Work Place Violence in Nursing: Personality Flaw or System Failure?

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Introduction: Definition

The age-old saying “nurses eat their young” demonstrates that workplace violence in nursing is not a new problem. In 2008 the Joint Commission for the Accreditation of Healthcare Organizations (JCAHO) acted on surveys reporting a high prevalence of workplace harassment. JCAHO required healthcare systems to implement processes reducing disruptive behaviors (Olender-Russo, 2009). Most healthcare organizations rushed to develop policies with a mandatory “zero-tolerance” for this troublesome conduct (Olender-Russo, 2009). After receiving national attention, this problematic behavior aroused the interest of researchers. Numerous studies and research papers on this subject are now available in professional literature. There appears to be a consensus among researchers on the types of behaviors constituting bullying. Workplace violence goes by many names: Horizontal violence, lateral violence, horizontal harassment, bullying, petty tyranny and antisocial workplace behavior. Regardless of the label, the behaviors are usually the same. They consist of systematic, repeated antagonistic behaviors by individuals or groups targeting a less powerful peer (Wilson, Diedrich, Phelps & Choi, 2011). The variance in power may be due to a difference in temperament, age, tenure, education, experience or other factors. Some activities are passive aggressive, for example, sabotaging, slighting and snubbing the victim or disseminating negative gossip; other actions are more overt, such as mocking, demeaning, threatening, unjustly blaming and admonishing the target publicly, even physical assault. When a supervisor is the bully, she or he may assign an insurmountable number of patients, hold back pertinent data, set unrealistic goals for work completion or require duties below victim’s capabilities (Cleary, Hunt & Horsfall, 2010).

Significance of issue
Researchers also agree on the high cost of horizontal violence for individuals as well as the healthcare industry. Nurses exposed to bullying are at risk for low self-esteem, “burn out, anxiety, depression, post-traumatic stress disorders and even suicide” (Wilson, et al., 2011, p. 453). Victims of work place harassment are more likely to have physical ailments, such as heart disease (Olender-Russo, 2009). They miss more work than their untroubled colleagues and have decreased performance issues (Hutchinson, Wilkes, Jackson & Vickers, 2010). Additionally, victimized nurses have lower job satisfaction, are more likely to resign and experience a disruption in their professional careers. Therefore, it appears that bullied nurses not only suffer emotionally and physically but also financially. This means that the negative effects of an unhealthy work atmosphere reach beyond the individual nurse to her family and home (Hutchinson, et al., 2010).

Health care organizations are another casualty of violent work place behavior. Financial losses due to increased sick leave and staff turnover, decreased employee commitment and productivity, are thought to be around “5% of the total annual operating budget” of hospitals (Hutchinson, et al. 2010, p.174). The price tag of replacing a single RN can be as high as 92,000 dollars when one considers recruitment, hiring and orientation (Wilson, et al., 2011). Other estimates put the additional annual expenditures due bullying at 3 to 36 billion dollars nationally (Olender-Russo, 2009). Furthermore, horizontal violence has been recognized as a hazard to quality and safety of patient care because of decreased cooperation and communication (Gaffney, DeMarco, Hofmeyer, Vessey & Budin, 2012). For instance, bullying has been cited as a contributing factor to medication errors (Olender-Russo, 2009).

Discussion
Scholarly papers clearly demonstrate the need to address the problem of horizontal violence in a timely manner and find workable solutions; however, disagreement exists on the cause and resolution for this issue. Some sources place the primary blame on perpetrators while others view this issue more as a cultural and systems problem. The arguments for a multi-dimensional approach, placing fault on structural, cultural and to a lesser extend individual flaws, seem more convincing.

Zero-tolerance policies and their limitations

The majority of hospitals have policies in place which outlaw disruptive employee behavior. However, bullying appears to continue. At the heart of these policies is the assumption that workplace violence stems from an escalation of interpersonal conflicts (Hutchinson, et al., 2010) and is caused by people with “personality flaws such as being stubborn to the extreme of psychopathic tendencies…” (Murray, 2009, p.273). In order for these clashes to be addressed and these sociopaths to be confronted, the troublesome conduct has to be brought into the open. Many studies indicate, however, that one of the main reasons for the lack of impact of these new mandates is under-reporting. Nurses are hesitant to complain to superiors because they are fearful of being seen as agitators or tattletales. One study found that 64% of bullied nurses did not communicate the abuse (Hutchinson, et al., 2010). When nurses did speak up, many found very little help from their superiors (Gaffney, et al., 2012). An international study of 43,000 nurses found that less than 50% of the healthcare professionals saw their superiors as responsive to their negative experiences (Croft & Cash, 2012). Moreover, studies found that 90% of even highly educated nurses find it “difficult or very difficult to confront “bullies themselves (Wilson, et al., 2011, p.2011). Additionally, Croft and Cash state that the nature of “zero-tolerance”
policies can lend itself to misuse by promoting a culture of “surveillance through reporting…without addressing the root causes” (Croft & Cash, 2012, p. 232).

The role of oppressed group behavior

Despite the fact that more men are choosing to become nurses, nursing remains a predominantly female profession. International research indicates that violence against women is prevalent throughout the world regardless of race, creed or financial status. It appears that there may be a connection between abuse of female nurses and women in general (Hinchberger, 2009). According to Hinchberger, nurses have a threefold greater likelihood of experiencing maltreatment than other professionals (2009). In years past, western patriarchal societies denied women the vote and financial independence. Marrying well was essentially the only way for a decent woman to survive. Therefore, Croft and Cash make the case that women have been “enculturated” to see other as adversaries (2012, p. 229). Additionally, the authors feel that this history of female subservience in combination with hierarchal hospital settings and lack of autonomy predisposes nurses towards oppressed group behaviors. Croft and Cash quote studies, which indicate that in oppressed groups, members tend to exhibit aggressive conduct towards each other because of their inability to target their oppressors directly (2012). Moreover, the authors propose that the increased focus on economic factors leads to bigger workloads with increasingly sicker patients and longer work hours in the new cookie-cutter nursing environment. The combination of the heavy responsibility of protecting patients’ lives without the power of self-determination is seen as a possible stressor leading to high frustration levels which may trigger horizontal violence.

Horizontal harassment as part of nursing socialization
Hinchberger used a “modified self-report online survey” (2009, p.37) to research the amount of aggression encountered by student nurses and found that 100% of the respondents had been exposed to work place violence; some students had been targeted while others had been observers. Furthermore, the author stated that this negative conduct was so wide spread that many nursing students accepted it “as a rite of passage” (2009, p.43). Other researchers point to the undergraduate education process as an initial introduction to these unhealthy communication patterns. Additionally, domineering preceptors can have a detrimental effect on new graduates not only by demoralizing the new nurses but also by legitimizing and coaching bullying behavior (Hutchinson et al., 2010).

Clique formation within healthcare systems as a vehicle for incivility

Hutchinson and colleagues found that bullying may become entrenched in organizations due to the creation of an informal subculture of oppression. Individuals form groups which effectively suffocate any attempt of systems change and make negative behavior patterns the standard. These bully alliances often abuse legitimate organizational disciplinary routes to increase their power and standing within the institution. Leadership may be tolerant of these practices if they appear to benefit the organization. Heavy handed tactics may give the appearance of strong governance and may even be rewarded by superiors (2010).

Possible solution

Potential solutions to workplace violence are multi-dimensional. The expectation of civility needs to begin in undergraduate nursing programs. Demeaning conduct by faculty or disrespect by students should be strongly discouraged from the very beginning (Luparell, 2011). Additionally, new graduates require nurturing and positive role modeling during their orientation
process. Therefore, organizational patient centered care goals might also be considered as a part of the hospital introductory course (Olender-Russo, 2009). Education on acceptable behavior and appropriate assertive responses to unsuitable conduct might also be a beneficial addition (Cleary, et al., 2010). Furthermore, some hospital systems have instituted new preceptor policies in order to prevent harassment related resignations and poor socialization of new graduates. The Indiana University Ball Memorial Hospital, for instance, placed the responsibility of new graduate retention with the staff. If a new nurse is no longer with the initial unit after a year, administration investigates the reasons (Hocevar, 2013).

Furthermore, hospital leaders and human resource departments need to be aware of the possible formation of oppressive cliques within their system. Units with high turnover, increased resignation rates, and repeated reports of bullying probably need a closer look even if departmental productivity goals are consistently met (Hutchinson, et al., 2010). Croft and Cash suggest that effective leadership requires excellent interpersonal and management skills in order to recognize and confront negative work place behaviors (2012).

Additionally, organizations need to make a commitment to an environment of civility. As the marginal success of zero-tolerance policies demonstrate, this change needs to be “process-dependent rather than people-dependent” (Olender-Russo, 2009, p.78). Healthcare providers need to be reminded of the core values of their profession. How can nurses participate in the healing of others when they themselves are broken? Caring should not be reserved for patients alone but encompass all individuals in the organization. The emphasis is on regarding the contribution of each person as integral to the attainment of organizational goals.
Moreover, organizations can decrease negative work place behaviors by empowering their nurses. Authoritarian, regimented treatment of employees decreases their sense of ownership and may create an unwillingness to speak up for just causes (Croft & Cash, 2012). On the other hand, when administration adopts an active listening approach with its staff, the formation of unhealthy intra-institutional groups is diminished.

Conclusion

In 1909 a physician wrote an article in The New York Times criticizing the conduct of managers towards their nurses (Gaffney, et al., 2012). One hundred years later the problem still exists. The longevity of this issue alone, suggests that simple, one-dimensional solutions are not likely to work. Studies propose that bullying behaviors may be the result of a combination of factors and solutions have to be multifaceted. Intolerance of intimidation needs to start in nursing undergraduate programs. Also, the socialization of new graduates into the hospital environment needs to be supervised and appropriate inter-personal behaviors have to be initiated. Additionally, hospital leadership ought to increase its awareness of unhealthy alliances within the organization. Finally, the expectation of civility throughout the healthcare environment and empowerment of staff is essential. Rudeness by any member of the healthcare team, including physicians, can be detrimental to employee morale. Vegas and Comer appropriately rephrased an old saying: “Sticks and stones may break your bones, but words may break your spirit” (2005, p. 80). Considering the high price of bullying paid by individuals as well as healthcare organizations, the added cost and effort to solve this problem may well be offset by the reduced expenditures on staff turnover and by higher reimbursements due to better patient outcomes.
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