication in their unit, develop strategies and skills, and share their best practices; and
- participate in multidisciplinary educational committees to develop organizational policies and strategies for abuse prevention.

Shewchuk^{8(p24)} uses plain language in her recommendations to make sure staff feel safe and to “deal effectively with the bullies.” In addition to these measures, Hastie¹⁷ recommends the following as personal actions that nurses who are targeted by this problem can take to avoid horizontal violence and foster a safer, happier workplace:

- Address the behavior immediately with the perpetrator (because some people may not be aware of their behavior).
- Employ conflict management strategies such as saying “I feel ... when you ...” Repeat your replies if the other person makes excuses, denies, or dismisses the incident. If no positive result occurs, keep records of incidents and communicate these to your supervisor.
- Break the silence regarding this problem by identifying it clearly when it happens to you or others and by raising the issue at staff meetings.
- Inquire about how to deal with this problem at your workplace.
- Raise your own self-awareness of the problem by engaging in reflective practice; keep a journal, if incidents occur.
- Take care of yourself via, for example, massage, exercise, peer support, good nutrition, adequate sleep, and time out.

Summary

We may not be able to eradicate this interpersonal scourge quickly, but with your input, we can take the first step by identifying the nature and extent of the problem of lateral hostility as it exists for critical care nurses. Help *Critical Care Nurse* speak out on this issue on your behalf.

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Grif Alspach, RN, MSN, EdD
Editor

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