

Nurses and Conflict: Workplace Experiences

by

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**We accept this thesis as conforming
to the required standard**

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ABSTRACT

Although conflict in the workplace is a frequent occurrence for nurses, little research has been done that allows nurses to define conflict for themselves. Nurses have been described as exhibiting the characteristics of an oppressed group. Literature describing aspects of conflict, such as horizontal violence, suggests that nurses' experiences of conflict are embedded in the context of oppression. An exploratory descriptive approach was used to allow frontline nurses to describe and explore incidents of conflict in their places of work. Five participants were interviewed. The themes that emerged from the data fell into several broad categories, labelled what happens (nurses eat their young, the nurse-doctor game, lack of support from nurse leaders), why it happens (oppressed group behaviour, power over), and how nurses respond (betrayal, disillusionment, fighting back, communication, moving on). Conflict was described as having a negative impact on the quality of work life. Nursing leadership and nursing education were implicated in contributing to conflict laden work environments for nurses.

Examiners:

Table Of Contents

	Page
Abstract.....	ii
Table Of Contents.....	iii
Acknowledgements.....	vii
Chapter One: Introduction.....	1
Introduction.....	1
Purpose.....	3
Research Question.....	5
Definitions.....	5
Background, Experiences, and Beliefs.....	5
Summary.....	7
Chapter Two: Literature Review.....	9
Introduction.....	9
Defining Conflict.....	10
Magnitude of the Problem.....	13
Impact of workplace conflict.....	16
Identifying Sources of Conflict.....	18
Oppression and Power: An Explanation for Nurses' Experiences of Conflict.....	20
Nursing Education.....	29

Nurses' Perceptions of Conflict.....	30
Summary.....	32
Chapter Three: Method Design.....	34
Introduction.....	34
Participants.....	35
Data Collection.....	38
Ethics.....	39
Analysis.....	41
Usefulness.....	43
Credibility.....	45
Other arbiters of rigour.....	47
Summary.....	48
Chapter Four: Findings.....	50
Introduction.....	50
What Happens.....	50
Nurses eat their young.....	51
The nurse-doctor game.....	57
Lack of support from nurse leaders.....	65
Why It Happens.....	70
Oppressed group behaviour.....	70
Power over.....	74
How Nurses Respond.....	78
Betrayal.....	78

Disillusionment.....	81
Fighting Back.....	84
Communication.....	88
Moving on.....	90
Summary.....	93
Chapter Five: Discussion	95
Introduction.....	95
What Happens.....	97
Nurses eat their young.....	97
The nurse-doctor game.....	100
Lack of support from nurse leaders.....	104
Why It Happens.....	108
Oppressed group behaviour.....	108
Power over.....	110
How Nurses Respond.....	112
Betrayal.....	113
Disillusionment.....	114
Fighting Back.....	115
Communication.....	116
Moving on.....	117
Summary.....	119
Chapter Six: Summary, Implications, And Conclusions.....	121
Introduction.....	121

Limitations.....	123
Suggestions for Further Research.....	124
Creating Change in Education and Practice.....	124
Education.....	127
Practice.....	128
Summary and Conclusion.....	129
References.....	132
Appendixes.....	144
Appendix A: Ethics Approval.....	144
Appendix B: Consent Form.....	145
Appendix C: Questions from Method section, p. 39.....	147

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*A drop of sunlight
through the cloud, illuminates,
radiant, uplifting.*

Chapter One: Introduction

We called him for orders, even though it wasn't his patient, because the admitting physician had left and he was the on-call.He started yelling at us and swearing. He said nurses are only one step away from whores, in front of the patients and everything. So I asked him what he was being paid for anyway, and now my manager is saying that I'm supposed to apologize to him! I sort of understand him...we're women, it's cultural. But I don't get why she [my manager] is shitting on me!

Personal communication with an acute care nurse in eastern Canada, 1998. Used with permission.

Since the time I entered the nursing profession in 1987, and, indeed, since my wife became a nurse five years before I did, I have become increasingly aware of the divisions that separate nurses. In a very real sense, we seem to be not a single profession, but an amalgamation of widely diverse practitioners, connected by shared beliefs around concepts such as health, caring, professionalism, prevention, and so on. At least, we should share such connections, but all too often we seem more divided than united along lines of education, experience, authority, area of practice, and so on.

Adding to this atmosphere of intraprofessional conflict, nurses also find themselves to be targets of abuse, harassment, and violence from a variety of people, such as patients, physicians, administrators, and others (Blanton, Lybecker, & Spring, 1998; Smith, Droppleman, & Thomas, 1996; Sofield & Salmond, 2003). This

phenomenon is worldwide and is increasing according to studies and articles from places as wide ranging as Britain, the United States, Australia, and Kuwait, and Canada. (Anderson & Parish, 2003; Archer-Gift, 2003a & b; Atawneh, Zahid, Al-Sahlawi, Sahid, & Al-Farrah, 2003; Farrell, 1999; Commission for Healthcare Audit and Inspection (CHAI), 2004). We even have catchphrases to identify some of the behaviours and experiences that help define nursing and our place within the health care hierarchy. These are spoken with chagrin, but also with an odd sort of acceptance, and form a part of nursing culture. For instance nurses are said to *eat their young*, participate in *the nurse-doctor game*, and, as we all know when it comes time to negotiate contracts, *are not in it for the money* the way other people with jobs are.

As a mature student, entering nursing at the age of 32, and having worked in a variety of jobs that commanded respect from others and took a back seat to none in terms of union assertiveness, I found myself wondering about what I saw as the willingness of many of my co-workers to tolerate, and even to excuse, treatment by colleagues and others that I found to be intolerable and inexcusable. The quotation that I used to open this chapter is a prime example. I worked for five years in the West Coast fishing fleet, and such behaviour from one fisher to another would be unthinkable. The fishers, male or female, might argue and even fight, but abuse of that public nature was not tolerated, particularly when directed at someone under the authority of another skipper, as this was directed by a physician at a nurse under the authority of a manager. When I heard of this incident, three distinct images crystallized in my mind: first, of a nurse subjected to abuse by a physician; second, the failure of a nurse leader to support her staff; and finally, the

image of a nurse excusing abuse from a physician with the statement “I sort of understand him....” These images were outside of my experience and understanding.

Once I entered nursing, I discovered that male nurses were not immune to such treatment, although my experience has been that I fare better in this sense than most of my female colleagues. Still, my interest in nurses’ experiences with conflict grew as I gained more experience within the hospital setting, first on an acute care ward, and then in critical care. When I attended the University of Victoria to attain my bachelor’s degree in nursing, I found the program was based in phenomenology, feminism, and critical social theory. In other words, I would say the program was situated in exploring lived experience, in recognizing and responding to power and oppression, and in creating change for the benefit of individuals and communities. This fit well with my own background in a family and community where social activism and social justice were topics both for the dinner table and for exploration and action in the wider world. Seeing and hearing of experiences such as the one described above spoke to me of a need to understand nurses’ experiences of conflict, and to work to create change in the workplace environments to which nurses are exposed.

Purpose

Thus, this is a study into the experiences and perceptions of conflict within the workplace for frontline nurses working in acute and critical care settings. In nursing journals, nursing websites, and popular magazines in Canada and abroad, nurses have been described as unhappy, stressed, burning out, under attack, and leaving the nursing profession. Reasons cited include increased workload, job uncertainty, increasing patient

acuity, and the atmosphere of upheaval and change taking place within health care (British Columbia Nurses' Union [BCNU], 1998; Driedger, 1997; Hrinkanic, 1998). My personal observations and experiences, however, have been that, as challenging as these things are, it is our interpersonal relationships within the workplace that can make the difference between difficult situations and intolerable ones. I believe that nurses often feel angered, betrayed, frustrated, and dismayed by workplace relationships that, rather than being supportive, involve conflict and even abuse. I have further observed that nurses' responses to such behaviours frequently include excusing or even enabling them. I began to wonder if this was a phenomenon particular to areas that I have had the opportunity to observe and practise in, or whether this was part of a more widespread culture, common to nurses elsewhere. As a result, I became interested in exploring how workplace conflict is perceived by nurses in hospitals in other parts of British Columbia than the area in which I reside. This questioning ultimately led to my current research proposal: to explore how workplace conflict was experienced by nurses working in direct patient care in hospital settings outside of what was then the Capital Health Region.

Nursing is becoming recognized as "an extremely dangerous profession" (Henderson, 2003, p. 83), a fact that has significant implications for nursing recruitment and retention (Jackson, Clare, & Mannix, 2002) and, thus, for any attempts to address the acknowledged worldwide nursing shortage. It can be inferred that, if nurses are critical to health care, understanding nurses' experiences of conflict is necessary to ensure nurses' successful participation as health care providers.

Research Question

How is workplace conflict experienced and perceived by frontline hospital nurses?

Definitions

For the purposes of this study, I am using the term *frontline nurse* to denote one who provides direct patient care within acute or critical care hospital settings.

I am using the term *conflict* in a deliberately broad manner intended to encompass a continuum of events and interactions, from minor to major, that the participants themselves define as having involved some form of conflict. I have chosen this unrestricted definition because it is important to the purpose of my exploration that nurses themselves define what conflict is for them. While the literature pertaining to nurses and conflict is specifically about certain types of conflict, I did not wish to constrain my participants, but rather to free them to use their own definitions and describe their own experiences.

Background, Experiences, and Beliefs

When I began this project, I was working full-time as a frontline nurse in a critical care area. During my time there, the unit underwent many years of uncertainty as to its utilization and future. It appeared to me that the processes by which the hospital and nursing administrators made and communicated decisions were perceived by the nursing staff as confrontational, evasive, and hostile. In addition to nurses' relationships with management, the interactions between the nurses and other professionals, particularly

physicians, became increasingly strained. During this period I was also completing a bachelor's degree in nursing science. In classrooms and clinical practice settings, I observed instances of conflict occurring between students and instructors, as well as seeing conflict between students and nurses within the hospital. Finally, I had occasion to observe nurses, newly hired as casual employees, who felt that they were not being treated with professionalism or respect, but instead were expected to take on the most difficult assignments with little assistance or support, and to accept different assignments each time they came to work, even when they came for consecutive shifts.

My own experiences and observations as a frontline nurse in a large hospital over a 16-year career, and my discussions with student and nurse colleagues over those same years, suggest a number of things to me. For instance, I have observed that many nurses experience conflict as a frequent, often daily, occurrence in their working lives. These conflicts involve interactions that may be satisfying when they are resolved in a positive manner, or that may be devastating for one or more of those involved. However, it seems more common that a pervasive atmosphere of conflict contributes significantly to an increasingly unhappy work environment for many nurses. In my experience as a nursing student, a nurse working with students, and as a nursing instructor, I have also noted that nurses receive little or no preparative education in the art and skill of conflict resolution, and thus may be poorly prepared to engage effectively and safely in situations involving conflict. Worse, the conflict that occurs between student nurses and the nurses who instruct and guide them, such as teachers, preceptors, mentors, and nurses they work beside in the hospital, has a profound effect on students' experience of nursing education and on the ways in which conflict plays out later in nurses' careers. We continue to

practise what we learn, yet what we are taught through experience, as observers or recipients of abusive or conflict-laden behaviours, outweighs the theory we are taught about creating supportive and caring environments for our patients and ourselves. Finally, neither health care employers nor professional nursing associations have, in my experience, provided effective support for frontline nurses addressing conflict, whether in the form of education, mediation, counselling services, or working towards the creation of safe work environments.

Summary

I engaged in this study because my experiences and observations of workplace conflict were greatly distressing, leading me to question nurses' abilities to function in a professional, collegial manner. I experienced, observed, and read about nurses working in what I considered to be conflict-laden, even poisonous, environments, which resulted in those nurses feeling increasing disillusionment with and despair about their chosen profession. Yet I could find little research or literature that described the experiences of nurses in relation to conflict, and I recognized that I could not draw conclusions on the basis of my personal experience because of my lack of familiarity with other workplaces. I wished to discover, through my research, whether nurses in other areas of British Columbia shared similar experiences of workplace conflict, with a similar impact on their feelings about nursing, or whether these experiences were limited to my own work environment.

In Chapter Two, I describe the professional literature regarding nurses' experiences with conflict, as well as some literature on related topics, such as oppressed

group behaviour among nurses. In Chapter Three, I discuss the methodology used to collect and analyze data, including how the participants were identified and contacted. In Chapter Four, I highlight the findings of my research. Chapter Five provides a discussion and interpretation of the findings. Finally, in Chapter Six, I discuss implications for change in education and practice, limitations of the research, and suggestions for further research.

Chapter Two: Literature Review

*More and more I get the impression that the working folks,
the frontline people, count for nothing in our society;
which among other things means that they start to turn on each other,
instead of supporting each other.*

*Personal communication, anonymous colleague,
2004, used with permission.*

Introduction

In numerous studies from around the world, various forms of workplace conflict have been found to be both a source and an aggravator of stress and trauma for frontline nurses, contributing greatly to burnout, job dissatisfaction, and general unhappiness with nursing as a profession. However, little of this research allowed nurses to describe and define conflict for themselves, or addressed issues such as aggression from the view of the nurse (Farrell, 1997). Instead, aspects or types of conflict specifically defined by the researcher, such as aggression, violence, verbal abuse, and bullying, have been the focus. The impact of these forms of conflict is undeniable. When I began my initial research into nurses and conflict, authors writing for magazines as diverse as Maclean's (Driedger, 1997) and *Monday Magazine* (Priest, 1999) were voicing concern about the worsening nursing shortage and were commenting on declining morale amongst nurses related to their job satisfaction and working conditions. Nurses were speaking out through their professional organizations as well. According to a 1998 poll for the British Columbia

Nurses' Union (BCNU, 1998), 49% of hospital nurses would leave the profession if they could, and 56% "would discourage young people from joining them in the profession" (p. 17).

There are many sources for nurses' stress and dissatisfaction with their jobs, such as the ongoing increase in workloads, paperwork, and acuity; deteriorating workplace environments; and diminishing resources (Berg & Hallberg, 1999; BCNU, 1998). Included in this list are various forms of conflict, arising from sources both internal and external to nursing. In this chapter, I will look at literature pertaining to conflict in a general sense, and to literature addressing specific aspects and types of conflict experienced by nurses, such as bullying, verbal abuse, and horizontal violence. I will then look at literature that explores possible reasons for nurses' experiences with conflict, particularly works pertaining to oppression and marginalization.

Defining Conflict

There is not a single, agreed-upon definition of *conflict* (K.B. Cox, 2001). The Centre for Conflict Resolution, at the Justice Institute of BC, presents several definitions in its texts, including one that describes conflict as "the actual or perceived opposition of needs, values and interests between people resulting in unwanted stress or tension and negative feelings between disputants" (Haddigan, 1996a, p. 14). Further, conflict is "a normal part of every-day life, and can be a positive or negative experience" (Justice Institute of BC, 1994, p. 63). Nowhere in the literature did I find workplace conflict described as a positive experience in the lives of frontline nurses, although it may help to create a more productive workplace by increasing competition and bringing issues into

focus (Kunaviktikul, Nuntasupawat, Srisuphan, & Booth, 2000). Haddigan's statement, with its specific mention of "unwanted stress or tension," seems more in keeping with the nature and effects of most of the conflicts that nurses routinely experience. K.B. Cox (2001) defines conflict as "processes occurring within a group in any of several forms, such as hostility, decreased communications, distrust, sabotage, verbal abuse and coercive tactics" (p. 18). Each of those terms suggests negative, potentially damaging interactions, rather than positive ones.

Conflict may occur within or between individuals or groups. Deutsch (1973) states:

A conflict exists whenever incompatible activities occur. The incompatible actions may originate in one person, in one group, in one nation; and such conflicts are called intrapersonal, intragroup, or intranational. Or they may reflect incompatible actions of two or more persons, groups, or nations; such conflicts are called interpersonal, intergroup, or international. (p. 156)

Even aspects of conflict that appear to be obvious may be understood differently by different people. Farrell (1997) states that "the concept of aggression is difficult to define" (p. 501), citing a dictionary reference in which aggression is defined as aggression. Quine (1999) states that one of the difficulties in studying bullying among adults is the lack of an accepted definition, although she goes on to report three characteristics of bullying behaviours: the perception of the recipient, the negative impact on the recipient, and the ongoing nature of the behaviour. Turnbull (1995) cites Patchett as stating that bullying is "the improper and frequent use of power to affect someone's life adversely" (p. 24), and also emphasizes the importance of the perception of the

victim, as well as the intent of the aggressor. The Workplace Bullying and Trauma Institute defines bullying as involving ongoing and repetitive mistreatment of a victim (Neuman, 2000).

Verbal abuse is another type of conflict that has drawn attention. Verbal abuse is defined as “some form of mistreatment, spoken or unspoken, that leaves its victim feeling personally or professionally attacked, devalued or humiliated. It is communication through words, tone or manner that disparages, intimidates, patronizes, threatens, accuses or is disrespectful toward another” (Araujo & Sofield, 2001).

Studies of violent and verbally abusive behaviours towards nurses, undertaken in different parts of the world, show somewhat different results, perhaps reflecting differing cultural beliefs. While some research shows nurses as the most likely health care workers to be victims of workplace harassment (Anderson & Parish, 2003; Uzon, 2003), Atawneh et al. (2003) state that, in Kuwait, physicians were more likely than nurses to suffer physical attacks with potential to cause injury, saying: “Our findings do not support the view that nurses run the highest risk of workplace violence as compared to other healthcare professionals” (p. 106). This was in spite of their findings that 86% of the nurses in their study had experienced a violent occurrence of some kind. They compare a “serious” physical assault rate of 28% for physicians to that of 16% for nurses, but do not mention the overall occurrence of violence experienced by physicians and are somewhat dismissive of nurses’ claims of lasting injury from non-physical abuse. Anderson and Parish (2003) point out that culture has a great impact on the perception and reporting of violence by nurses, showing an association between intimate partner violence and workplace violence, and stating that “Mexican American women have been shown to

perceive fewer types of behaviours as abusive and to exhibit a more tolerant attitude towards abuse by partners than do Anglo-American women (Olavarrieta & Sotelo, 1996, in Anderson & Parrish, 2003, p. 238). Interestingly, they also cite Thompson (2002), who found that as Hispanic women brought in a larger proportion of family income, their incidence of reported abuse increased.

However it is defined, conflict is an accepted part of daily and work life for nurses. Kunaviktikul et al. (2000) describe conflict as “natural and inevitable” (p. 9), but even if inevitable, workplace conflict can have serious consequences for employees. Nursing organizations are identified as being particularly prone to conflict, resulting in decreased satisfaction and, according to some, increased turnover in nursing. Intragroup conflicts within nursing may occur for a variety of reasons. Clearly, conflict occurs when nurses encounter differences of opinion over patient care issues, incompatible needs around staffing, or any of the other interpersonal issues that occur daily in the workplace. Such conflict is a normal part of life and is inevitable in health care work sites (Ahuja & Marshall, 2003). However, “the reality is that nurses’ working environments are often fraught with workplace violence in the form of horizontal violence, also known as bullying” (Taylor, 2001, p. 407).

Magnitude of the Problem

“Conflict in nursing is pervasive” (Gardner, 1992, p. 76). Nor has the incidence of conflict changed significantly over the past 15 years. In repeated surveys, H.C. Cox (1987) and Araujo and Sofield (1999) found that over 90% of nurses had experienced verbal abuse (cited in Stringer, 2001; Tabone, 2001). These findings, together with

anecdotal evidence of physician misconduct, prompted the Texas Nurses Association to adopt, in 2001, a resolution calling for zero tolerance of physician abuse of nurses “to prevent erosion of morale and loss of nursing staff due to toleration of verbal abuse” (Tabone, 2001, p. 1). In a survey of 461 nurses, conducted in 1999, 94% reported experiencing verbal abuse (Watson & Steiert, 2002, cited in Buback, 2004). A 2004 survey by Britain’s National Health Service (NHS) found that over one third of health care workers had experienced abuse, bullying, or other forms of harassment at work within the preceding year, with one sixth reporting incidences involving physical violence. Nurses were among the most frequent victims. Although health care staff were familiar with procedures for reporting such incidents, only half of the victims had reported it, rising to two thirds who reported incidents where physical assault was involved (NHS, 2004).

Much of the literature about aspects of conflict, such as bullying, in the workplace comes from areas outside of health care, such as trade unions (Quine, 1999; Taylor, 2001). Little research has focused on nurses’ own experiences of conflict in the workplace (Farrell, 1999). However, while there has not been a great deal of research on the broad subject of conflict for nurses, certain aspects of nurses’ conflict have received increasing attention in the past few years. One area of particular note is the growing body of research into nurses’ experiences with physical and verbal violence in the workplace, either within health care institutions or, in the case of home care or visiting nurses, in the field. Sieh and Brentin (1997) spell this out:

As first-line health care providers, nurses feel the brunt of many angry and violent clients. How pervasive is the problem? The answer is that the prevalence is

frighteningly high. Health care workers are verbally threatened or physically abused on a regular basis. (p. 113)

Henderson (2003) describes nursing as “an extremely dangerous profession” (p. 83) in both Europe and North America, citing numerous studies to support this contention. In addition, she reports that although violence against nurses is common, nurses who expressed concern about doing home visits because of dangerous clients were ridiculed and abused by physicians and supervisors, and directed to proceed with providing in-home care. Where assaults did take place, managers and even police were obstructive and uncooperative with nurses’ attempts to lay charges against patients.

The issue of nurse abuse is international in scope, with studies on nurses’ profound experiences of physical and emotional violence, abuse, and bullying reported from Australia, New Zealand, Great Britain, the United States, Canada, Pakistan, Turkey, Kuwait, Israel, Thailand, and many other countries (Atawneh et al., 2003; Bronner, Peretz, & Ehrenfeld, 2003; Cooper & Swanson, 2003; Jackson et al., 2002; Kunaviktikul et al., 2000; Lee & Saeed, 2001; Uzun, 2003). The results are disturbing, as they reveal the immense scope of violence nurses are subjected to. In 1990, Cox and Kerfoot stated that “verbal abuse is clearly rampant in our [nursing] profession.” There is no evidence that things have improved since then. Cooper and Swanson, in a 2003 report for the International Council of Nurses, state that “health care workers are more likely to be attacked at work than prison guards or police officers” and that “nurses are the health care workers most at risk, with female nurses considered the most vulnerable” (p. 1). Worthington (2001) cites a survey of 4,826 nurses, conducted by the American Nurses Association in 2001, in which “seventeen percent [of nurse respondents] had been

physically assaulted in the past year and more than half (57%) had been threatened or verbally abused” (p. 2). Sofield and Salmond (2003) found that 91% of nurses had experienced verbal abuse in the month before their survey, with physicians, in this case, being the most frequent abusers. Sofield and Salmond further suggest that incidents of abuse and assault are underreported “because of an archaic impression that assaults [on health care workers] are considered part of the job” (p. 3). Jackson et al. (2002) report similar findings, observing that in 48 US states, assault on nurses is considered a misdemeanour, while assault on other members of the public, including state or federal prisoners, is a felony. In other words, in much of the United States, assaulting a felon is a felony, while assaulting a nurse is merely a misdemeanour. A study of Israeli nurses and nursing students found that 91% had experienced sexual harassment (Bronner et al., 2003). Closer to home, nurses in British Columbia experience almost four times the workplace violence of any other profession (Cooper & Swanson, 2003, p. 2).

Impact of workplace conflict

A number of studies have demonstrated a direct connection between verbal abuse and the creation of a hostile workplace, decreased morale, poor job satisfaction, and nursing turnover (Sofield & Salmond, 2003). Some researchers dispute these findings. K.B. Cox (2001) for instance, states that while increased workplace conflict negatively affects job satisfaction, it has little direct impact on either job performance or turnover for nurses. Kunaviktikul et al. (2000), also failed to find a correlation between conflict and job satisfaction. The preponderance of the literature however, does describe a connection between workplace conflict and issues related to job satisfaction and performance.

Randle (2001) describes a link between low self-esteem and poor patient care. Farrell and Dares (1999) state a clear connection between job satisfaction and quality of care. The Institute for Safe Medication Practices ([ISMP], 2004a) reports that when physicians and others involved in the prescription of medications exhibit intimidating behaviour towards nurses and other health care workers, it leads to increased medication errors. The same study found that organizations and supervisors were not seen to be responding effectively to intimidating behaviours by physicians and others. Thomas (2003) finds that “research shows that nurses who report the greatest degree of conflict with other nurses also report the highest rates of burnout” (p. 87). She relates this to decreased retention. Cox and Kerfoot (1990) state unequivocally that “the effect of verbal abuse can be devastating. We know that nurses leave hospitals and the nursing profession because they make choices to avoid situations where they can be verbally harmed” (p. 416). Other researchers have also found a correlation between job satisfaction and retention in nursing (Hackman & Oldham, 1975 and Kramer & Schmalenberg, 1991, both cited in Farrell & Dares, 1999; Quine, 2001; Thomas, 2003). Thus, even where it is not studied directly, there appears to be a demonstrable link between a conflict-laden environment, low job satisfaction, compromised patient care, and decreased retention. It is clear that further, more specific study is required on the potential connections between variables such as conflict, job satisfaction, patient care and retention. Interestingly, K.B. Cox found that a higher number of registered nurses on a unit’s staff led to an increase in intragroup conflict, but also created a perception of higher unit morale, perhaps demonstrating that conflict can be part of a constructive environment for nurses in some instances.

Identifying Sources of Conflict

“Workplace violence (WPV) against nursing professionals is common” (Anderson & Parish, 2003, p. 237). This bald statement opens a paper looking at Hispanic nurses’ experiences with workplace violence. Health care workers in general are cited as being 16 times more likely than other service workers to experience violence, with nurses the most common victims. Several researchers identify physicians as common offenders (Araujo & Sofield, 2001; Duchscher, 2001; Sofield & Salmond, 2003). Duchscher states that “they [nurses] universally described verbally abusive behaviour directed toward themselves and others by senior staff physicians” (p. 428). The reasons for nurses’ vulnerability are described as many and varied, having to do with gender, ethnicity, area of work, lack of experience, lack of education regarding WPV, lack of support and a personal history of abuse.

Horizontal violence is an area of conflict that has received increased attention of late. It is defined by Duffy (1995, cited in Farrell, 1997) as “overt and covert non-physical hostility, such as criticism, sabotage, undermining, infighting, scapegoating and bickering” (p. 502). However, horizontal violence may also be referred to as bullying (Taylor, 2001), and the terms are often used interchangeably. Bullying includes physical violence as well as non-physical, expanding Duffy’s definition. In addition, the term *horizontal* implies that this form of violence occurs only between peers. Skillings (1992) used a broader definition, where “horizontal violence was applied to all people who experience oppression in the world, including patients, women, and all nurses regardless of their position with an institution or society” (p. 177). Thus defined, bullying or abusive

interactions between nurses at differing levels of power and authority may still be considered in the category of horizontal violence.

Namie (2003), in a web-based survey, found that both men and women were victims and perpetrators of workplace bullying. Of particular relevance to the female-dominated profession of nursing is the finding that while both men and women who bully chose women as the targets of their aggression most of the time, women bullying other women was the most frequently reported dynamic. Indeed, other research indicates that horizontal violence is a significant problem for nurses in many parts of the world. A *Nursing99* survey account (1999) points out that while a majority of an instructor's or leader's comments may be supportive, negative experiences cause lasting damage and are all too frequent. Meissner (1999) in an article arising from that survey, makes it clear "Nurses: Are We Still Eating Our Young?", that the answer is yes, as it was in her original article in 1986. Duffy (1995, cited in Farrell, 1997, p. 502) states that "the nursing world is rife with aggressive and destructive behaviours propagated by nurses on nurses." Jackson et al. (2002) conclude that "the most common perpetrators of this form of violence [bullying] to nurses are other nurses" (p. 15). A New Zealand study also found that many new nurses experienced distressing intragroup conflicts during their first year of practice, with 34% considering leaving nursing as a result of an incident (McKenna, Smith, Poole, & Coverdale, 2003). Dunn (2003), surveying operating room nurses in New Jersey, found high levels of horizontal violence and sabotage among nurses, although this did not correspond with low levels of job satisfaction. Dunn postulates that this may be related to "cognitive dissonance," whereby "nurses may perceive sabotage as simply part of the job and even as part of fitting in" (p. 986). In

contrast, Davis and Thorburn (1999) cite research demonstrating the importance of effective peer support as a positive influence in reducing job stress for nurses, indicating that peer relationships, both positive and negative, have a profound impact on the workplace environment.

Oppression and Power: An Explanation for Nurses' Experiences of Conflict

Collectively, nurses exhibit many characteristics of marginalized and oppressed groups (Keen, 1991; Roberts, 1983, 2000; Sieloff, 1999; Skillings, 1992; Taylor, 2001). As a predominantly female profession, nurses' experiences can be seen as rooted in the experiences of women as an oppressed group within society. "Women are often considered to be a subordinate group within society in general, and the health care arena in particular" (Dunn, 2003, p. 978). Oppression involves intolerance of differences between people and groups, denial of freedoms such as self-determination, and expression, and relative powerlessness or lack of control, with respect to social structures such as the health care system (Dunn, 2003; Roberts, 1983, 2000; Skillings, 1992). Members of oppressed groups may begin to exhibit characteristics of the dominant group, to "internalize the values of the oppressor in the belief that this will lead to power and control" (Bent, 1993, p. 296). The oppressor group maintains the status quo, in this instance the hierarchy established in health care placing physicians and hospital administrators in control.

Roberts (1983), in an article frequently cited as the basis for understanding nurses' oppression, writes: "It is the premise of this article that nurses can be viewed as an oppressed group and that doing so is instructive in understanding the behaviour of

nursing leaders” (p. 26). Roberts goes on to say “The style of leadership within nursing has evolved because nurses, like other groups throughout history, are an oppressed group, which is controlled by societal forces that have determined its leadership behaviour” (p. 21). Thus, for nurses, and other predominantly female professions, such experiences of intragroup and same gender conflict may be rooted in the reality of social and cultural oppression of women.

Skillings (1992) states that “participants described horizontal violence as a nursing reality that stems from oppression and oppressive conditions” (p. 177). Begley and White (2003) comment on “the well documented oppression that occurs within nursing” and suggest that this may result in the fact that “the self esteem of nurses is usually considered to be low” (p. 391), a view supported by Roberts (1983). As mentioned earlier, Begley and White (2003) found that nurses’ sense of self-esteem rose during nursing training; however, Randle (2001, 2003) found just the opposite, reporting that learning normal standards of nursing practice and behaviour negatively impacted students, leading to a decrease of self-esteem. This is in keeping with Roberts’ (1983) description that “nurses have found it natural to think of themselves as second class citizens (p. 27). To understand a behaviour such as *eating their young*, where nurses who have been misused, proceed to misuse newer nurses, Alavi and Cattoni (1995) cite Canetti’s “metaphor of ‘stings’” (p. 345). When a painful stimuli, such as public humiliation as a student, is experienced, the nurse receives and remembers being *stung*. The nurse perceives that the only way to relieve the pain from this sting is to pass it on to others when a similar situation arises. Thus a repeating cycle of eating their young is established.

The research indicates that nurses are often violent towards other nurses physically, verbally, and emotionally, at and between all levels of authority, and in all areas of practice, with profound negative impacts on patient care and nurses' own well-being (Jackson et al., 2002). Among the most common bullies are nurse managers, who bully the nurses under them (Patterson, 1997, in Jackson, et al., 2002). Conflict between nurses in management and those providing patient care, bullying and undermining between peers, and disputes between practitioners and academics are but a few examples of how fractured and divided our profession has become. Farrell and Dares (1999), in a study of nurses' job satisfaction, state: "It would appear that the nursing staff on this unit, in general, do not always value each other and feel that as individuals they are not valued by other disciplines or their nurse managers" (p. 55). This fits with the findings about bullying in other workplaces, as described by Namie (2003). Namie found that 71% of bullies were of higher organizational rank than their victims, as opposed to 17% who were peers, and 12% who were of lower rank. In discussing oppression and nurse/nurse leader relationships, Keen (1991) states:

If you've ever had the feeling that nurses have more loyalty to medicine or to the hospital administration than they do to nursing, you've probably been right.

Rewards provided by an oppressive system are very effective in the creation and maintenance of token suboppressors. (p. 181)

Thus nurses tend to be promoted into leadership positions because of their willingness to support the existing hierarchy of administrators and physicians. Once promoted they frequently become separated from the frontline nursing community, even coming to regard their former peers as being at fault for their own, ongoing oppression (Bent, 1993;

Roberts; 2000). Leadership acquired in this way “fosters the divisiveness and internal conflict that is so typical in oppressed groups (Bent, p. 298).

One frequent expression of oppressed group behaviour is the inclination of nurses and their supervisors to see assault and abuse as part of the job for nurses, or to expect that nurses should take responsibility for violence directed towards them, as if it were somehow their own fault (Sofield & Salmond, 2003). Nursing education may even contribute to this cycle of blame and abuse by helping to maintain and normalize a culture of oppression and horizontal violence within nursing, where “nurses are dominated (and by implication oppressed) by a patriarchal system headed by doctors, administrators and marginalized nurse managers” (Freshwater, 2000, p. 482).

Duffy (1995, cited in Farrell, 1997) is another researcher who holds that horizontal violence in nursing is related to nurses being an oppressed group within physician-controlled, patriarchal, health care systems. Farrell (2001) himself states that the origins of intragroup conflict in nursing are complex, and that while oppression is a useful lens, focusing on it too closely may obscure other, equally valid, areas of understanding.

Whatever the root causes of intragroup conflict, it is crucial that we resolve the issues if we wish to retain the nurses we now have or recruit new nurses (Thomas, 2003). Further, nurses internal strife damages the entire profession (Dunn, 2003). If we wish, as a profession, to significantly influence health policy development, we will be far more effective if we present a unified front, for “if nurses would begin to care for other nurses, the profession would have more than enough power necessary for positively shaping its destiny” (Ashley, 1980, cited in Keen, 1991, p. 173).

Conflict between nurses and patients and their families also interferes with the abilities of nurses on the front lines to work holistically and caringly. In pediatric nursing, for instance, an increasing focus is on what has come to be called *family centred care*. The philosophy of family centred care is to establish a nurturing and mutually collaborative relationship between the nursing staff, the child, and the family (Curley, 1997; Dunst & Trivette, 1996). Yet Ahman (1994) describes a significant gap between the philosophy and the practice of involving the family in all aspects of care and decision making, resulting in conflict between nurses and families. Narrowing this gap is likely to be a challenging task, as roles are redefined and negotiated between nurses, families, and administration. However, nurses report that they are not being educated in the skills needed to successfully negotiate such issues of potential conflict and to work with families, or others, in a collaborative manner (Bruce & Ritchie, 1997).

As is clear from the literature, and to anyone who works in the hospital environment, many nurses experience conflict on an ongoing basis. Attridge (1996) describes “situations in which they [nurses] felt powerless in the course of their nursing work” (p. 37). In each of these situations was a conflict, where a real or perceived difference in power between the participants resulted in a profoundly distressing experience for the nurse and, frequently, an unsatisfactory outcome or unnecessarily dangerous situation for the patient. Such things seem unthinkable in a modern context, where nurses are supposed to be equal members, even coordinators, of a patient-focused health care team. Yet the workplace reality is frequently different. When nurses attempt to advocate for patients, give the best care that they can, and provide the best information

possible to other members of the team, particularly physicians, they frequently find themselves negated, ignored, and misused.

Smith et al. (1996), in a study of nurses' work-related anger, identify a theme of *under assault*, with sub-themes of *scapegoating/blaming*, *disrespectful treatment*, and *lack of support or affirmation from the hostile [work] environment* (p. 25). The nurse who is abused by a physician, as in the situation described at the beginning of this thesis, is often left unsupported by his or her manager (Canadian Nurses Association, 1990; Smith et al., 1996). The implication is that she, or he, for such events also happen to male nurses, is somehow at fault – and often the nurse seems to believe that she does not deserve support.

There is a parallel between nurses' reported perceptions of their experiences within the health care system, and the feelings expressed by some female victims of rape when they describe their treatment within the justice system. Both groups feel blamed by others and by themselves for what has been done to them, and in both cases this has to do with the oppression of an identifiable group, that is to say, women. "I believe that we have gotten to a predominantly non-caring stance toward each other because nurses, due to who we are (primarily women) and what we do (undervalued work), are an oppressed group" (Keen, 1991, p. 174). Thus, in spite of the fact that male nurses do report experiencing oppression (Brooks, Thomas, & Droppleman, 1996), nurses' experiences with conflict are largely rooted in gender discrimination against women.

The literature supports the notion of nurses as an oppressed, silenced, and disempowered group (Attridge, 1996; Keen, 1991; Roberts, 1983, 2000). Power and conflict co-exist in close relationship, with conflict experienced differently depending on

the power differential between the parties involved (Haddigan, 1996b; Johnson & Johnson, 1994). Nurses' ways of dealing with conflict support this notion. Kunaviktikul et al. (2000) describe the primary conflict strategies of many nurses to be "avoidance, which is an unassertive and uncooperative strategy in managing conflict" (p. 10), and accommodation; these are behaviours of the powerless, not the powerful. Duchscher (2001), describing the responses of nurses in her study to verbal abuse by physicians, says that they did not challenge the physicians' actions, but "adjusted to the behavior, learning new ways to manipulate the situation so they could get what they needed, while least antagonizing the physician" (p. 428).

The last quote presents a clear example of *the nurse-doctor game*, a term for a pattern of nurse-physician interaction, first coined by Stein (1967, in Zelek & Phillips, 2003), which described a method of gamesmanship in which two groups, predominantly female nurses and male physicians, provided patient care and avoided open conflict through nurses deferring outwardly to physicians' authority, while making recommendations for care in a manner that suggested they were the physicians' ideas (*Nursing90*, 1990; Zelek & Phillips, 2001). Stein, Watts, and Howell declared in 1990 that nurses had decided to stop participating in the nurse-doctor game and were understandably becoming rebellious in light of nurses' oppression by the medical establishment (cited in *Nursing90*, 1990). Reasons given for this rebellion include the increase in female physicians and male nurses, "both of whom were unable to play" (Zelek & Phillips, 2001, p. 2), since they did not fit into the established gender-dominance pattern. However, a study by Zelek and Phillips (2001) and a survey by *Nursing91* (1991) both show that relationships between nurses and physicians continue to

be heavily influenced by the gender patterns described by Stein in 1967, and that the nurse-doctor game continues to be played. Duchscher (2001) puts it more bluntly, describing a continuing environment of intimidation and fear experienced by new nursing practitioners working with physicians. Corser (2000) states that “few nurses or physicians may fully appreciate how their routine interpersonal exchanges may still be influenced by the organizational, educational, or communication legacies that have been internalized through multiple generations of caregivers,” legacies that “can perpetuate an almost institutional form of subservience of nurses to physicians that may prevent most collaborative dialogues from ever occurring” (p. 264).

Nurses may also feel a sense of helplessness in their interactions with physicians. Von Post’s 1998 study of perioperative nurses’ experiences of value conflicts with physicians reveals stories of nurses and physicians with differing roles and agendas. She identifies the physician’s goal as being to see “that his prestige is protected, that he can carry out his task without help or that the operating programme is carried out as quickly as possible” (p. 86). The nurse’s priority is to act as the patient’s voice, to advocate for and protect the patient. The nurses in this study felt that they were silenced and devalued by the physicians with whom they worked, and that they were unable to choose to work collaboratively in a manner supportive of the patient. Similarly, Bucknall and Thomas (1997) identify physicians’ dismissal of nurses’ values and work, and nurses’ lack of autonomy, as causes of decreased job satisfaction and potentially of decreased self-esteem.

Many of the ways in which nurses engage in conflict with each other can also be viewed in the light of oppressed group behaviour. For instance, when a nurse moves from

patient care into management, her or his primary allegiances may shift from nursing colleagues and patients to those people with power, such as administrators and medical staff (Hall, Stevens, & Meleis, 1994; Keen, 1991). The subsequent relationships with those who were previously peers can become conflict-ridden, as both the staff members and the manager feel increasingly betrayed. Quine (1999, 2001) reports that bullying occurred for 38% of 1,100 nurses surveyed in England, and that the bully was most often a nurse manager. This bullying significantly lowered nurses' job satisfaction, as well as increasing stress, absenteeism, and the desire to leave the job (McKenna et al., 2003; Quine, 1999, 2001). Tovey and Adams (1999) found that primary reasons for nurses' low job satisfaction included poor relationships with managers and the absence of team support.

Furthermore, bullying and other forms of intragroup conflict tend to be cyclical, with those who are bullied going on to bully others (Randle, 2003). The problem may run even deeper in nursing: Herdman (2001) goes so far as to suggest that the professionalization of nursing is in itself a form of oppression and subjugation of nurses and of women, propagated by an American socio-economic image of nursing, and accepted uncritically by much of the rest of the world. She cites Wagner's (1980) statement that there exists "an unwritten history of nursing' that has been 'obscured by professional nursing leaders who are still suppressing revolts of rank and file nurses against the conditions of hospital work'" (cited in Herdman, 2001, p. 6).

Nursing Education

One of the ways that oppression may be maintained is through education. Both oppressor and oppressed are educated, overtly and covertly, to believe that the values and behaviours of the dominant group are the most desirable, and that the path to power lies only through allegiance to the oppressor (Freire, 1970; Roberts, 2000). Eventually “both groups come to believe that the oppressed have always been inherently inferior, and the history of the development of the hierarchy becomes lost” (Roberts, 2003, p. 72).

Given the acknowledgement of oppressed group behaviour in nursing culture and the role education might play in such a dynamic, little is written that focuses on the relationships between two nursing groups with clearly differentiated levels of power: nursing students and their teachers. A few researchers report that instructor-student relationships may not always be supportive. Meissner (1999) states: “I have to say that too many nurses at all levels of responsibility commit a kind of genocide when it comes to dealing with young nurses....Nurse-educators are the first offenders” (p. 43). Begley and White (2003) found that although nursing students’ levels of self-esteem appeared to rise throughout their education, they were, at best, average by the end, and that students suffered from the fear of negative evaluations throughout their education. However, Begley and White state that their findings are not consistent with other studies, and they suggest a strong correlation between the manner in which nursing instructors interact with students and the development of self-esteem in those students. Gillespie (2002) differentiates between connected and *nonconnected* [sic] student-teacher relationships in clinical settings. Connected relationships were based on compassion and commitment and on the teacher’s use of knowledge in support of student learning. Students did learn

from nonconnected teachers, but they reported that the learning was limited to nursing skills and tasks, that it was more by rote, and that the use of knowledge to demonstrate the difference between the standing of the teacher and the student, for instance humiliating a student over an incorrect answer, resulted in a nonconnected relationship.

Another area in which nursing education may be failing new nurses is in the field of addressing or resolving the conflicts they will encounter. Beech and Leather (2003) state that student nurses experience frequent aggression, yet receive little training specific to addressing this issue. Beech (2004) states “At present training designed to deal with the problem [of workplace violence] is poorly regulated and highly variable in quality and approach” (p. 35). I found no other research which referred to educating nursing students about conflict, addressed the likelihood of their encountering conflict, or prepared them to practice in a conflict-laden environment.

Nurses' Perceptions of Conflict

Conflict and collaboration are not mutually exclusive. Healthy relationships, be they personal or work relationships, include conflict. At issue is how conflict is approached, engaged in, and resolved. The stories described by Attridge (1996) tell of nurses facing the loss of control of a situation, due at times to

the imposition of control by usually more powerful others....Operating in many incidents was the notion that others, usually physicians or administrators, knew the nurse's job better than she did, and therefore could intervene with impunity....The reciprocal notion, that the nurse knew and could intervene in the job of these more powerful others, was not given credence. (pp. 45–46)

In contrast, what nurses actually desire in the workplace is leadership, rather than management, from nurse leaders who communicate well and are honest, supportive, and nurturing (Wieck, Prydun, & Walsh, 2002).

Conflict and conflict resolution are not prominent topics in nursing education, nor in the literature about nurses' workplace environments. In my search through the literature on nursing practice, one of the few books that mentioned conflict in the index, Frisch and Kelley's *Healing Life's Crises: A Guide for Nurses* (1996), addresses conflict resolution only with respect to patient issues, from the perspective of the nurse as healer and mediator. *Nurses in the Workplace* (Cowert & Serow, 1992), a book that focuses on the reasons for, and solutions to, nursing staff shortages in the United States, has no index listings for *conflict* or *conflict resolution*. Nor are *harassment*, *anger*, *abuse*, *violence*, or *collegiality* mentioned, although *nurse-physician collaboration* is briefly discussed. These are significant omissions. Stories such as those discussed by Attridge (1996), Smith et al. (1996), and Brooks et al. (1996) make it clear that some nurses are feeling angry, abused, and helpless as a result of workplace relationships.

Rather than focusing on frontline experiences, much of the literature that does exist around general conflict and nursing is aimed primarily at conflict management by health care management and administration and by nurse educators (K.B. Cox, 2001). Hrinkanic's (1998) article on negotiation is one exception, in that it teaches nurses a skill they may find useful during conflict. Still, it only brushes the surface of nurses' experiences.

Conflict need not be, indeed should not be, a negative experience, yet the literature makes it clear that for nurses it frequently is. However, the experiences and

consequences of nurses' negative workplace relationships are not well addressed in the literature from the perspective of frontline or other nurses. Little is written that assists the individual nurse in identifying, working through, and understanding the holistic experience of conflict.

As the preponderance of the research shows, nurses experience conflict in its many forms as an ongoing part of their daily work lives. It contributes to stress and job dissatisfaction, which in turn affects retention and has the potential to increase staff turnover. Ann Landers recognized this when, in 1998, she published a column that contained letters from nurses regarding their opinions of their profession. After a number of comments from distressed nurses, Landers concluded her column by saying:

Dear Readers: I had hoped to balance this column by printing some letters from nurses who were happy in their profession, but there weren't any. How sad.

Unless something is done to help our nurses, there won't be any, and we will be up that well-known creek without a paddle.

Summary

The literature on nurses' experiences and perceptions of conflict per se is sparse. However, research is revealing that certain types of conflict, such as horizontal violence, and verbal and physical assault, are common occurrences for nurses, and that nurses around the world work in increasingly violent and hostile environments. Violence towards nurses comes from a variety of sources, including patients and their families, physicians, nurse administrators, nurse educators, and peers. There is evidence that working in conflict-laden environments decreases nurses' job satisfaction, which in turn

decreases the retention of nurses in both specific work sites and in the career of nursing. Thus, there is a direct connection between nurses' negative experiences with conflict and the increasing nursing shortage.

Ultimately, nurses' negative experiences with the various aspects of conflict are described in the literature as being largely rooted in the gender-based oppression of women. Nurses are described as an oppressed and marginalized group, displaying the characteristics of, and sharing experiences with, other oppressed groups, such as women. Oppression is seen as pivotal to every aspect of nursing, particularly with respect to intragroup dynamics. Oppressed group behaviour is demonstrated when nurse leaders ally themselves with the dominant power structure within hospitals, usually male administrators and physicians, rather than with other nurses. It is also in evidence when nurses turn on each other in acts of horizontal violence. Both behaviours are described in the literature as characteristic of oppressed groups, and both are evident in nursing culture.

Chapter Three: Method

Human beings make generalizations all the time

from the particulars of their lives.

Margarete Sandelowski, 1997, p. 127

Introduction

For this study, I used an exploratory descriptive qualitative research method. Thorne, Kirkham, and MacDonald-Emes (1997) state that “within the traditional empirical science domain, description served as the crudest form of enquiry” (p. 170), one that became subordinated to qualitative methods that were viewed as having greater credibility, such as grounded theory and phenomenology. However, they go on to discuss the failure of both qualitative and quantitative methods from other disciplines to adequately address the research needs of nursing, a “holistic, relational practice discipline” (p. 170). Thorne et al. make a case for qualitative research methods which integrate description and interpretation of a phenomenon, and articulate the term *qualitative interpretation* as a possible nursing method. However, they go on to state that interpretive description “orients the inquiry, provides a rationale for its anticipated boundaries, and makes explicit the theoretical assumptions, biases and preconceptions that will drive the design decisions” (p. 173). Thus strict interpretive description goes beyond the scope of this study. Sandelowski (2000) sees descriptive qualitative research as “less interpretive than “interpretive description” in that they do not require researchers to move as far from or into their data”, nor do they “require a conceptual or otherwise highly abstract rendering of the data” (p. 335).

That said, interpretation remains a part of this descriptive research. Luborsky (1993) discusses the “issues and dilemmas in the interpretation of themes” (p. 191) and suggests that the identification of themes from the data is a process shared by the researcher and the participants, one “rooted in widely shared sociocultural settings” (p. 192). The stories told to me by the participants, from the contexts of their experiences, were interpreted by me, during the process of analysis, in the context of my own experiences, beliefs and biases. The connections drawn between the data and the literature are also based on how both are interpreted. Indeed, “no description is free of interpretation”, but “basic or fundamental qualitative description...entails a kind of interpretation that is low-inference, or likely to result in easier consensus among researchers. (Sandelowski, 2000, p. 335).

Exploratory descriptive research is a methodology that serves what I believe to be the unique needs, values, and essence of this study, and of nursing. My goal, in seeking to understand nurses’ perceptions of their experiences, goes beyond simple description. Exploratory descriptive qualitative research seeks to describe phenomena and to explore their nature and complexity in depth (Polit, Beck, & Hungler, 2001) “without identifying a specific philosophical perspective” (Molzahn & Sheilds, 1997, p. 16). It is a useful method when little is known about a specific phenomenon. Since, as discussed in the previous chapter, there is little Canadian research specific to nurses’ experiences with conflict, exploratory description is an appropriate method.

The stories which the participants told me are of their own experiences and perceptions of conflict, and may or may not be indicative of the experiences a larger sampling of nurses. At times I found that their experiences matched those of other nurses described in the literature. At other times, the participants of this study reported unique

experiences, reflecting their own individual perceptions and understanding. In all cases the stories are their own, and, in keeping with the values of qualitative descriptions and explorations, I have attempted to uncover and to honour the essence of their descriptions and understanding as revealed by their words.

Participants

In this study, I focused on the experiences of individual nurses working in direct patient care in acute and critical care hospital settings. I made this restriction solely for logistical reasons, as a way of limiting sample size and diversity, and it does not imply a belief that conflict is any less an issue for nurses in the community, extended care, or any of the many other specialties or practice areas in nursing.

I selected participants through purposive sampling. In purposive sampling, a researcher seeks participants who have experienced and are knowledgeable about the phenomenon being studied, and who are willing to speak about their experiences (Molzahn, McDonald, O'Loughlin, & Starzomski, in press; Molzahn & Sheilds, 1997; Thorne et al., 1997). I advertised the study in a number of ways. I used my professional organizations, asking that Registered Nurses Association of BC (RNABC) representatives and BCNU stewards in hospitals outside of what was then the Capital Health Region help me make contact with nurses interested in participating in such a study. I also discussed my project with nurses I knew through school and work, requesting that they place notices in their own work sites. To assist in this process, I sent out information about the project to be distributed and posted. In all cases I asked that

nurses interested in participating in the study contact me by telephone or e-mail, and I included several ways to do each.

As a result of these activities, I was contacted by a number of nurses who expressed interest in what I was doing. From those who approached me, I selected all who met the inclusion criteria: they had had personal experience with conflict; they felt, on consideration, that sharing their experiences would not be unduly traumatic or distressing; and they were articulate and fluent in English. I did not place limitations on participation based on gender, race, sexual orientation, age, or length of service, all of which undoubtedly affect the experience of workplace conflict. I wished to remain open to all nurses who expressed a desire to participate and with whom I could communicate effectively.

Although a number of nurses with whom I worked, as well as several other nurses working in what was then named the Capital Health Region (CHR) expressed an interest in participating in this study, I elected to interview only nurses who lived and worked outside of the CHR. I made this decision because the topic is one that requires a high degree of confidentiality. I felt that including stories by nurses who were known to work with me or within the area, could jeopardize the confidentiality of the participants and of those about whom they spoke.

I met with five nurses in all. The participants were all female, between the ages of 25 and 50, and Caucasian. They all spoke of being in heterosexual relationships at the times of the interviews. All names used are pseudonyms.

Anne was the youngest participant, in her mid-20s. She was a registered nurse (RN), had graduated from a college program, and had five years of nursing experience at

the time of the interviews. Prior to nursing she had a variety of work experiences, none specifically dealing with conflict or conflict resolution. She was married and planning to start a family soon. Anne anticipated that she might have to complete a BSN at some point, but had no wish and no plans to do so at the time of the interviews.

Barb, in her late 40s, had been nursing for 25 years. She received her RN through a hospital program in Eastern Canada and had recently earned a BSN from a British Columbia university. Having worked in a number of nursing team leadership roles over the years, she was acquainted with nurses' experiences with conflict from a number of perspectives.

Connie was in her mid-30s. She was married and was expecting her first child at the time of our interview. She had worked and studied in the criminal justice system and considered going into law before moving to health care. She had a BSN, having attended a degree-granting nursing program from the beginning of her nursing education, about 10 years earlier.

Donna, the oldest participant, was an RN in her mid-50s, with 22 years of experience. She had several degrees, but not a BSN, and had no intention of getting one. She had worked on acute care wards and in the community, and was married, with children and grandchildren. She came into nursing as a mature student in her 30s, and she attended a college program.

Elaine was in her early 40s, with over 20 years of acute and critical care experience. She also received her RN through a hospital program and was working towards her BSN at the time of the interviews. She was married, with two teenage children.

Data Collection

The initial data collection took place via relatively unstructured face-to-face interviews lasting from one to two hours. The interview format was conversational and informal. Each interview was tape-recorded, and the recordings were supplemented with field notes taken during the interview.

I opened these initial interviews with a brief review of the topic under study and a reminder that their comments would remain confidential. I then asked the participant to share an incident involving conflict that she had experienced. From that point on, each interview became as participant-driven as possible, as each nurse proceeded to tell her stories in her own way. I prepared prompting questions relating to the experience of conflict, which I used only when necessary, as a means of furthering the conversation (see Appendix C). These questions were not used in all cases, but were interjected at times, and modified to fit the particular interview.

Following the initial analysis, I created a summary document that I sent to the participants, in which I described common threads from their stories. After giving them time to review the summary, I invited the participants to respond to the themes identified in the document via a second tape-recorded interview, conducted over the telephone. Four of the original five nurses participated in the telephone interviews. The fifth participant had moved and I was not able to locate her. These interviews were transcribed, and the data were incorporated into the ongoing process of analysis.

Ethics

Before I obtained each participant's consent, we discussed the intent, scope, and both my and their expectations of participation in this study. I wanted to ensure that each participant was fully aware of all the implications of participation, including her right to withdraw, with her data, at any time. In particular, I again asked each person to consider whether discussing her experiences of conflict might be painful or distressing, and I asked that she carefully consider the risks of reliving feelings of anger or hurt. I did not wish to avoid the emotions inherent in such exploration, but I also did not want anyone surprised by the degree of distress she might still feel. This did not in fact occur, and while several participants expressed strong emotions during the interviews, none reported any distress. Nevertheless, I was prepared, if necessary, and to the degree to which I am competent, to move out of the role of researcher and into a more therapeutic role, as Hutchinson and Wilson (1994) describe. We also discussed the resources available for stress counselling in their respective institutions and communities, and I ensured that the participants knew how to access those, if it were necessary.

Trust between the researcher and the participant is a vital component of a study of this nature. The participants might have wished to say things that were highly critical of their workplace, colleagues, employers, or patients. Therefore, it was vital that they felt comfortable their statements would be held in absolute confidence. For this reason I conducted the study outside of Victoria and the Capital Health Region and identified geographic locations in a general manner, such as "somewhere in British Columbia, outside of my home city." The letter of consent (see Appendix B) stipulates that the

recordings of the interviews will be held in a secure location. Names and any identifying information about individuals or locations were removed from all transcripts, and pseudonyms were used throughout the thesis. All tapes will be destroyed following the completion of the thesis. As a beginning step, of course, the study received the approval of the University of Victoria Human Ethics Review Committee.

Finally, I explained to potential participants that part of my research would include them in the analysis process by asking for their feedback on my findings. As stated previously, they were provided with a summary of my findings from the initial interviews, and I asked if I could contact them by phone to discuss any issues that arose for them about the interviews. Such telephone interviews became, with their permission, part of the data.

Analysis

Qualitative data analysis involves finding descriptions and interpretations that reflect the words, perceptions, beliefs, and language of the participants as a whole. Rich, deep, or complex description should be reflected in interpretation (Early, 1997). In part, I achieved this depth through repeated immersion in, and deep familiarity with, the data. By repeatedly listening to the taped interviews, doing most of the transcription myself, reading and rereading the transcripts and my observations, and reflecting and writing about my thoughts and findings, I increased my familiarity with the data and with the themes, categories, and concepts arising from it.

The literature on qualitative research methods describes a variety of techniques for identifying themes, although the definition of a theme remains vague and poorly

described, and “the diverse uses and definitions of theme in the literature may be confusing” (Beck, 2003, p. 231). DeSantis and Ugarriza (2000) state: “When the term theme is found in the nursing research texts, the definition provided is largely uninformative or is really a definition of thematic analysis rather than theme” (p. 353). Data reduction took place through the identification of meaning units, key words, and patterns within the transcripts. Working with the meaning or “natural” units (Kvale, 1996, p. 195), and living with and rereading the raw data, allowed themes to emerge (Early, 1997; Tanner, Benner, Chesla, & Gordon, 1993).

DeSantos and Ugarriza (2000) describe themes “emerging” from the data in such a manner that they “(a) unite a large body of data that may otherwise appear disparate and unrelated, (b) capture the essence of the meaning or experience, and (c) direct behavior across multiple situations” (p. 355). Sandelowski (2000) encourages the use of counting responses as a way of beginning to identify “patterns and regularities” (p. 338) in the data, but makes it clear that “in qualitative content analysis, counting is a means to an end, not the end in itself” (p. 338).

Incorporating and experimenting with these various techniques, and living closely with the data over an extended period, was a frequently painful learning experience as I embarked on an in-depth analysis for the first time. As part of the initial process, I indeed counted responses, noting the numbers of times conflict with particular types of people, such as physicians, peers, or managers, was reported. I noted how often participants spoke of conflict in a positive manner or as a negative experience. Following this, I moved to a deeper level of examining words and phrases that described the meaning of these experiences, and I discovered that numbers alone did not reveal the depth of feeling

that various conflicts generated. This was when the analysis truly began, and the themes began to emerge from the participants' stories. To this day, upon each re-examination of the data, I discover new depths of meaning, and I am moved again by the stories I have been privileged to hear.

In the end, I interviewed all the participants who came forward who met the inclusion criteria for the study. During the last interviews I was aware that some degree of saturation was occurring, as there began to be a considerable amount of repetition in the stories I was hearing. This is not to say that new stories would not emerge given a larger sample size, but for the purposes of this study, the information obtained from these five participants was sufficient to describe the phenomenon of conflict in the workplace. Each individual's experiences were unique, but there were commonalities evident, and themes began to emerge, connecting and unifying the essences and meanings of the experiences for the participants. The findings that emerged are described in the following chapter.

Usefulness

When I started this research, I struggled to find a method that fit what I perceived to be the needs of nursing, while remaining true to the principles of qualitative research. In particular, I was concerned about the seeming contradiction between the perception of the non-generalizability of qualitative research, and the need that I perceive for qualitative nursing research to be creditably applicable to nursing practice — in other words, for research findings to be useful. Two criteria in particular were critical to my choice of method: usefulness and credibility. In my experience, nurses tend to be

pragmatic people. Whether they are reading research or considering whether or not to participate in it, I have heard them ask questions like: “What will come out of this research that I can actually use in my practice?” and “Can I trust the researcher and the results?” Thus if nursing research is to be of use to practitioners, it is necessary that the research, and researchers, be accessible, understandable, and credible to frontline nurses.

Nurses are inclined to prefer qualitative research because “the method is consistent with their world view and they can identify with the findings” (Molzahn & Sheilds, 1997, p. 14). This creates a paradox with respect to usefulness if, as is commonly stated, qualitative research findings are not generalizable. However, I concur with Sandelowski (1997), who states: “Arguably, the single most important factor contributing to the failure to take the findings of qualitative studies seriously is the frequently cited but false charge that they are not generalizable” (p. 127). Beck (2001) goes further, saying: “Misconceptions about the generalizability of qualitative research findings prevent the use of these valuable findings to their fullest extent... These results are generalizable, but not in the same manner as quantitative findings” (p. 101). I believe the difficulty to be, in part, one of language. The stated goals of empirical science — to predict and control events — are indeed inappropriate when applied to the complexities of human behaviour. Yet we do, I hope, learn from our experiences, which is the essence of generalizing from qualitative research. In the words of Sandelowski (1997): “Human beings make generalizations all the time from the particulars of their lives. The casuistry of nursing and medicine demands that the generalizations of science be fitted to the particulars of the case” (p. 127).

Ultimately, the usefulness of this study will be demonstrated by the manner in which the findings are received and found to be helpful by the participants and by other frontline nurses. If nurses recognize themselves in the stories of the participants, they may realize that they are not alone in their experiences of conflict. This may lead to an increased ability to initiate actions that will lead to change in the workplace, decreasing conflict, and decreasing its negative effect on nurses. A concrete example exists in my own work as a nurse educator, where I have become more aware of the conflict to which my students are exposed. I have discussed my observations and findings with other nurse educators, and with the nursing students with whom I work, and we have become both more aware and more proactive in our approach to dealing with conflict in the workplace. Specifically, we are taking actions to try to prevent nursing students becoming the victims of the types of harassment discussed in the literature, and to address situations that do arise promptly, collaboratively, and effectively.

Credibility

The credibility or rigour of my research is validated primarily by the participants themselves, and by the reactions of other frontline nurses. According to Sandelowski (1986), "A qualitative study is credible when it presents such faithful descriptions or interpretations of a human experience that the people having that experience would immediately recognize it from those descriptions or interpretations as their own" (p. 30).

Other criteria of rigour must also be considered. Sandelowski (1986, 1993) and Molzahn and Shields (1997) speak of criteria such as auditability or trustworthiness,

confirmability, and fittingness or applicability, which establish rigour in qualitative research.

Auditability refers to the process by which the researcher makes visible the course of his or her research, so that “another researcher can clearly follow the ‘decision trail’ used by the investigator in the study” (Sandelowski, 1986, p. 33). I maintained an audit trail (Polit et al., 2001) consisting of transcripts, notes, presentations, and drafts throughout the study. I have also kept extensive computer files of drafts and transcripts, which show the process by which this thesis was developed. I have given two formal presentations, one to the Camosun College Nursing Faculty and the other at the University of Victoria, and have kept outlines and the presentations for reference.

Confirmability means that these findings and descriptions are not only recognized and experienced by participants and readers, but also they “assist in understanding or illuminating the issue being studied” (Molzahn & Sheilds, 1997, p. 17). Thus, as previously discussed, practitioners find them useful for understanding their own workplace experiences. In this study, confirmability was revealed by the responses of the participants on reading the findings, and by others, who expressed agreement with the findings during discussions and presentations.

Fittingness indicates that the findings fit into the experiences and lives of readers in situations outside the specific research context. That is, readers not only recognize the interpretations, but also feel them reflected in their own lives. In other words, credibility in the form of fittingness exists when the participants and others “can recognize the experience when confronted with it after having only read about it in a study”

(Sandelowski, 1986, p. 30). This was true for me as a nurse, as the themes reflected experiences I had had with intragroup conflict during my nursing career.

Participant verification plays an important role in assessing rigour in qualitative studies, yet Sandelowski (1993) expresses concern that when follow-up interviews are used as a method of confirming qualitative findings, the individuals will either fail to remember the specifics of what they have said or will be looking primarily for their own voice in the work. To avoid this pitfall, I made it clear I was inviting feedback on themes and interpretations that were emerging from material provided by several people, and that what I was asking was whether these themes and interpretations elicited a sense of familiarity or rightness, rather than specific recognition of events. Related to this issue, Dreher (1994) states that “the quantity, validity and reliability of the data are grounded in the skill of the investigator to establish relationships with informants” (p. 286). She goes on to say: “Thus validity and reliability are not irrelevant in interpretive research, as so many proposals claim. They are achieved through an extended, trusting and confidential relationship between investigator and informants” (ibid). Trust and respect must be reciprocated in a relationship. Therefore, Sandelowski’s concerns notwithstanding, I believe that the participants remain the primary arbiters of rigour in this study. Their recognition of the experiences emerging in the themes, which was expressed during the second round of interviews, coupled with their trust in me as researcher, shown by their willingness to explore such difficult territory, endorses the rigour of the study.

Trust between participant and researcher is an issue for another reason as well. The participants may speak of things that they believe could reflect poorly on them, leaving them open to judgement or criticism. If they are to respond fully and openly, they

must have confidence that they will be heard in an open and non-judgemental manner, without reproach, and that the information will be held confidential.

Other arbiters of rigour

Confirmability, fit, and credibility may be further enhanced when other nurses, particularly those on the front lines in acute and critical care, have the opportunity to review the study and “view the findings as meaningful and applicable in terms of their own experience” (Molzahn & Sheilds, 1997, p. 18). Indeed, that other nurses can recognize the experience is crucial, as “the target audience for our work is often not a member group, but rather our own peers” (Sandelowski, 1993, p. 7). Initially, such review has occurred through my presentations to colleagues and students at Camosun College and the University of Victoria, and through informal discussions with many nurses in a variety of settings. Invariably, and distressingly, when I have talked about this project with frontline nurses, nursing instructors, and student nurses, they have indeed recognized my research findings. Almost without exception, the initial reaction of nurses hearing of my study is a knowing nod or a rueful laugh, followed by a comment such as “That’s a timely topic.” Often they ask whether I have need of further participants, and frequently they share a story or experience of conflict with me on the spot. While encouraging and useful, these reactions leave me distressed and sad that nurses appear to feel so universally oppressed by the conflict they experience in hospital settings.

Further comment and review may occur when I publish articles derived from this study. Lincoln (1998) refers to “the community as the arbiter of quality,” where “the new researcher is more interested in developing a community’s ability to devise its own

standards for judging when a piece of research within its boundaries has been particularly useful in promoting positive change” (p. 22). Obtaining validation from my peers in the wider community of acute and critical care nurses in British Columbia, in the form of a response such as “Yes! Your findings reflect my experiences with conflict, and you have given me some thoughts on how to respond,” will confirm that this research was well done. Currently this response is common when I discuss my research findings with colleagues and students. Wider exposure to the nursing community will come in the form of continued presentations, articles derived from the research and published in nursing journals, and finally in my own practice as a nurse and nurse educator in taking action to address nurses’ experiences with conflict in the workplace.

Summary

An exploratory descriptive qualitative research method was used in this study. Five participants were selected using purposive sampling. The participants were interviewed in person, and the interviews were tape-recorded and transcribed. Following a thematic analysis, the participants were sent a summary of the initial findings, after which, follow-up interviews were conducted by telephone with four participants. The fifth was no longer available to participate. The second interviews were also tape-recorded and transcribed, and the data incorporated into the thematic analysis. Confirmation of the findings was established primarily by sharing the findings of the study with the participants and with other nurses through discussion and presentations, as well as through the maintenance of drafts, notes, and transcripts. In the following chapter, I describe those findings in detail.

Chapter Four: Findings

Looking back to two years ago, to the conflict that we discussed, I'm amazed that I didn't leave the nursing profession altogether, because the conflict that I went through was, I hope I never experience anything like that in my career ever again. It was that big and that bad.

Anne, follow-up interview.

Introduction

In this chapter, I describe the themes that emerged from the interviews conducted with the participants. My goal in this study was to explore the participants' experiences and perceptions of the participants regarding conflict within the workplace. The themes that follow do just that, as revealed in the participants' own words. While the experiences of each participant remain unique, there are significant areas of commonality. The themes fall into three broad categories, which are labelled "What Happens," "Why It Happens," and "How Nurses Respond."

What Happens

The themes in this category specifically describe the experiences of the participants during conflict. They include details of who conflicts occurred with and what forms conflict took. The themes are: *nurses eat their young; the nurse-doctor game; lack of support by nurse leaders.*

Nurses eat their young

All of the participants discussed the phenomenon of nurses eating their young, which represented different experiences for each of the nurses participating in this study. For some, it referred to treatment they experienced as students from practising nurses or from nursing instructors, a phenomenon that will be discussed later. For others, it referred to experiences they had when they began working in a new practice area and were the targets of abuse from colleagues and supervisors. Where colleagues were involved, participants spoke of conflict between nurses who were peers, yet where a power imbalance existed based on seniority, experience, or personality, rather than an official delegation of authority. Thus, eating our young was described as nurse-to-nurse conflict, both in the form of *horizontal violence* and as *violence from above*, or violence involving *power over*. Donna described being hired on a new ward:

One instance was when I was hired onto another floor, and the nurse that I was paired with for half of my nights had wanted a casual nurse from that floor to get the job, and she was very angry. Basically, I didn't know until much later what the problem was, but she was assigned to orientate me to certain pieces of procedures and equipment that were unique to the unit, and she made it as brief and as uninformative as possible.

Elaine recounted observing similar experiences happening to new nurses in one of her previous workplaces:

We've had two people...that new nurses were frightened of. What's frightening is, they both have a lot of knowledge. They certainly aren't dumb. I mean, they

are very experienced nurses, and they know their stuff, they flaunt their superiority. So how does a new person deal with that?

Anne both observed, and then experienced, similar treatment when she began a new job, but from her nursing team leader rather than from a peer.

I'd observed the team leader picking on people, sort of, in, like, a predatory manner, and I thought, "Hmm, well I'm sure glad she likes me" and "I'd sure hate to be on the wrong side of that." But just in the last month, apparently, the winds have changed and I'm now on the wrong side of this person.

Team leaders have a responsibility to monitor the care nurses give and to give feedback. However, Anne felt that her team leader was targeting individuals randomly and without just cause. She would be willing to accept critique of her nursing practice if it was constructive, and she acknowledged that there may have been basis for some criticism, but she felt that the overall relationship was one of random attack. Her supervisor, she said,

was willing to engage in criticising me, in embarrassing me, in twisting my words, and in putting me in my place. She was very willing to do that, but as far as the actual, what I would call healthy, conflict of working out what the real issues were, she was very unwilling to do that.

Barb, a skilled and experienced nurse at this time, was treated dismissively by nurses she had been asked to assist when her own ward was quiet. She found she was not allowed to truly assist, since the nurses were set in their ways and quite elitist.

Now they had very high clinical standards. You can't argue with that, really. I mean, why would you? But the situation was so rigid. I would go up there to help,

and I would be in awe of how these people worked, because they worked very well, but I could never keep up with them. Every time I went to do something, they'd already done it, so it's like, "Why am I here?"

Barb went on to describe how the nurses' attitudes created an unworkable atmosphere, in which even the nurses who created it became ill, took leaves, and moved on to other jobs:

It was just such a poisonous work environment. And I believe that it was nurtured by this group of people who are very well-meaning, they're nice people in their own right, but they had just created this really elitist, exclusive, rigid enclave that was detrimental, and it was incredibly detrimental, to their health. Unfortunately they're going off to these other places and spewing their poison elsewhere.

In exploring where these behaviours arise for nurses, participants described experiences and observations of conflict between nursing students and their instructors that indicated the eating-our-young behaviour was modelled by nursing instructors, and thus was learned by student nurses as an appropriate way to treat nurses who are newer or more vulnerable. I was told that such behaviours are cyclic, becoming an accepted and routine way in which new nurses are initiated, to their detriment. Anne related her feelings about the nursing school experience:

The nursing instructors, not all of them, but some of them, they were like, they were like immature women with power, and they lost their sense of what's rational and what's not. That's definitely when it started, though, in nursing school. That humiliating, stripping apart of your ego. You know: "You don't know anything. Everything that you think is right is wrong, and we're just going to rewrite you the book. [sic]" So that was a common experience in my class.

Anne went on to talk about how these behaviours were clearly learned and passed on in nursing school.

I found it very ironic that in nursing school, that what they were trying to teach us was skills [sic] plus the ability to nurture, and what they were teaching us was cannibalizing their young. I don't think you teach people to be caring. I think you teach people to be caring by caring for them. You model professionalism to get people to understand professionalism. And if you, if you beat a child, they don't grow up to be caring and nurturing without a lot of help! You learn what you live, right?

Connie had similar things to say about her experiences and observations of the relationship between students and instructors from her days in nursing school. She felt strongly that some nursing instructors were deliberate in their attempts to humiliate and to "break" students, and that this behaviour was condoned, or at least tolerated, by her hospital-based nursing school. Her condemnation was harsh:

It was brutal. I went to the hospital, and it wasn't an adult learning facility. I was an older student coming in and I raised Cain....I thought it was ridiculous because they seemed to be trying to break people down, to make them cry. I couldn't understand this mentality. Why would you want to break someone down? Why are you not just building them up? Why are you not enhancing their strengths and helping them cope so they get better at whatever areas they're weak in? It just didn't make any sense to me to try and make somebody stressed and miserable. You're not encouraging any kind of good performance out of these people. What's the point? They must get a kick out of it, right? That's the only thing I

could come up with. They must get a charge out of this, so they're mean, vindictive people that need to have their noses slapped.

Connie's feelings were clear. She believed that these actions were deliberate and malicious. Anne made a statement that was distressingly similar, again declaring that nursing instructors, holding power over their students, were deliberate in their outright abuse of nursing students:

I experienced this in nursing school, that nursing is the only profession that eat their young. I would agree with that, yeah, yeah, that was, nursing school was very much like that for me.

Elaine told a story of learning quickly what was expected in nursing school and of feeling that what was expected of her in terms of instructor evaluation was not honesty and integrity, but that she should merely fill in the expected blanks. To do otherwise was unwise and unsafe.

It was in my first training area, and we had anecdotal notes you had to write, and you did evaluations, and you had an opportunity to evaluate your instructor. Well, they asked questions, and I answered them truthfully and went into my evaluation session. And the instructor was really peeved at me for my evaluation of her. This really stands out, because I went to myself, "I get it. You're not really supposed to tell the truth in these things. Silly me. OK, I understand how we're doing this now." Basically, that set the tone for me. "OK, I can tell you what you want to hear about your teaching style, if you want, and not how I see it." And that set the tone for my whole nursing school thing.

Elaine also remembered being afraid of her nursing instructors.

They were all, to me, pretty serious, tough, battle-axe type theory of nurses back then. Maybe in some ways that was good training, and in some ways not. Maybe I'm more traumatized than I realized. You were scared to death when you had to go in and demonstrate that you know how to make a bed, for heaven's sake. The things you took so seriously, and the things they put the stress and the pressures on. You look back and go, what's the point? Why would they do that?

In fact, all five participants spoke of nursing school, not as a place of safety, but as a place where the practice of nurses eating their young was learned. Barb discovered that her classmates also spoke about nursing school as an unsafe environment, saying:

When I went to my 10-year reunion a few years ago, well, it was more than a few years ago now, people were, they were very definite about intimidation and oppression, and that's what their memories are all about.

Barb also recalled how she and her fellow students coped with this type of learning environment:

The students who often did just fine in school were the ones who made no waves, asked no questions, didn't challenge in any way, shape, or form. They don't make better nurses, necessarily, but they did make better students, because life was a lot easier. I have a friend who's a nurse who says that, in her opinion, that nursing faculty were there to essentially make the lives of their students hell, and that they always picked on the weakest ones. It was kind of like a peck and kill kind of approach.

Barb then told a story of a more recent experience during her university education when she returned to complete a BSN after 25 years of practice in acute and critical care:

I felt that [a particular instructor] was respectful to me, but I could see clearly that she was far more condescending towards other people, especially the younger students. It was so consistent, it seemed to be ingrained. And once again, you know, I think that that's the difficulty of all of this. If you've got people in power positions, whether they're in education or managerial leadership positions, their behaviours are ingrained. Their behaviours are learned and have been supported and rewarded over the years. It's a huge shift for them to make. And how do you do that? Who are their role models? Who's there to hold them accountable for their behaviour? Who's there to teach them the new way?

She clearly saw these as learned behaviours, passed on from older nurses to newer ones, perpetuating a cycle of hostile and abusive behaviour.

In summary, the nurses reported that eating our young occurred in the workplace, aimed at new nurses and nurses new to an area, and arising from more experienced or senior peers and from nurse leaders in various positions of authority. In addition, they said it was experienced, and thus learned, in nursing school from interactions with, and through behaviours directed at students by, their nursing instructors.

The nurse-doctor game

Physicians were one group of health care practitioners with whom all the participants had experienced conflict. The participants' perceptions were that conflict with physicians involved an extreme imbalance of power. Issues such as autonomy and collaboration were raised, but the nurses' primary concerns related to providing the best

care for their patients. The participants' stories revealed their engagement in a competition of sorts, with the physician holding the authority, and the nurse believing that she had a clearer picture of patient needs. This interaction was specifically referred to by one participant as the nurse-doctor game, invoking a term that has become a part of health care vernacular. Barb described such an interaction at length, and then came to a realization, which she shared:

D'you [sic] know, that just twigged something. We [nurses] manipulate to get what we need, we manipulate to get the orders we need, but what is it that we're needing? I'm not asking them for something for me. It's not what I'm asking them [physicians] for. It's something that my patient needs, that I, as a professional, based on my knowledge and skills and experience, have decided is important for my patient. But why should I have to manoeuvre and manipulate and placate to get something that they should be interested in? I mean, this is what, this is what really blows my mind. I mean, we've got this nurse-doctor game thing, you know, that's been well documented in the research and is sort of the source of all the passive/aggressive behaviour and all that kind of stuff. But you know, it's for patient care, so why should I have to do all this manipulation for something that should be obvious? I mean, that's what makes me really angry.

Barb stated that the nurse-doctor game is played, not for the benefit of nurses, but as something that the nurse engages in to advocate or care for her patients. There are alternative approaches, of course, such as going through the hospital hierarchy to a nursing or medical director, but these take time, may have uncertain outcomes, and certainly poison any relationship with that physician in the future. Barb told of how, in

her facility, that would not even be an option: “One of the [specialists] is also the chief of medicine. He doesn’t even answer his pager when he’s on call. If that isn’t a difficulty, I don’t know what is!”

Most of the nurses in this study stated that, all too often, the only way they felt they could achieve the best care for their patients was to be indirect or manipulative with physicians, rather than direct and straightforward. In fact, interacting directly could be hazardous to the nurse and, indirectly, to the patient. Anne experienced abuse when she interrupted a physician, even though it was out of concern for a patient’s safety:

I did have one experience with one [specialist], a woman, and she tore a strip off me that hurt. I interrupted her while she was speaking, and apparently that’s a no-no [sic] for this woman. Everywhere else I’ve ever worked, you work as a team, but she was in her spiel, she was saying, “You understand that you might have these side effects and these benefits,” and she was sort of doing the verbal consent thing, which we, the nurses, are responsible to get, and the patient started to shake uncontrollably, and I thought maybe she was having a reaction to one of the antibiotics I had just given her, and I asked her, “Are you OK? What’s happening?” and what it was, was that she was afraid. But, unfortunately, I interrupted the wrong woman at the wrong time, and I think we were about five inches from each other’s nose, ’cause I was holding the patient, and she said, “Don’t you ever speak when I’m speaking, don’t you ever interrupt me again!” And it was, it was said in such a powerful way that the patient flinched, and I felt like I’d been slapped.

So, instead, nurses may play the nurse-doctor game, sometimes referred to, with wry humour, as learning Physician Manipulation 101. Elaine, in a follow-up interview, found these concepts to be familiar and suggested they were detrimental to the working relationships between nurses and physicians:

There is conflict with certain physicians, depending on how they work with people. If they see themselves as the experts all the time, not requiring or wanting any input from the nurses, then I think those physicians probably run into conflict more than the ones that work with the nurses as part of the team, that don't seem to have so much egotistical things involved, probably don't have quite as much in the way of conflict [sic].

Nurses experience conflict with physicians in ways other than face to face. Elaine had to contact a specialist twice during one night shift, and she recounted the following, less traumatic, experience that also came from trying to provide appropriate care for a patient:

This one specialist, I called him one night and I explained to him what was happening with this patient, and he gave his orders and they were orders that sort of, usually the specialist is there on hand for doing things. He didn't come in, in that situation....[The patient] then started getting massive chest pain and global changes on his ECG more, and I phoned up the specialist again...and I said, "So are you coming in?" It's like 2:00 or 3:00 a.m., and he said, "Yes," and hung up. He was quite offended when he came in. He said, "Who was I talking to on the phone?" and said, "What do you mean, am I coming in? Of course I'm coming in"....I said, "Well you didn't say you were and you didn't come in two hours

ago”....He was a bit put off by the whole thing, that a nurse should be telling him, and questioning him. My thought of that was, “I just saved your skin, bud.” In that conflict, I thought, “He doesn’t know yet. He’s going to blow it a couple of times because he’s just not listening, and because he’s above us.”

Elaine has had many interactions with physicians over the years. In spite of her skills, education, and experience, she found that she could not provide the care her patients required by interacting with physicians in a straightforward manner. This disturbed her, as she revealed in the following passage:

I still adjust my behaviour. There is still one physician at work that you kind of don’t even suggest any drug, anything, because the minute you suggest one, that’ll be one for sure he will not order, because you have suggested it. So you still present the facts in a rather manipulative way, I hate to admit, to get what you feel you need out of him for a patient. I don’t always play the game; he’s just known to be the one you play the game with.

Barb expressed feelings about a similar incident when she said, “Why should our patients deteriorate because we’re playing this game? Because it’s not, it’s not a game, and we’re not, we shouldn’t be secondary players.”

Beyond issues around patient concerns, participants also discussed issues of abusive behaviour not directly related to patient care. Barb told of a physician she had worked with on and off for a long time:

He’s a physician that’s, he’s brilliant, he’s, he is really very smart. He’s also very personable, and he, when he sits down to talk to a patient, he’s a model in that kind of situation....and he has had a history ever since I’ve known him, for years,

of frequently blowing up and having temper tantrums when things aren't going his way....He's taking it out on nurses. He may be taking it out on other people too, but we don't hear about that. But he's taking it out on nurses. And one of the ways he does that is he, he [sic] yells and screams and calls them incompetent and, you know, "They're killing patients!"

Barb also discussed her experiences with this physician at greater length in relation to other themes, as she went on to describe the reactions of management to the nurses' experiences, and her feelings about why, as she said, "We're letting him do it." Of interest also, however, was her description of the overall relationships that the nurses on her ward had with the specialists:

We had students in, who were doing post-grad work in our area, and they were in for a couple of weeks, and their response to their instructor, who happens to be one of our nurses, was that they had observed what was like an abused spousal relationship between the specialists and us....What there was, was us placating, trying to find favour, being ignored, and not so much being beaten up, per se, individually, but that sort of the beating down of spirit. And they were quite taken by it, and every single one of them, 'cause they had to do post conference kinds of stuff, and that's what they wanted to talk about. They didn't want to talk about clinical situations. And so when it came back to us, when the instructor brought it back to us and said this is what they said, I was shocked. Because I thought, I mean, had anybody asked me that morning "What kind of relationship do you have with these specialists?" I would have said, "Pretty good."

When I asked what she thought of the students' observations in retrospect, Barb's reply was a clear and decisive "I think they're right on!" Clearly she believed that outside observers were able to detect a pattern of behaviour that was so ingrained as to feel natural to the nurses who lived it, regardless of how destructive it appeared to them once revealed.

Not all nurse-physician interactions, even those involving some conflict, are so traumatic to the nurse. Anne recalled an experience of the nurse-doctor game with some amusement:

A doctor walks into a room where I've been setting up a patient for a procedure, and he walks into the room unannounced, I didn't know he was coming, walks up to me and holds out his hands and says, "OK, I'm ready"; and I said, "Excuse me, what are you ready for?" And he said, "My gloves." The procedure rooms are all set up the same, and everything's in the same drawer on the whole ward, and I just looked at him and said, "I'm in the middle of doing something. Last time I checked, all the gloves are kept on the cart," and he just looked at me. I thought it was so funny. I just couldn't believe the nerve of this guy. And he just looks at me, and it was like he stopped, and he had to think, and it was like you could almost hear the wheels turning, and he said, "Alrighty then," and off he went to get his gloves.

For the most part, however, these stories were not happy or amusing ones. Some participants described the nurse-doctor game as being rooted in the dynamics of hospital hierarchies. They also thought that the nurse-doctor game was a pattern of nursing

behaviour that, like eating our young, was learned during nursing education or early in a new nurse's career.

Barb objected to this game eloquently. She again pointed out that it places nurses in the position of appearing to be asking for things for themselves, when in fact they are striving to bring their professional expertise into play to provide the best possible care for their patients.

The patriarchy is physician at the top — the nurses are used to maintaining that. And because we need to get certain things out of doctors; we need to get orders, we need to get, sometimes the orders are after we've already performed, provided the care, whatever, we have learned ways to get what we need [sic]. It's manipulative, but, so often I think that a lot of the ways that we avoid conflict is by manipulation. And we're taught to do that very subtly, all through nursing school, and certainly initially as we practise. How you get the orders that you know you need, how you interrupt and ask for stuff in a way that perpetuates an abusive situation. This perpetuates a "them and us," does not recognize equal professionals of different professions working together in a collaborative manner. But on some level we all think that it does, but it doesn't, you know.

In summary, the nurse-doctor game was seen as a process of nurse-physician interaction that was imposed on the nurse by the attitudes of the physician, the hierarchy of the workplace, and the needs of the patient. It was a method of interaction learned in nursing school, or early in a nurse's career, and was based on manipulation rather than collegial communication. As such, the nurse-doctor game was seen as detrimental to nurses' self-respect and professionalism. The nurse-doctor game also became a focal

point for contention between nurses and nursing leaders, as nurses looked to their managers for support and failed to find it. This is discussed further under the following theme.

Lack of support from nurse leaders

When experiencing eating their young or the nurse-doctor game, the participants expected to find support from their nurse leaders, whether those leaders were managers, senior administrators, clinical educators, or nursing faculty. As described in the opening scenario, this expectation is not always met, which leads to increased stress and feelings of betrayal, distrust, and frustration for frontline nurses. As I reviewed the data repeatedly, it became clear that the lack of support from their nursing leaders during situations of conflict was a consistent theme for each of the participants. All of the participants described lack of support in a similar way: It was the failure of their nurse leaders, either as individuals or representing leadership within their organizations, to support the nurse when she felt herself to be under attack, or when she felt that the care of her patients was being compromised.

This occurred for Elaine when a conflict arose between staff nurses and a manager. When staff felt that a patient's best interests were not being met and took their concerns forward, their manager invited their input, but then rejected their suggestions and requests in a manner that was perceived as dismissive and patronizing. Elaine described her feeling in the following way:

Discussing it with her [the nurse manager], the major stress is feeling like we're not being heard, that she has an agenda and a plan, and she wants to stick to it,

and is not hearing what the rest of the nurses feel are very valid points to be made.

Other participants discussed similar concerns. Anne experienced a conflict with a nurse in charge of booking casual shifts. When she was unable to resolve it, she said, "I went to my supervisor, who also wasn't willing to admit that there was an issue." This had serious consequences for Anne, ultimately resulting in her departure from that workplace. As I will discuss later, Anne moved on, but some scars remain. The memory of being unsupported by her manager was so profound that she commented during a follow-up interview:

Looking back to two years ago, to the conflict that we discussed, I'm amazed that I didn't leave the nursing profession altogether, because the conflict that I went through was, I hope I never experience anything like that in my career ever again. It was that big and that bad.

Barb's experiences surrounding abusive behaviour towards nurses by a physician were compounded for her when the behaviour was ignored or even excused by her nursing leadership. Because of her education and approach, and because of some of the positions she has held, Barb has long considered herself to be, and is perceived by others as, a nurse leader. She believed that increased her responsibility towards her fellow nurses, and she stated:

In my role, because I'm not just another staff nurse, and I'm not saying that to be belittling, but I think in my role I have a responsibility to protect the staff nurses, a greater responsibility than somebody else would have.

However, she did not receive that kind of support from her own leadership, but instead found that, in the case of the brilliant physician who had temper tantrums, the physician's

abusive behaviour was excused by both medical and nursing management, a situation she found unacceptable:

I also don't think that just because he is brilliant, just because he can be everything that we want doctors to be, we [nurse leaders] should allow him to abuse nurses. I don't think that, I mean, he doesn't have that right. But because people don't want to, I mean, they're either intimidated and don't want to make it worse, or they don't want to ruin his career. They [management] allow nurses to be ruined. Now there may be some people who think I'm using strong language, but I don't think that I am. I think nurses at my level, like staff nurses, are intimidated. I think his colleagues and management, either nurses or other hospital administrators, are letting him get away with it because he's brilliant.

Because of these types of experiences, where nursing management were unable or unwilling to help nurses deal with conflict, Barb was scathing about the state of nursing leadership in her hospital environment:

I don't know about other organizations, but in ours, these people [nurse unit managers] are at meetings, and so, I mean, their job's a whole other thing, not about conflict and that kind of stuff. I don't even want to comment on that! But you know, how then are they able to be leaders within the nursing groups that they're officially said to be leaders of? Because they're no longer leaders, they're managers, and there's totally different implications.

Donna also experienced a failure of nursing leadership to provide support to frontline nurses, this time following abusive behaviour from a nurse leader, a head nurse. The consequences of both the abuse and the lack of support for the nurses on the ward

were devastating and were never adequately addressed:

I had a head nurse who was undergoing a nervous breakdown and did things like throw chairs at staff, yell at her staff in front of patients, doctors, other nurses, family, and it created a situation in which people felt that they weren't safe in coming to work, or that they felt like they never knew when they came through the door whether it was going to be a day in which it was bearable or whether they were going to be attacked. The head nurse in question went on leave, which was good, but there was never any real work done with the staff in terms of what they underwent, and the consequence was that there were a lot of people who were either taking anti-depressants or taking stress-leave days from work because it was such a stressful place to be....Nobody ever recognized that there was trauma there, and fairly serious trauma, to the staff. The organization did recognize that she was having problems and removed her from the unit, but they didn't recognize that there was a fallout that was happening with the nurses. That was never dealt with, never recognized.

Connie told a truly distressing story of being unsupported in relation to a patient care issue, which resulted in her leaving the unit where she was working. While a physician's failure to respond to her patient's needs was at issue, it was her nurse leaders who she felt let her down, and whose actions led her to resign and move on:

There was a patient who was palliative and was expected to die at any kind of point, but she was conscious and she was alone....Our nursing management had decided that it wasn't a priority to staff any more than they did. I felt this was very poor of them, and by 8:00 p.m. at night, they were slapping you on the back,

going, you know, "You can cope, you can cope," and quite frankly, after a certain amount of time, you're very tired of hearing that....I called the specialist who was on call for us, and he refused to come in....I remember this as being a really big conflict in the two branches of the higher-ups [medicine and nursing] that I felt had failed this patient. Certainly I felt failed by it....I really felt that the management that left merrily at 5:00 p.m., I didn't see why they couldn't have stayed around longer. I mean, time and time again they would leave when basically the shit was hitting the fan, and they would still leave at their appointed time, or half an hour early, because they had a movie to catch. It blew my mind.

Connie was unable to get what she thought would be appropriate physician orders for her patient in order to provide palliative comfort, and she was unable to spend the time with the patient in the way she felt she should. This left Connie feeling that she had been utterly abandoned, and she decided that she could not work in such an environment. Prior to resigning, she filed an incident report about the experience, hoping to create change in staffing levels and in physician awareness. She found that her concerns were unwelcome:

It [the incident report] went up the little ladder, and the head nurse of the area wanted me to retract it. I was leaving the area, so I was really just thumbing my nose a bit and feeling that, no, this was really true, this wasn't something I had made up, or something I was angry about at that moment and could feel more rational about it later. It's been years and I still feel, not as upset as I did at the time, but certainly that this was not a justifiable action that they [nursing management] had let this kind of situation arise.

The outcome, for Connie, was that she moved on, a theme discussed later. Connie retained a residue of anger about this incident, which came out clearly during the interview. She also expressed a sadness and sense of failure that she had allowed a patient to suffer in such a way, although she had no ability to change the outcome in this case, having done all that she could in her capacity as a nurse.

In summary, lack of support from nurse leaders was seen as a betrayal, with a profound impact on the experience of conflict for nurses and on the quality of work life that nurses experienced. In terms of emotional trauma to the participants, it was a more significant factor than conflict with physicians or with peers.

Why It Happens

The second major category focuses on the participants' perceptions of why conflict occurred for them in the ways that it did. There were two themes all participants discussed at one time or another: *oppressed group behaviour* and *power over*.

Oppressed group behaviour

Each of the participants described the concept of nurses as an oppressed or marginalized group. The participants specifically named the behaviours they saw in peers and nurse leaders as oppressed group behaviour. Barb, Connie, and Elaine, who were taking or had finished bachelor's degrees in nursing, used explicit language to discuss marginalization and oppression, and talked about the work of specific nursing scholars. Anne and Donna used less academic language, but both described the same phenomenon,

and they recognized and commented specifically on it during the second round of interviews. Barb explained her understanding of this phenomenon:

My sense of the conflict between nurses and their supervisors is that it has been documented by [author Susan] Roberts....It's oppressed group behaviour, and what she said is that groups that are marginalized through whatever — blacks, Natives, any group that's been socially marginalized, women, poor women particularly — there's certain characteristics of behaviour that are very common across them. Part of it is not identifying, you develop some sort of separation from your group, and you identify with the dominant group.

Elaine also felt that the concept of oppressed group behaviour explained some of her experiences, such as finding that a nurse manager acted as a “buffer” between the hospital administration and the nurses, preventing the nurses from having their voices heard. She, too, mentioned Susan Roberts' work specifically to illustrate a point about a nurse leader in a direct management position:

In reading about oppressed groups and marginalized people, I went through this one article, Roberts, and it described this person to a T, and the fact that you get the impression this person dislikes the peers that they are representing, but is rewarded for being the middleman between us, who are the rabble rousers, and the upper administration. Just sort of buffering everything for them and keeping us at bay, and keeping the status quo, seems to be more their agenda than representing us.

Barb went further and identified two specific behaviours she personally felt were indicative of oppressed group behaviour in both frontline nurses and nurse managers: assigning and accepting blame.

When they [nurses with a conflict issue] went to [nursing] management, management basically said, "Well, it's your fault"....I feel, in retrospect, it's like a pattern, but I'm not sure I recognized it beforehand. I think we're socialized to accept the blame. And that's one of the oppressed group behaviours; as you move up, you can move away from accepting blame to assigning blame.

Several participants reported being a recipient of, or a witness to, violent or aggressive behaviours from peers. Donna experienced this in one of her workplaces, both as a witness and as a victim:

One of the nurses who was particularly bad about doing as little as she could a lot of the time, but talked very well, she was also very rude in things like team conferences and would cut off a number of the nurses, not just me, but some of the casual nurses, so that it became very difficult to talk about difficult patients, when you're trying to gather your thoughts and you're trying to present a problem and think about it to people as you talk, to the point where people didn't want to talk about their problem patients.

As Donna worked longer with this nurse, her behaviour progressed from verbal bullying to include physical abuse.

It got to be very uncomfortable. This same nurse then started to get even more aggressive, utterly rude, but at one point [she] took her elbow and whammed it

into my stomach as she was going down the hall and told me to get out of her way.

Donna's responses to this situation are addressed later. However, she had a final observation about the effects of power and oppression on nurses:

I guess I think that the worst behaviour comes from burned-out nurses towards their peers. And from nurses who have already been, who've felt so marginalized, so used up, that they start to turn on, and attack, their own.

Anne, who has never taken courses towards a BSN or been interested in doing so, did not speak about literature on oppression or use academic terminology. However, she recognized the concepts in the words of the other participants. In a follow-up interview, she said:

Some of your notes made brief reference to the fact that when somebody moves from staff nurse to supervisor to management or administration, that, this was a quote that somebody has said from a book or something like that, that you look down upon where you were and that there's some kind of power mentality that takes over. And I just thought, "Wow! That's so interesting." Because if we valued where we started, and we valued where we've come from, and the whole journey that it takes to get there, then I don't think we'd be stepping on each other. But we all know that nurses don't value themselves, as you can see in the contract negotiations and that kind of thing....So it's interesting, like, is this something that happens just amongst nurses?

In summary, in the eyes of the participants, nurses demonstrated the behaviours of an oppressed group, both when they are frontline workers and when they are promoted.

into management positions with power over those who had been their peers. They exhibited their oppression through behaviours such as horizontal violence and, when promoted, allying themselves with physicians or higher management rather than frontline nurses.

Power over

The participants strongly believed that being in conflict with people who held some form of power over them contributed significantly to negative experiences of conflict. These experiences began during nursing school, where instructors and other nurses have the power of defining the success or failure of student nurses. Anne described her perception of the effects of power imbalances on her supervisor's interactions with her staff. She believed that power played a role in her supervisor's feelings of inferiority to physicians, and that she compensated for this insecurity by dominating her staff.

She just has this Dr. Jekyll/Mr. Hyde type personality. I see a lot of nurses where there's this Dr. Jekyll/Mr. Hyde personality, and I see it, like, I see it with nurses who, they feel very much that doctors are more powerful than they are. So it's kind of like, it's almost like they've got in their minds that there's power, you know, that there are different levels of power. Like, "I'm a supervisor, so I have more power than you. But those big scary doctors, they have way more power than me."

In contrast, when power and authority were not involved, Anne found conflict easier to work with. Even conflicts with peers, which Donna reported as being very difficult, were seen by Anne as being more manageable:

I have had, you know, personality conflicts with different people that I've worked with, particularly very strong personalities, but those, those were all conflicts that with time became much easier....It was a matter of just getting to know one another, to know that this person reacts this way in certain circumstances, and that it had nothing to do with me. That they were either excitable or grouchy early in the morning or whatever. But I just didn't perceive it as threatening, as I would perceive it from a supervisor.

Connie felt that power over could exacerbate conflict for reasons that had little or nothing to do with patient care or with personalities, but merely because those without power were unable to resist, and those with power were able to abuse it. She stated specifically: "Well definitely, I think that people who don't feel they have power will back down, and sometimes people with power will abuse it." She then went on to explain her perceptions in greater detail:

[There's] the manager who's not professional, who will make a public issue out of an error that somebody else made, or, like, [sic] sometimes there's a scapegoat in the area, and they always pick on that one person. Or they're having a bad day, so, damn it, they're just going to take it out on you. I've certainly seen unprofessionalism [sic] from both a specialist and the nursing [management] side. Generally, the person with the power either gets to vent and get what they want, or they just get to vent, and what they wanted was to just feel more powerful than

the other person. If the other person doesn't retaliate, or walks away, they probably feel that they bested that person.

Barb described the power imbalances she sees existing between physicians and nurses in hospital settings, where physicians clearly have more power than nurses, even though that power may not be reflected in management structure or formal authority. Nurses within hospitals do not work for physicians, in the sense of being employed by them, yet Barb clearly described the power structure as it is seen by those involved:

The physician has been seen as the person with the power, with the power because they have the skills, with the power because they have the money, with the power because they are in a higher place in the hierarchy, and it is a patriarchy that we work in, and the patriarchy is physician at the top.

She went on to describe how that power imbalance made, and continues to make, her feel about her relationship with the previously discussed specialist:

You know, the interesting thing is, just going back to that, that I find myself becoming more and more powerless in the relationship with that physician. And I find myself less and less — what's the right word? It isn't "able," necessarily, but inclined, I guess — less inclined to challenge that man.

Barb had spoken earlier about the "beating down of spirit" that may occur with ongoing abuse. She was a strong, skilled, articulate nurse leader, yet she clearly expressed how the imbalance of power within her workplace was eroding her ability to work for her patients and her staff.

Elaine took part in a union-sanctioned job action as part of an ongoing contract negotiation. It was done in a manner that did not put patients at risk, but did

inconvenience managers, who had to provide coverage. As a result, Elaine found herself one of a number of nurses in conflict with her hospital administration. She felt that the administration actions were based in a power-over stance and were both inappropriate and profoundly disempowering to nurses:

I got a letter of reprimand from our CEO that will go on my file, of course, saying that this sort of thing would not be tolerated in the future, etcetera, and that there would be stronger things to deal with this in the future should I do something like this again. So I see that as a definite “power over” structure. I mean, you are totally shut down in our discussion, and we had no voice. That was a way of them dealing with the conflict and them being in a power situation, to rule that this wouldn’t be tolerated anymore.

She said, “At first I was totally bewildered” by the letter, and she considered what the appropriate response would be, but later she found that it was a source of pride:

A lot of people grieved it and had the letter pulled off, and I said, “Nope, I want that on there for when they see that maybe they should have listened to us.” I want it on record that I was there protesting, and I’m honoured to have it there.

Such actions take courage, but also carry consequences, such as a deteriorating relationship with an organization, and feelings of being betrayed and devalued.

In summary, power over described the impact that authority and hierarchy have on the experience of conflict for the participants. The effects of power over are reflected in all of the other themes, whether conflicts occurred with peers, managers, or physicians. The participants said that being subordinate to a person with whom one experienced conflict exacerbated the negative effects of conflict and contributed to nurses’ distress.

How Nurses Respond

The final category includes themes that arise from the participants' descriptions about how conflict, as they experienced it, made them feel, what they have done in response to an environment of conflict, and what the outcomes have been. The themes are *betrayal, disillusionment, fighting back, communication, and moving on.*

Betrayal

The participants used the term *betrayal* to cover a number of emotions that culminated in a sense of being let down or betrayed by others within the organization. Those others may be peers, nurse leaders, senior administrators, or the system in general. The feelings leading to a sense of betrayal included anger, frustration, dismissal, and pain. Donna described her feelings following an ongoing period of aggression from a peer, during the course of which she received no support from her manager or from her peers:

I would say that conflict with peers comes out of a sense of being powerless. It really is a sense of being part of an oppressed group. And I would say it is more traumatic due to the sense of betrayal and loss of support as well as face. I was once goaded into yelling back at [a nurse] who was in a rage, and I was a convenient person to rage at, but I didn't know it at the time. And I was left with a deep sense of shame that I had been goaded into yelling back. And that made going to work so difficult for me for quite a while that it was almost unbearable.

Donna's experiences in trying to cope with horizontal violence in this situation were made more difficult by the failure of her nursing leaders to support her. When I asked about that sense of betrayal, she stated:

I think it increases one's sense of powerlessness if there is not support from administration in resolving it. And I think it also reinforces a sense of powerlessness if one feels that there's no one that one can talk to about it. So it does make you feel more marginalized, it does make you feel more like you are on your own.

Donna's first experience with the powerlessness that follows betrayal by a nurse leader came early, when she realized that a nursing instructor was being dishonest in an evaluation:

I can remember having a nursing instructor misquoting me and putting it into the written evaluation, stating that I had said that. And it was what she said, and it was wrong! And she was writing it up as my understanding, and it was incorrect. And I remember how angry I felt about that, and powerless to do anything about it. It was like, what do you do?

Elaine discussed betrayal in the context of a peer being promoted into a management position. As mentioned in Chapter Two, the literature on oppressed group behaviour suggests that nurses who are promoted to positions of authority over their peers may choose to ally themselves with those higher up in the hospital hierarchy.

Elaine observed:

We did have one of our nurses move up to a manager position. And we all felt that that would be a good thing, and that she would sort of, of course, relate to

where we were, 'cause that's where she was. But she became very pressured from the powers above, I guess, and quickly became much more severe as an administrator type person. And we did see that as a real betrayal. The nurses found that really hard to deal with.

The consequences of this sense of betrayal did not just fall on the frontline nurses, but also on the nurse manager. Elaine described how, in response to these feelings, some nurses went behind the manager's back, opposing her in both overt and covert ways:

There was conflict, and there certainly were those that, because we had worked with her and knew her well, we felt actually spurred on by that sense of betrayal, that we were able to go say, you know, some people went, you know, "What are you doing?" and called her to it. But mostly there was just the talk behind, behind-the-back talk, of a real distaste for this person all of a sudden. Which put her in a very difficult position, but we just weren't impressed.

This resulted in an unhealthy workplace for all involved, nurses, manager, and patients. We continued to talk about this situation, specifically in the context of the power-over dynamics and the betrayal of trust that accompanied the change in relationship that occurred in this situation when a peer became a manager. When Elaine and her colleagues challenged this nurse on her behaviour and decisions:

She would appear to be uncomfortable with it, get all red in the face and a little uncomfortable, but remained quite hard in her choices. Seemed like she was really pulling power issues, and it didn't go over too well. Yeah, those two things [power over and betrayal] really do hit the nail on the head. It's hard to deal with somebody that sees themselves in a more powerful position. And the people that

are most difficult to deal with, I think, are the ones that see that, or feel like that power is being threatened. I think the ones that are really comfortable in dealing with conflict maybe don't see it so much as a challenge to themselves personally. It's the more insecure ones, I think, that take it personally, and then conflict becomes more of a personal issue than dealing with a work situation.

Connie and Anne also spoke in terms of betrayal, although not using such specific language. However, Anne's discussion of being targeted by the team leader in her new job, after feeling welcomed and accepted by her, and Connie's story of having management abandon her with a dying patient, were both eloquent examples of the theme of betrayal, even though they never used the word.

In summary, the term *betrayal* encapsulated feelings such as anger, pain, and abandonment that the participants felt when their nurse leaders and the organizations they worked for did not support them in workplace conflicts. The emotions of betrayal were sharp and immediate to the participants, who were increasingly left feeling frustrated and powerless.

Disillusionment

Disillusionment finds participants moving past betrayal and into a sense of losing the potential of nursing as a caring endeavour or even as a career. Connie expressed the beginnings of these feelings when she said, "I started off wanting to save the world. Now I'm to the point where, OK, if I can make this 12-hour shift a little bit better, then I've done a good job." For Anne, however, disillusionment was a very clear and present expression of how she was feeling:

I also think that we need to discuss the whole disillusionment that occurs as graduate nurses or student nurses realize that the profession idealizes nurturing, but that that doesn't work its way out in the way that we treat each other. And just the word "disillusionment" seemed to be really key to me.

Anne felt strongly that disillusionment was part of the learned repetitive cycle of eating our young, starting in nursing school, which nurses needed to be aware of and understand if they were to have any hope of changing it:

If I would add anything, it would just be that disillusionment thing, and how does that work. See, 'cause if you could draw a cycle, I think that it would, that you could probably make up a cycle that starts something like, baby nurses experience this, you know, and that the teaching is that we teach ideals about nurturing, but our experience is cannibalism, and that brings about disillusionment, which maybe brings about lack of respect for the profession, which brings about treating each other poorly. And on it goes.

Donna did not use the word disillusionment, but she described developing feelings that contributed to the sense of being disillusioned and disempowered as a nurse. She felt that guilt and shame are endemic in nursing and that they are learned through experience:

If you have been embarrassed by a nurse administrator or a doctor or anybody else, a peer, and you have been a recipient of that, there is still a sense of shame. I think that there is also a sense of guilt, that you should have done it better, and nurses are either self-selected for the ability to heap guilt on themselves, and/or

[sic] they're taught that. But it certainly, guilt is the gift that keeps on giving, and it seems to be something that is endemic in nursing.

Barb also clearly described the feelings of powerlessness and frustration associated with a conflict-laden environment, which led to a nurse being disillusioned with nurses' work:

The people I'm working with, I don't have a lot in common with, but I still have an expectation that we will be polite to each other, we will behave respectfully towards each other, we will help each other out. And when other people don't behave that way, and I'm tired, I'm pissed off. And it makes me, quite frankly it just makes me want to walk away and leave the whole thing, because then that exacerbates all my feelings of powerlessness, and I very rarely give in to powerlessness. I mean, I do believe I can make a difference in the world. I'm committed to making a difference in the world, and not many people can persuade me that I can't, but when I'm tired and I hear this, it just makes me not want to care. Not to not care about my patients, but to not care about nursing. And because I have a definite passion for nursing. I mean, it's just that it's, it's [silence] frustrating.

Elaine was another participant who described disillusionment without using the word. She spoke of those things that were cumulatively wearing her down and forcing her from the bedside. She started by denying that conflict affected her decision, citing "shift work, long hours, just generally how it affects my health, how the stress of my job affects my home life...I'm not concentrating well, and that's stressing me." But she went

on to say, “The more you stay away, the less you want to be here....That’s basically how it hit me. I don’t want to play this game.”

In summary, disillusionment described a loss of belief in nursing as a caring profession and in nurses as caring professionals. The participants described moving from being angry about what was happening to and around them to a place of no longer caring about nursing, although they still cared about and for their patients. However, for them, nursing had lost its joy.

Fighting Back

How do nurses cope? How did the participants respond to environments of chronic and ongoing conflict, especially to conflict that involved abusive or attacking behaviour, and to this sense of disillusionment? When I first interviewed these nurses, I was caught up in their pain and sense of betrayal about the way they had experienced conflict. I heard them tell stories about leaving their workplaces, and some were considering leaving nursing altogether. I felt overwhelmed by their experiences, and thus I initially failed to hear some of the positive experiences they had had. However, as I’ve grown more familiar with their stories and have become more attuned to their words, I am struck by their courage, commitment, and determination not to be victims any longer. Each discussed this in different ways, so I have chosen to identify this sense of renewal as *fighting back*. Fighting back took different forms for each participant, but each spoke in a manner that denoted growing self-respect, awareness of what she faced, and an internal commitment not to take it anymore.

Elaine spoke of a realization that there were alternatives to feeling powerless.

While we spoke, she hunted through a file of articles:

This one quote that I found said that you can listen to the people that you oppress, and you can hear their voices, and you can learn from them, or — what did they say? — you can choose to become encrusted residue [laughs], and I went, “Whoa! OK, that sounds pretty apt.” Oh, wait, here it is. [reading] “We all have the power to listen to voices that are seldom heard. If we choose to make the time to learn, to listen, and to struggle with the pain and frustration that disempowered people feel, we will see new vision, feel new energy, and find hope in our future. There is power in the powerless. We can be catalysts, or encrusted residue. The choice is ours.” Pierpoint, 1989. “All Welcome, Everyone Belongs: Leadership From Voices Seldom Heard.” And that’s in the *International Review of Education*, 35(4), 491 to 503. Your quote from the Bible for today [sic].

Elaine and three of the other participants have deliberately pursued further education (Donna has taken a non-nursing degree since gaining her RN) as a way of augmenting their confidence and obtaining the personal power to fight back. However, in the same sentence, Elaine described nursing education both as a maturing influence and as contributing to learning behaviours that she believes she needs to overcome.

I’m also more, through my [current BSN] schooling, I guess, I’m just also maturing. I don’t feel threatened, and I feel the ability to speak up if something doesn’t seem right to me, so that could be just a, the maturing aspect, the old nurse versus the young nurse type thing. Or maybe it’s just overcoming my [past

RN] education gradually. My training. Put it down to, it was more like training back then.

Participants identified fighting back as being a result of increasing maturity, of growing into the role of being a nurse and becoming generally more confident and mature. All made a deliberate choice to initiate a change from having conflict being something that happens “to” them, to being an active participant in the issues affecting themselves, their workplace, and their patients. This reflected a personal commitment and was usually a clear and conscious decision to effect a change in themselves. As Anne stated, about standing up for herself, “I have a personal investment in it, because I’m trying to work out my own healing as well, ’cause I wasn’t raised with healthy conflict. So I’m learning as I go, but it’s hard work.”

Exploring experiences of fighting back led to stories that described what had changed for the participants, and how the experience of conflict was different for them now, compared with earlier in their nursing careers. As a student, Barb witnessed nursing instructors eating their young, although she felt that she was never a target because she avoided confrontation and conflict. “I was such an obedient, passive little pap that nobody, I never caused anybody any grief.” She became a nurse who stood up for herself, her colleagues, and her patients. When I asked how this came about, her response was: “I moved. I took a three-year assertiveness training course! [laughs] No, I think I just grew up.”

Elaine echoed both of these experiences. About nursing school, she said, “You didn’t feel like they were supporting you. I really felt like it was just a matter of keeping a low profile.” Yet now she would also speak out when pressed, although with some

reluctance. She disliked conflict and preferred to avoid it, yet increasingly found herself in the role of advocate. She was consciously changing her approach to conflict from avoidance to a more direct and straightforward style. When asked why and how this was occurring, she replied:

I guess it's because I feel I'm coming into my own more powerfully. I have done a lot of reading over the past, and a lot of my reading is feminism centred, so it doesn't stem so much from conflict resolution, although I have been an avoider of conflict, but it's been about gaining power, of accepting myself as somebody I value, with things to offer, and being older, having some wisdom to offer, and trusting that wisdom that I have.

The verbal and physical assaults that Donna suffered from a peer forced her to take a leave of absence from a job she loved. However, after a period of reflection and recuperation she was able to find the resources, both internal and external, to address the issue:

Shortly after that point, I went on stress leave, and when I came back I talked to the occupational health nurse about what had been occurring, and she said, "This can't happen, this is harassment," and went to my head nurse. The head nurse and the assistant [head] nurse, in fact the two assistants, and the occupational health nurse got together, and I explained what had been going on. They then got together and spoke to, and there had been observations of what was happening with this nurse in terms of the way she was treating other nurses in conference [sic], so that it was clear that other people were experiencing conflict with this person as well. They then spoke to this nurse and presumably found out what was

happening with her and told her that this behaviour was not acceptable, and things got better for quite a while.

In summary, the participants described fighting back as the result of increased experience and growth as people and as nurses. To fight back implies trust in one's own abilities and, as Elaine stated above, in one's own sense of self. It is a major step towards making changes in one's own behaviours, in one's workplace, and in the types of behaviour one will accept from others. It means learning new skills and applying them in challenging situations.

Communication

One of the benefits of maturity is an increased facility with communication, arising from increased knowledge due to experience and education, and from increased confidence. Participants identified communication — talking — as the one thing the individual could do that might help to resolve situations of conflict or attack.

How did communication help these nurses resolve conflict or, if necessary, fight back? As discussed, the participants believed that organizational and administrative support was poor, so any attempts at conflict resolution fell largely on their own shoulders. The outcomes varied, but direct communication was the one thing that the participants thought was necessary in their attempts to uncover and address the real issues at stake. This was particularly true of conflict involving patients and family members. Much of the conflict they encountered from patients or family members was the result of fear, which may be founded in a lack of information, knowledge, or understanding of events that seem straightforward or self-explanatory to the nurse. Connie described an

experience with a family member that reaffirmed for her that nurses must not take other people's understanding for granted:

There was this [family member] who phoned...and he was freaked...I had been warned that he was a very hostile man. I was taking an instructional skills workshop around that time, and I really believed that a lot of conflict happens because somebody doesn't understand something and they feel loss of control, loss of power....When I heard this man was hostile, there was a piece of me that wondered if he understood what was happening or not. When he called he was angry, not rude, angry....I explained that [the patient's] lungs had filled up with fluid and they had to put a tube in to drain some of it....He said, "I don't understand what lungs do." I thought, I hadn't even thought about that, so I explained. He said, "Oh, I understand," and he calmed right down.

It takes courage to confront someone under those circumstances, but Anne found it effective when she took the risk and communicated clearly with a colleague who was acting inappropriately without being aware of it:

I remember this one girl I worked with, she had quite a strong, unique personality. She got really upset about something one day and she was just raving angry about the doctors and it was really affecting the tone of the whole ward. She was moving so quickly I had to run to catch up with her. I grabbed her when she was in the supply room and said, "You just have to stop for a moment and recognize that you're really angry and that you're making it very difficult for me to work right now because you're so angry." She just had so much momentum with this rage, but when she finally did stop it was like she went "Oh my gosh! Oh, OK."

She didn't realize that she had sort of gotten out of control. That had a very positive outcome.

Being direct does not always work, however, as Anne discovered. Before approaching a supervisor for assistance in her previously discussed conflict with a booking nurse, Anne approached the nurse directly:

This person was rude and curt, not the sort of person who should be on the phone talking to people about booking hours. I had quite a lot of discomfort dealing with her, and one day I confronted her with it. She wasn't willing to deal with the conflict, or even admit that there was one.

In summary, communication was a skill that participants found developed with maturity and with increased experience as nurses. Communicating directly with a colleague during conflict could be risky, particularly if that person had some form of authority or power, but it was described as the only effective strategy for attempting to resolve conflicts. The participants talked about using communication effectively, but also of having to live with the consequences.

Moving on

Each of the nurses who participated in this study had been involved in moving on from at least one position, due in part to an atmosphere of conflict that existed and that made remaining in that workplace untenable. For Anne, the outcome of attempting direct communication during her conflict with the booking nurse was severe. Her supervisor did not support her efforts to resolve this conflict, and ultimately Anne had to leave that workplace because, she said, "She [the booking nurse] was in charge of doing the casual

pre-booking and didn't like me. I didn't get any work, so I wound up leaving the ward and going to another ward."

Moving on, as demonstrated by Anne, was a decision taken as a last resort by the participants when, in an environment of conflict, with support lacking and communication failed, each nurse found that she was no longer able to remain in that particular workplace. Each took the final recourse of leaving her job and finding new employment, either on a different ward or with an entirely different organization. None to date had left nursing, although Anne, at least, continued to seriously consider it.

Barb, in a follow-up interview, talked of her perceptions of the consequences of nurses eating their young, giving the example of a unit adjacent to her own, where turnover was high and morale very low, in spite of the unit offering a challenging and exciting specialty nursing area with an excellent orientation program:

That is the situation in this neighbouring unit right now. They have had, they've got a lot of empty positions, almost half of their staffing requirement, they have had 70 new people in three years. All of them left. And these are people who they've specially trained and oriented, so they've been paid to come in. Some of them have lasted less than six months.

However, for Barb herself it was the environment of conflict on her own ward, among her own colleagues, which motivated her to begin seeking a change:

Quite frankly, in the last two years, conflict, hearing about other nurses' conflict with each other, or hearing how one nurse talks about another nurse, has been sort of a defining moment in my ultimate frustration. I need to get out of here. I'm thoroughly pissed off with the world.

Barb also discussed the ongoing atmosphere of conflict with one physician, in which nurses experienced verbal abuse but were not supported by nursing leadership, as contributing to her decision. Her feelings were a summation of disillusionment, betrayal, oppressed group behaviour, lack of support from nurse leaders, and the nurse-doctor game.

I think it's an insidious "wearing down," as near as I can figure it out. And I have, I mean, I've told my manager I'm not inclined to challenge him anymore, and it really pisses me off that I'm unable to do that. I mean, I know what I'm doing, it makes me angry, but I just don't want to get into it with him anymore. And I'm also then more inclined to hold the [medical] division responsible for his behaviour. So, I'm not sure, I'm trying to make changes to get me out of that man's sphere, but it's a bit disconcerting to me to recognize the personal changes occurring in me in relation to him. And I never really thought I'd go there.... Well, I think it's one example of how, you know, from the side of the oppressed individual, the system conspires through one individual to wear you down, without the support of either others or without the support of your own management. I mean the person who's in a position of power, it's far less wearing on them, in part because they're probably convinced of their own rightness to begin with.

Connie left when she saw that her concerns around patient safety issues were not going to be addressed. She left a workplace where she felt both she and her patients were betrayed. She believed that her concerns were ignored and that she was unable to practise in a manner that met her standards:

I also left, and went to another area of the hospital within six months of that, because I wasn't going to have people tell me anymore that it was OK for someone to have this kind of problem, and that if someone dies alone, that it's OK. That wasn't why I went into nursing.

This comment also speaks to feelings of betrayal, of disillusionment, and of being let down by nursing leadership. It speaks to the heart of a nurse's decision to move on.

In summary, the participants were all nurses who brought skill, commitment, and dedication to their nursing work. For them to speak, as Barb did, of "not caring about nursing" or, as Elaine did, of feeling like she was "walking away from a sinking ship," was profoundly disturbing. They had passion for the profession of nursing, and years of experience and education to support them through the highs and lows of work life. If they were falling victim to disillusionment and seeing no choice but to move on, how can those new to nursing, vulnerable and with limited experience and resources, hope to cope?

Summary

The themes arising from the participants' stories are: *nurses eat their young, the nurse-doctor game, lack of support by nurse leaders, oppressed group behaviour, power over, betrayal, disillusionment, fighting back, communication, and moving on*. Each

theme represents many experiences and has multiple meanings for the participants. As a whole, they show a progression in behaviours and experiences that have occurred throughout their careers, from their initial experiences as students in nursing school to their moving from one workplace to another as experienced nurses. In the following chapter, I will discuss these themes further in relation to the relevant literature.

Chapter Five: Discussion

*I and the public know
What all schoolchildren learn,
Those to whom evil is done
Do evil in return*

W.H. Auden, September 1, 1939

Introduction

The findings in this study seem unequivocal and are largely in keeping with the available literature. The nurses who participated in this study, and nurses in general, experience frequent conflict in the workplace and are victims of aggressive behaviour (Anderson & Parish, 2003; Farrell, 1997; Henderson 2003; NHS, 2004; Quine 1999; Sieh & Brenton 1997; Sofield and Salmond, 2003; Uzon, 2003). Much of the conflict and abuse reported in the research occurs with patients, family members, and physicians, with peers and nurse leaders being cited less frequently as common sources of conflict. In contrast, in this study, the participants reported that the most common and most damaging conflicts they experienced occurred with nurse peers and nurse leaders, followed by physicians. Few conflicts were reported with patients and family members, and those were generally resolved more easily than conflicts with colleagues.

Several of the participants considered leaving the profession of nursing because of the atmosphere of conflict they worked in, and all left at least one position of employment and moved to other areas because of conflict. Several took stress leaves. All

reported experiencing negative impacts on their work and home lives as a direct result of workplace conflict. These experiences are similar to those identified by the majority of researchers, who noted a connection between workplace relationships and job satisfaction (Cox & Kerfoot; 1990; ISMP, 2004a; Randle, 2001; Sofield & Salmond, 2003).

However, a few researchers, Kunaviktikul et al. (2000) and Dunn (2003), for example, did not find specific connections between conflict, leaving a workplace, and poor job satisfaction.

Conflict is a part of every work environment to some degree. No one, particularly not people in a high-stress profession such as nursing, would expect otherwise. However, being aware of the likelihood of conflict, and being willing to engage in conflict when appropriate — for instance, when advocating for patients — is one thing. Being subjected to a poisonous environment, where conflict is a word that carries implications of abuse, bullying, and harassment, is quite a different matter. My experience as a nurse was and is that both positive and negative types of conflict exist in nursing work environments.

Disagreements frequently arise over patient care issues, leading to conflict with physicians, managers, patients, and, in my experience as a pediatric nurse, with parents and family members. These conflicts can be heated and difficult, but if they are engaged in without power-over tactics and in a respectful manner, with the goal of best outcome for the patient foremost in everyone's mind, they are an accepted and acceptable part of the job. However, I have also experienced and witnessed conflict where abuse, degradation, and even the potential for physical violence have been at the forefront, and the issues have been of far less significance than the emotional residue.

In this chapter, I discuss each of the themes in order to describe in greater depth the experiences and perceptions of workplace conflict for these nurses.

What Happens

The three themes in this category, *nurses eat their young*, *the nurse-doctor game*, and *lack of support by nurse leaders*, refer to the most common forms of conflict experienced by the participants.

Nurses eat their young

Nurses eat their young is about peer conflict, although even among nurses working side by side there may be factors such as seniority that convey personal power or organizational authority on one individual. All of the participants discussed various examples of nurses eating their young, supporting Meissner's (1999) position that this practice remains prevalent within the nursing profession. The term *eating our young* refers to the common practice of nurses behaving in ways that are abusive, intolerant, or violent towards other, more vulnerable nurses, perhaps, as discussed by Alavi and Cattoni (1995), as an attempt to relieve the pain of experiences from their own days as "young" nurses. This behaviour is experienced in a variety of manners. Much of the most recent literature discusses nurses' experiences of physical violence and verbal assault, often from physicians, or from patients and their families (Araujo & Sofield 1999; Atawneh et al., 2003; Buback, 2004; Cooper & Swanson, 2003; Cox & Kerfoot 1990; Jackson et al., 2002; Kunaviktikul et al., 2000; Lee & Saeed, 2001; Tabone, 2001; Uzun, 2003). However, the nurses in this study reported different experiences, with the most frequent

and damaging conflict-ridden interactions involving other nurses. Eating their young may or may not involve an overt power imbalance, but the literature recognizes that “nursing has a long tradition of hierarchical power-structure in which the young and less experienced are the targets of victimization” (Taylor, 2001, p. 408). Eating our young may even occur when experienced colleagues join their peers in new settings, as Barb found when she went to assist on another ward, or as Donna experienced when in conflict with a peer. However, the more common and more damaging experiences of this type of conflict involved differences in power, where the participants felt attacked by nurses who held positions of authority or influence over them. For new nurses this may occur, and is particularly devastating, when they first begin their careers after graduating (McKenna, 2003). For others it may involve nurses in formal positions of authority. The term used to describe these nurses as a group in this study is *nurse leaders*, a label suggested for this purpose by Barb, that encompasses team leaders, nursing administrators and managers, and nursing instructors and mentors. Not all of these people may have seen themselves as nurse leaders, but all of them had responsibility for other nurses in a supervisory or educational capacity. Nurse instructors and nurse administrators are both identified by *Nursing99* (1999) and Meissner (1986, 1999) as being involved in this part of nursing culture.

The behaviour and attitude of nurses that eat their young had the potential to expand to involve the entire culture of a ward, creating what Barb referred to as a “poisonous work environment.” This environment was unhealthy for all concerned, not just for the nurses who felt themselves to be victims of attack. In fact, an atmosphere of conflict seemed clearly stressful for all who worked in it, even those most responsible for

its existence, and it appeared to affect job performance and satisfaction and, ultimately, retention in the specific workplace. This connection between conflict, decreased morale and job performance, and increased stress is supported in the literature (Ahuja & Marshall, 2003; Atawneh et al., 2003; Henderson, 2003; Jackson et al., 2002).

All of the participants described one of the most distressing and significant aspects of nurses eating their young as occurring in nursing school. This aspect was perceived as significant for two primary reasons. First, it created injury and distress for student nurses at the time, making nursing school a less pleasant and less useful learning environment. Second, the participants felt that being treated in a dismissive or hostile manner indoctrinated them into a culture of intragroup conflict and aggression, where nurses learned as students that this was how nurses related to each other. This finding is supported by Meissner (1986, 1999) and by Begley and White (2003), who describe the negative impact of nursing school on the self-esteem of new nurses.

It is in nursing school where there exists the greatest onus on the empowered nurse, the nurse educator, to act ethically, and with care and compassion when in conflict with nursing students. This position of authority has tremendous potential for abuse, and for causing harm to nurses at their most vulnerable. Nursing school is where the beginning nurse has the greatest right to expect fairness and safety, and it is also the venue where beginning nurses should learn appropriate behaviours to deal with conflict between nurses. For the most part, in my experience as a student and an educator, and in the reporting of the participants, nursing instructors meet this challenge. However, all too often they fail in their responsibilities, with potentially catastrophic results. All five of the participants recounted powerful, unpleasant memories of experiencing or witnessing

humiliation and injury in the name of education. Thus, as pointed out by Freshwater (2000), nurse educators may in fact perpetuate a culture of nursing oppression, rather than engendering change.

If nursing leaders do not change, the nurses they teach and manage clearly learn that eating our young is an appropriate way to respond to the newer, more vulnerable nurses with whom they work. This assumption is supported by stories I hear from nursing students, and by my observations as a practitioner and clinical instructor, about the treatment nursing students receive on the wards. Many nurses work skilfully and appropriately with students, treating them with respect and doing everything they can to create a rich, supportive learning environment. However, as Meissner (1999) also indicates, the experiences that frequently stand out for students are the negative ones, where they recall being abused and misused. Elaine's experience that "you are kind of a peon when you're in nursing training" is unfortunately not merely a memory of a harsher, bygone era in nursing.

The nurse-doctor game

The nurse-doctor game refers to the unequal, non-collegial ways in which nurses and physicians often interact in the workplace, frequently with negative consequences for nurse, doctors, and patients. The expression, originally described by Stein in 1967 (Zelek & Phillips, 2003), refers to a perception among the participants that nurses' professional assessments, evaluations, and opinions are not respected and valued by physicians and may even be treated with disdain. This can lead to relationships in which collegiality and mutual respect are replaced, on the one hand, by nurses' manipulation and gamesmanship

and, on the other hand, by physicians' intimidation and aggression. In such a circumstance, a nurse may try to lead the physician to write orders that the nurse feels are most appropriate, without actually requesting those orders specifically. The physician is "allowed" to feel powerful; the nurse feels justified because the patient's needs are being met. Both may be tacitly aware of the game, but feel unable or unwilling to engage in working together to change it. These interactions may be grounded in the historical differences in autonomy and authority that exist between medicine and nursing within the existing health care system. These differences are described by Corser (2000) as "the contention that the traditions surrounding the professional nursing and medical practice paradigms can perpetuate an almost institutional form of subservience of nurse to physicians that may prevent most collaborative dialogues from ever occurring" (p. 264).

In my experience, many nurses truly believe that the nurse-doctor game is a thing of the past and that all nurses should, and do, clearly and directly express their professional judgments about their patients and expect to be heard. As a nursing teacher and as a critical care nurse, I have generally found this to be true. However, for the participants in this study, and for many of the ward nurses I have observed and talked with, the nurse-doctor game remains a reality in terms of how they interact with the most influential and powerful health care practitioners within the system. They may be right. In fact, if anything, the power differential is becoming more, not less pronounced, as practice changes recommended by the Health Professions Council (HPC) in British Columbia demonstrate. According to the Registered Nurses Association of British Columbia (RNABC), the HPC's report *Safe Choices: A New Model for Regulating Health Professions in British Columbia* suggests "that much of the current practice of

registered nurses should depend on orders and delegation from other health care providers, most notably physicians,” rather than encouraging an independent and increased scope of practice for nursing, or even maintaining the status quo (RNABC, 2001, p.2). In contrast, the RNABC recommends that nurses’ authority match their responsibility, a recommendation ignored by the HPC. Nurses, and other non-medical health care practitioners, have been placed on notice that, in many situations, their practice may at any time fall more directly under the control of physicians. While the initial recommendations restricting nursing practice in this report were relaxed, the message about the political clout of nurses with respect to physicians was clear. Indeed, as Rob Calnan, president of the Canadian Nurses Association, said from the floor of the 2003 annual general meeting of the Registered Nurses Association of British Columbia, Canadian medical associations have greater financial resources to spend lobbying governments in a single month than the combined Canadian nursing associations can spend in a year.

This differential in power and authority exists in a more intimate manner within the hospital setting. Many physicians are described as willing to engage in collegial relationships with nurses, particularly in specialty areas. For instance, nurses on a neurological unit may enjoy a closer, more collegial relationship with a neurologist than nurses on a general medical ward that receives many stroke patients have with that same physician. However, this closer relationship tends to be at the invitation and control of the physician, not the nurse, and is by no means a given. Even with today’s emphasis on the professionalization of nursing, few nurses seem truly comfortable with equality, as demonstrated by the issue of names and titles.

Language, in particular the use of names and titles, is an indicator of power in relationships. Few nurses automatically address a physician by his or her first name, but how many of those same nurses wear a name tag with only their first name on it and expect and permit the physician to use it? For example: “Good morning, Dr. Smith. How are you?” “I’m fine, Steve. And you?” A similar conversation is cited by Keen (1991) as an indicator of possible exploitation of nurses as an oppressed group. Gordon and Grady (1995) submit that no physicians would tolerate being addressed by their first names if they were required to use a professional designation for a colleague. Yet the terms nurses use, and permit to be used about us, influence how our colleagues and the public view us, and indeed how we view ourselves. The public at large tends to use these forms of address when interacting with nurses and physicians, and they see them demonstrated in movies and television shows, such as *ER*. Even books that indoctrinate children into nurse and physician roles show this pattern, as pointed out by Gordon (2000). I challenge nurses to think of any circumstance where the use of a title by one party and a first name by the other does not clearly set out a relationship of unequal power and authority. The most common example, of course, is the way names are used between adults and children. This is a telling rebuke to the professionalism of nurses who expect and permit this disparity. Still, many of the frontline nurses I know do allow it, without question.

As previously stated, the nurse-doctor game also reflects the ways in which nurses try to get the best possible care for their patients. The nurses who participated in this study were all experienced practitioners. Three of them had been critical care nurses in various areas; three had been clinical instructors. All had areas in which they were justly proud of, and confident in, their expertise in assessment and nursing diagnostics. Yet all

had encountered situations in which physicians failed to listen to their concerns, and most, as described in Chapter Four, had experienced physicians responding angrily to a nurse “overstepping her bounds.” I have observed that some nurses learn quickly that they do not dare suggest a particular course of action, as it would almost inevitably preclude that action being taken by the physician, regardless of how critical it was to the health of the patient.

A number of the participants experienced verbal abuse from physicians, although this was not reported as being as prevalent a phenomenon as reported in the literature, nor as having the same degree of negative impact as intragroup conflict had. However, several participants reported being yelled at or treated in a threatening and potentially violent manner. Such actions go beyond any sense of a game. While not a central theme of this study, assault, verbal or otherwise, directed at nurses is a subject requiring both further study and immediate intervention.

Lack of support by nurse leaders

One of the primary issues the participants discussed in this study was the lack of support they felt from their nurse leaders during situations of conflict, a theme that is closely related to nurses eating their young. *Lack of support* is a deliberately broad term. In most of these stories the participants found that support was lacking in the places and people they would have most expected it from: nurse managers, team leaders, clinical teachers, and nursing instructors. Support from peers was also frequently lacking, which was an extremely painful experience for several participants. Yet it was the failure of nursing leadership that was the most painful to others, and that was troubling to all,

leading to the themes discussed under the category of “How Nurses Respond.” Lack of support was described by the participants as constituting a failure, on the part of nursing leadership, and also by health care organizations as a whole, to care for those who do the frontline work.

Looking at the areas of nursing leadership discussed, two specific groups came to the front: nurses promoted into positions of authority over nurses, and nurses who educate nurses. The former included nurses in such positions as manager, coordinator, and team leader, with a variety of terms used in different institutions. Some of the issues the participants discussed as a failure of support included: their leaders not supporting them during confrontations with physicians, leaving them understaffed for the conditions of the ward, and imposing decisions that went against the better judgment of a majority of the nurses within a specialty area. The participants generally felt that their managers should have been there to make nurses’ work more manageable, but that, instead, the leaders themselves either became sources of conflict or failed to take responsibility for assisting in the resolution of conflict between nurses, or between nurses and others. This is consistent with the literature. Quine (1999, 2001) found that when nurses initiated action following an incident of bullying, they were usually disappointed with the outcome. Laschinger (2004) reports hospital nurses’ perceptions that managers frequently treated them with lack of respect or concern, fail to support good care, and do not appear to value either nurses or nursing work. Dunn (2003) also found that nurses saw their nursing administrators as being distant, unsupportive, and uncollaborative, especially in addressing conflicts with physicians or when making decisions that affected nurses. This is consistent with Taylor’s (2001) statement that “bullying in organizations tends to filter

from the top down, and is often seen as an acceptable way of managing and getting promoted” (p. 407). Keen (1996) also notes that nurses who are promoted may ally themselves with administrators and physicians, to the detriment of nurses as individuals and nursing as a profession. Henderson’s (2003) descriptions of the failure of nursing supervisors to support nurses following physical assaults are particularly disturbing and are suggestive of a particularly invidious form of abuse, where an act of violence is compounded by betrayal by one’s nurse leader. Research also indicates that nurse managers are at times directly responsible for bullying and aggressive behaviour (Jackson, 2002; Quine, 1999, 2001)

Nursing leadership also failed nurses in their formative years as nursing students. Nurse educators are seen as nurse leaders, and as such provide both role modelling and guidance as to standards of practice and interaction for nurses. Yet the participants all related stories of conflict with, and abuse from, nursing educators. They saw nursing school as providing the foundations for inappropriate learned behaviours, both between nurses, such as perpetuating an atmosphere of eating our young, and between nurses and physicians, perpetuating the nurse-doctor game. Further, none of them had stories of nurse educators observing and interceding on behalf of students. In other words, nurse educators, in their leadership roles, were not seen to be monitoring their own behaviour or that of their colleagues. Students’ perceptions of conflict may differ from those of their teachers, but it seems telling that all of the participants shared similar experiences and perceptions, even with the hindsight of many years of experience or as mature students returning to school.

The small amount of literature that is available indicates some indirect support for the participants' experiences of oppression occurring within nursing schools. Gillespie (2002) does not directly address the question of conflict. However, the participants in her study identified that nursing knowledge was used by some *nonconnected* teachers to establish differences in standing. This is clearly a power-over behaviour. Further, the participants told Gillespie that these teachers had a "tendency to 'grill' them with questions, offer only 'negative' feedback, to 'constantly critique', and 'watch them like a hawk'" (p. 8), resulting in students focusing on the instructor, rather than on learning. One participant told her: "I was so concerned about answering her questions...that the whole big picture (of the patient) wasn't important. The important thing was all those little questions she was going to ask me" (p. 8). Begley and White (2003) also found that nursing students feared negative evaluation from their instructors, and they suggest that the transfer of nursing education from hospitals to universities has resulted in larger classes and less small group or one-to-one interaction, negatively affecting the development of self-esteem in nursing students. However, the implication that hospital training was kinder and more supportive is not borne out by the stories told to Begley and White, or Gillespie, or those told to me. Those trained in the "old" system reported the same issues of conflict with their instructors as did those educated in colleges and universities. Neither Begley and White, nor Gillespie, investigated conflict specifically as a component of the relationships between instructors and students, however Randle (1999, 2003a) describes bullying towards students as commonplace.

Nursing educators, in their role as developers of curriculum, also fail student nurses by neglecting to provide them with the tools to address the conflict and aggression

they will inevitably encounter. None of the participants received formal conflict-resolution training as part of their nursing education, nor do students elsewhere appear to receive education in effective responses to conflict (Beech & Leather, 2003). Articles that do address conflict resolution tend to be found in journals catering to nursing management, rather than to frontline nurses. Since nurse educators know that nurses eat their young, and that nursing students and new nurses will be working in a practice environment that is rife with conflict and aggression, failing to provide them with the tools to survive seems in itself an act of violence.

Why It Happens

Discussion of the two themes in this category, *oppressed group behaviour* and *power over*, examines the relationship between the participants' experiences of conflict, and literature suggesting that that nurses are an oppressed group, lacking power within health care hierarchies.

Oppressed group behaviour

Nurses are caring people, and people enter nursing because they wish to care for others. Those truisms are commonly heard, both within nursing and in the public perception of nurses. Yet it appears, based on the descriptions presented by the participants and by the literature, that nurses are terrible at caring for themselves and for each other. Why is this?

The participants all spoke of nurses being an oppressed group. Those participants who had post-diploma education tended to speak in a more academic manner, using terms

like *oppressed group behaviour*. They cited authors, such as Susan Roberts (1983, 2000), who discuss these behaviours in detail. Other participants, who had not read the literature, still spoke of the behaviours and of the hierarchical structure of health care, which left them, as nurses, without authority and without recourse within the system. All of the participants spoke of such behaviours as their nurse leaders supporting physicians rather than nurses, or shifting their primary concerns to issues other than patient care. They spoke of being subject to verbal abuse from those with power. They spoke of horizontal violence, and of a culture of internal conflict. They spoke of lack of accountability by nurse leaders, and of leaders allying themselves with other members of the health care hierarchy. Members of oppressed or marginalized groups may exhibit specific types of behaviours under stress, during conflict, or as a way of advancing themselves out of the group. They may act in ways that betray the needs and goals of the group they come from, in order to gain access to the oppressor group. The participants spoke of being blamed for the conflicts they experienced, even when those conflicts were based in their desire to get the best possible care for their patients. All of these are among the behaviours identified by Roberts (1983, 2000), Keen (1991), and Freire (1970/1997) as characteristic of oppressed groups.

A further behaviour that comes to light in nurses' words is the tendency towards apologist behaviour. Nurses frequently excuse those who abuse them, and they have a culture of expecting such treatment as an accepted, if unpleasant, part of the job. When they recalled intragroup conflicts, several of the participants, in spite of their anger at what had occurred to them, also attempted to excuse the nurses who engaged in negative behaviour. Barb prefaced her description of a poisonous workplace by lauding the nurses'

high standards and expressing her feeling that they were “very well meaning” in a manner that appeared to let them off the hook to some extent. The implication was that this behaviour was perhaps more tolerable, given the skills and intent of the nurses. It is not only nurses who are excused. In the opening story, after being verbally abused, the nurse states: “I sort of understand him [the physician]...we’re women, it’s cultural.”

Nurses, nurse leaders, and hospital management appear to accept physicians’ abuse of nurses because they are “brilliant” and to accept patients’ abuse of nurses because they are needy or ill. In many jurisdictions, legal standards around the assault of nurses are different, and less punitive, than those around assault of other citizens. All of this contributes to nurses seeing themselves as sharing responsibility for being victims of aggressive conflict, rather than expecting and demanding protection and respect — another example of oppressed group behaviour. Nurses experience blaming in other areas, from Worker’s Compensation Board adjudicators who imply fault when injuries occur to nurses, to managers who assure them that a physician who is verbally abusive really means no harm and would be injured by an incident report.

The role nursing education plays in perpetuating these cultural behaviours is also in keeping with oppressed group behaviour, as knowledge, and thus education, are “the expression of historical moments where some groups exercise dominant power over others....After years in passive classrooms, students do not see themselves as people who can transform knowledge and society” (Shor, 1993, p. 28). Students, including nursing students, “internalize values and habits which sabotage their critical thought” (p. 29), resulting in the continuation of self-destructive, cyclical behaviours.

Power over

Power is tightly connected to oppressed group behaviour, and is integral to the relationships which exist within organizations (Lee, 2001). *Power over* relates specifically to the participants' experiences of conflict with people who have more power or authority within the health care system. In the experience of the participants, the implications of power over during conflict were significant. When differentials in power existed during conflicts, the participants found those conflicts to be more traumatic and more difficult to resolve or endure. Conflict with peers was more commonplace and happened more frequently in terms of straight numbers. Conflict with patients was seen as being part of the job and was often easily resolved. However, conflict with nurse leaders and physicians caused more harm and was difficult to engage in successfully. This is consistent with the findings of Cook (2001) who found that verbal abuse from physicians had a high, negative impact on perioperative nurses. Quine's (1999, 2001) studies of workplace bullying among nurses in Britain found that the most frequent perpetrators were managers. Farrell (1997, 1999) found that it was conflicts with other nurses at all levels which caused the most distress and concern for Australian nurses. The participants in this study made it clear that conflict with nurse leaders, in other words nurses in power over positions, caused them the most trauma, and were the most difficult to cope with. Even the decision to attempt to engage in conflict resolution in power over situations was often beyond the control of the nurse and rested with the other party, or with a third party, generally a nurse manager, whose decisions about whether and how to proceed may be grounded in oppressed group behaviour and therefore be unsupportive of the frontline nurse.

Power over conflicts exist outside of the hospital setting. Nursing instructors and senior nurses are in clear power over positions with respect to students, and their actions may establish patterns that the students carry forward. Randle (2003a) found that bullying was common towards students during nursing education, and that “by the end of the course they were venting their frustrations towards those who were in a subordinate position” (p. 400), thus learning and perpetuating a cycle of oppression as discussed by Freire (1970) and Freshwater (2000). Students are particularly vulnerable during a preceptorship, where the relationship between a student and a senior nurse may be both new and stressful, and is only monitored at some distance. If the relationship breaks down both the student and the preceptor may experience frustration and disillusionment (Yonge, Myrick & Haase, 2002).

Even the efforts to increase the professional status of nursing, through such actions as the implementation of baccalaureate as entrance to practice, are seen by some as power over action of violence against existing registered nurses (Daiski, 2004; Herdman, 2000). This disparity between the goals and aspirations of differing groups of nurses serves to emphasize the divisions attributed to oppression, and to the lack of communications and consultation perceived by frontline nurses. “There is just a general lack of respect for...and inclusion of nurses into the decision-making process” (Participant Danielle, cited in Daiski, p. 46).

How Nurses Respond

The five themes in this category, *betrayal*, *disillusionment*, *fighting back*, *communication*, and *moving on*, describe the stage that each participant went through in

response to working in conflict-laden environments. There is generally a poorly documented response to the overwhelming evidence of hostility and high levels of violence in the nursing workplace. Indeed, there is little evidence of a serious response at all” (Jackson, 2002, p. 17). Certainly I found little literature relating to these themes. In particular, the language used by these participants and thus specific to these themes, seems unique. I have included examples of research describing findings I feel are comparable to the themes described here.

Betrayal

The participants summed up the feelings they experienced when their nurse leaders failed them, which they identified as the most damaging of all the conflicts they encountered, with the word *betrayal*. “Nursing itself colludes to promote an environment in which all forms of violence, including bullying and sexual harassment, prosper” (Jackson, 2002, p. 16). This is the very essence of betrayal, towards the typical nurse, who enters what they believe to be a caring profession. The realization that someone who had been a peer or co-worker, or at least had been a bedside nurse, was failing to understand the issues of patient care at stake, or was supporting an abusive physician, left scars that led to increased stress, anger, and frustration. These feelings carried over into the participants’ home lives, affecting sleep and otherwise decreasing quality of life. Ultimately they led to the following theme, disillusionment. Betrayal is not a term that I found used anywhere in the literature, however it summarizes the feelings described by several researchers. Laschinger (2004), in discussing hospital nurses’ perceptions of the lack of respect and valuing they felt from their managers. Heavy workloads and a failure

to provide sufficient resource to ensure that nurses could give care of high quality were cited as examples of the lack of respect.

Horizontal violence may occur as sabotage, backstabbing, gossip, and other forms of undermining behaviours between nurses who work closely together (Dunn, 2003; Freshwater, 2000). Since these behaviours involve presenting one face to a co-worker, while acting with covert hostility, to feel betrayed is an appropriate and understandable. To see a co-worker move into a leadership role and as described by Keen (1991), begin to associate and ally with physicians and administrators, is also a betrayal, although that term is does not come out in the literature.

Disillusionment

Disillusionment occurred when the participant lost faith that nursing was a career in which she believed and that nurses were the caring professionals she had thought they were. The participants spoke of feelings of powerlessness and hopelessness, about being unable to make a difference for their patients. They became worn down and no longer enjoyed working as nurses. At least one considered leaving nursing altogether at this time. The literature also speaks of nurses as becoming burned out, using increasing sick time, and of difficulties recruiting new people into nursing (BCNU, 1998; Daiki, 2004; Jackson, 2002).

When nurses lose trust in their employers disillusionment was identified as a specific outcome (Ray, Turkel & Marino, 2002). In new graduates, higher levels of workplace conflict are identified as increasing dissatisfaction with nursing within the first six to 12 months of starting work (Gardner, 1992). Many nurses also do not want their

children to pursue the same path (BCNU, 1998), which speaks to me of disillusionment with their own chosen career. A study by Callaghan (2003) found a similar result among British nurses, where half of the participants “would discourage others from becoming a nurse” (p. 88). Callaghan described nurses’ morale as very low, due to issues that included lack of managerial support and resources.

Fighting back

Fighting back occurred when the disillusioned participants realized they were not entirely powerless. Fighting back meant taking a stand, finding external resources, and finding or recalling an internal resolve not to be driven from a career or a position that they had loved. Anger, which was a factor in betrayal, was also a factor in fighting back, but it was anger of a different nature. Frustration gave way to determination and a decision to not go quietly.

Fighting back frequently accompanied increased education and understanding about oppression, as well as increased experience and maturity as a nurse and as a person. Kendall (1992) discusses the necessity of this for members of oppressed groups, saying “Gaining emancipation requires that there be people within oppressed and disenfranchised groups who recognize the existence of oppression and help people learn about the roots of oppression and that together they value the group and its members” (p. 5). Daiski (2004) supports this, citing education as the key to creating change in nurses dis-empowering relationships. At the same time, she acknowledges the current failing of nursing education to do this.

Understanding more about their situation enabled the participants to begin to work towards change. Fighting back took courage and commitment and was not always successful. However, even when conflicts were not resolved, fighting back left the participant feeling stronger and more personally empowered, with a greater sense of self-worth. In later conflicts, or in new places of work, participants found themselves learning more about conflict and engaging in it differently, being less willing to put up with abuse, and gaining confidence as a person and as a nurse.

Communication

Communication was identified as the primary tool of fighting back. Having made the decision to fight, the participants sought out resources in the form of support services, education, and, in some cases, nurse leaders. They made deliberate approaches to those with whom they were in conflict, usually, but not always, with the support of others. These nurses found that, although being direct and clear did not always lead to resolution, it did increase their sense of personal power and assertiveness, and it made them more able to cope with the atmosphere of the workplace. Communication laid the groundwork for renewed confidence in themselves as people and as nurses, whether they stayed in a workplace where conflict was occurring or moved on.

Laschinger (2000) found that establishing a relationship of respect and trust increases nurses morale and job satisfaction and commitment. Doing this requires open and direct communication, in a collaborative and respectful manner. Hrinkanic (1998) stress the importance of negotiation as a skill required by nurses, to facilitate communication between frontline staff and managers. Effective, collaborative

communication is clearly the cornerstone of negotiation and mediation, since the clear communication of ideas, particularly mutual and conflicting interests, forms the basis for conflict resolution (Haddigan, 1996, 1997).

Communication was not always a successful strategy for the participants. While education and increased personal power led the participants to feel more able to engage in conflict resolution, if they were working with a power imbalance the decision to proceed towards resolution was not in their hands. Several participants experienced being shut down, or being verbally abused, as a result of attempting to communicate during situations of conflict with physicians or nurse leaders. Opening dialogue during conflict carried risk for the participants, particularly when the other person held more power.

Cook (2001) goes so far as to suggest that, in the case of perioperative nurses experiencing verbal abuse from physicians, that this may be a coping mechanism for the surgeon, and appears to imply that nurses may bear some responsibility for these behaviours, stating "learning more about the physician's preferences is an effective way to cope with verbal abuse" (p.327). In contrast Namie and Namie (2000), stress the importance of victims or targets of bullying avoiding a sense of responsibility, stating that if the behaviour is allowed to continue, the victim can begin to see herself as responsible for the abuse. Avoiding self-blame is particularly important for nurses as an oppressed group, since such people "often exhibit self-hatred (Dunn, 2003). Cook's suggestion appears to me to play into this. Unfamiliarity with a physician's preferences, even a nurse making a mistake, does not give permission for any form of violence to be directed at the nurse.

Moving on

The participants moved on when they realized that their work environments were no longer endurable due, at least in part, to a pervasive atmosphere of conflict in the workplace culture. Laschinger (2004) found a strong correlation between a lack of trust in management, decreased job satisfaction, and decreased commitment to remaining with an organization. "When the resources are not there to support nurses, many aspects of care are left undone...if these conditions persist over time, many nurses experience symptoms of burnout. Many leave the profession altogether in frustration" (p. 361).

Daiski (2004) had similar findings, related to nurses' perceptions that they have little influence over the changes taking place in health care policy, leading to feelings of frustration, anger and powerlessness. Restructuring resulted in changing workloads, as less skilled practitioners replaced nurses. Those who remained coped with increased workloads, and as a result, many left nursing and moved on. The imposition of wholesale changes affecting nurses, without meaningful consultation, again speaks to the subordination of nurses as a group by a powerful hierarchy. Moving on becomes the only action open to the powerless. Thus each participant's decision to move on was initiated, to some extent, by feelings such as disillusionment and betrayal, but there were also positive aspects to these decisions. Each was a deliberate, proactive decision, rather than just an escape, and left a feeling of having taken a positive action. However, all of the participants ultimately spoke in terms of regret, disillusionment, and betrayal that nursing, and nursing leadership, was not living up to their expectations of what nursing and nurses could be.

Many of the disillusioned nurses in Callaghan's (2003) study were considering

leaving nursing altogether. In this study only Anne had considered leaving nursing for a different career, but all of the participants expressed increasing unhappiness with the nursing culture they were continuing to work within. This seems tragic, as all of these nurses have loved what they do and bring years of experience, dedication, and devotion to their work. If nurses such as Barb and Elaine have lost faith, what can we expect for the new and vulnerable entrants to the profession?

Summary

Given these descriptions of workplace conflict, of experiences causing such distress and unhappiness, why would any intelligent, dedicated young person, with the potential to be anything she or he wishes, choose to become a nurse? What other profession holds the possibility, if not the likelihood, of being physically or verbally assaulted by your clients, your peers, your colleagues, and your managers on a regular basis? What other profession accepts this as part of doing business, without expecting and demanding serious consequences to the aggressor? There is only one other profession that comes to my mind, also involving primarily female workers, in which conflict and violence are an accepted part of doing business, and where assault is not treated as a serious matter by those in authority. As much as nurses are reportedly accorded the respect and trust of the public, does societal acceptance of violence towards nurses indicate that they are in fact seen by some in the public as “only one step away from whores,” as the physician in the opening story claimed? In what other profession is guilt such a part of contract negotiations, where nurses are routinely reminded that increasing wages decreases resources available for other aspects of health care, where they are

portrayed as grasping and greedy if they ask for more, and where, even amongst ourselves, we repeat the litany that it is “not about the money”? Few, if any, of us would be working as nurses if we were not paid to do so. That makes it “about the money” when it comes to negotiating contracts in good faith, just as it is for any other trade or professional group. If we are to attract and keep new nurses, we have to provide a work environment that reflects professionalism, free of harassment and abuse, free of violence, free of any conflict that is not conducted in a professional manner and that does not involve issues of practice and patient care.

It may be inappropriate to use the term *conflict* to describe many of the interactions these nurses reported. Some of these conflicts could more accurately be labeled abuse, bullying, violence, whether horizontal or otherwise, and so on. I began this work using the term conflict in a general manner so as not to limit the responses and stories of the participants, and the findings and themes reflect their experiences. Conflict, for them, is not usually “a normal part of every-day life” that “can be a positive or negative experience” (Justice Institute of BC, 1994, p. 63), but rather an unpleasant and far too frequent part of their workday lives. In exploring their experiences with me, several of the participants came to realize the extent to which conflict was an ongoing and omnipresent part of their workplace culture, and they considered working towards creating change, either in the workplace, themselves, or both.

Chapter Six: Summary, Implications, and Conclusions

Hope is a state of mind independent of the state of the world.

Muriel Duckworth, Quaker activist, 2004

Introduction

I undertook this study to describe how workplace conflict is experienced and perceived by frontline nurses. The term *conflict* was left deliberately broad, my intention being that the participants of the study would define it themselves, in their own words and experiences.

A review of the literature revealed little research on nurses' experiences with conflict in a general way, or as defined by nurses themselves. However, there was research into specific aspects of nurses' experiences of conflict, such as bullying, violence, and verbal abuse, which suggests that nurses experience frequent conflict in the workplace, with a variety of people. The literature cited physicians, patients, family members, nurses leaders, and peers as being involved in such conflict with nurses. Nurse researchers explored the role that the oppression and marginalization of nurses plays in conflict, and they described nurses as behaving in ways that are characteristic of oppressed groups. They also discussed evidence linking conflict with job dissatisfaction and decreased retention, making a connection between workplace conflict and the nursing shortage.

An exploratory descriptive qualitative research method was used in this study. Five participants were selected using purposive sampling. Interviews with the

participants were tape-recorded and transcribed, and thematic analysis performed. The findings were validated by participant confirmation, by sharing the findings with other nurses through discussion and presentations, and by the maintenance of drafts, notes, and transcripts.

The thematic analysis elicited the following 10 themes: *nurses eat their young*, *the nurse-doctor game*, *lack of support by nurse leaders*, *oppressed group behaviour*, *power over*, *betrayal*, *disillusionment*, *fighting back*, *communication*, and *moving on*. Overall, the participants described conflict as a frequent and negative experience in the workplace. The themes show a progression in experiences and responses occurring throughout the participants' careers, from student to experienced nurse. Some of the themes have much in common with the literature, such as nurse-physician interactions. Others, such as lack of support from nurse leaders, especially interactions with nursing instructors, are less supported by existing research.

Following my experiences and observations during more than a decade as a practising nurse in a hospital setting, I was saddened and disturbed, but not unduly surprised, by the stories of nurses who participated in this study, or by the themes that emerged. The themes pertained to what conflict meant to these nurses, what repercussions it had, and what sometimes helped to ease the situations in which they found themselves. Primarily, however, they spoke of the distress caused by working in an atmosphere that is burdened with frequent, unresolved conflict, particularly when much of that conflict involves feelings of powerlessness, betrayal, and anger. They are damning statements. The nurses who participated in this research reported experiencing conflict on a regular basis, and experiencing it with those in whom they should be able to place the

greatest trust: their peers and leaders. This has had a profound, negative impact on their professional lives, and for some, on their home lives as well. While this is a small study, with obvious limitations, results such as these indicate an urgent need to act. Therefore, among the implications discussed in this chapter is the question of what to do next.

Limitations

It is clear that there needs to be further study on conflict in nurses' work environments. One qualitative study with five participants does not provide definitive information about anything. Specific types of conflict were not identified or isolated, nor were issues such as gender or ethnicity explored, although these undoubtedly affect the experience of conflict. However, the fact that the findings have resonated with many nurses who have heard them, whether at presentations to Camosun College and the University of Victoria or in discussions I have had with colleagues and students, indicates that the research is revealing some trends that deserve further investigation.

In terms of the practice environment, one of the first steps to creating change is raising awareness of issues. Until a problem is identified and named, it cannot be addressed. Therefore, bringing this information to nurses in as broad and comprehensive a manner as possible is an important step towards increasing individual and group awareness of workplace dynamics and nursing culture, and towards encouraging nurses to consciously recognize behaviours that they may have come to accept as merely "the way things are in nursing."

Suggestions for Further Research

There is a clear need for further research into nurses' experiences with conflict in the workplace. Further studies, incorporating both qualitative and quantitative methods, could deepen the understanding of this phenomenon. For example, a survey of a large number of nurses in British Columbia, using questions developed from the results of this study, would identify whether the experiences of the participants in this study are similar to those of other British Columbia nurses. Of particular interest to me would be further study of how differing levels of education and authority affect conflict between frontline nurses and nurse leaders with respect to the implications for nursing unity in an increasingly hostile workplace.

Creating Change in Education and Practice

It is all very well to call for further research into what is clearly a complex and poorly understood phenomenon, but it is also clear from the literature and from the participants' stories, that strategies need to be initiated at once to begin to create change for nurses currently on the front lines, and to break the cycle of patterns of behaviour being learned by new nurses. Education and practice for nurses are inextricably intertwined, and the implications for both are profound. When I entered nursing, no one informed me or my peers that conflict, verbal abuse, and even physical assault would be almost inevitable experiences during our careers. Why not? Nursing education prepares students for other hazards, such as infectious diseases, but does not educate them about self-care or safety with respect to the equally real dangers that occur during conflict with patients, peers, physicians, administrators, and even instructors. It seems unethical to

send students into such a dangerous and hostile work environment without giving them forewarning and the tools with which to ensure their own safety. A first step towards creating change is openly acknowledging the problem; until nurses, nurse educators, and their respective organization are prepared to do this little will be accomplished.

Nurses are not effectively educated about, or encouraged to pursue self care as a high priority in their lives, instead being taught, overtly and covertly, that they should put patient needs before their own (Daiski, 2004). However, nurses' duties towards their patients do not, in fact, preclude their rights to a safe and secure workplace.

Coomaraswamy (1995) states "Women's right to be free from violence is an absolute right which cannot be mitigated by empirically discovered social causes" (p. 22). When a woman, or a man, becomes a nurse, they continue to have the right to a workplace free of violence.

Not only do nurse educators fail to properly inform students of these risks inherent in nursing, but the participants also clearly identified behaviours occurring in nursing school as being key to propagating behaviours nurses exhibit during conflict. The theory of oppressed group behaviour suggests that nurses, including nursing instructors, in positions of power over other nurses are at high risk of becoming oppressors of nurses themselves. Nurse managers and administrators, nurse educators and academics, nurses who mentor, ward nurses who work beside students or with new employees — in fact, all nurses — have a responsibility to meticulously examine their own behaviours, and those of their peers, and to challenge behaviours that perpetuate the abuse, in any form, of nursing students, new nurses, and nurses generally.

The participants spoke of how conflict in the workplace impacted their quality of life, both at work and at home. They spoke of how ill-equipped they felt to handle conflict, and how conflict resolution was not a skill that had been included in their nursing education. My own experiences as a teacher in a college program suggest to me that we encourage students to create change, to challenge the hegemony and the status quo, but that we do not give them the tools or the education to do so safely. This needs to change. Nurse educators have a responsibility to help new nurses acquire all of the skills needed to create, and practise in, a safe, constructive, and positive environment. Not only new nurses, but all nurses need and deserve safe practice environments, as do all people who find themselves within the health care system, regardless of their position or role.

Talk is cheap, however. Topics such as the oppression of nurses and eating our young have been discussed for many years. Only by consciously naming behaviours, and engaging in specific actions to break the cycle, will change begin to occur. Change must occur on institutional levels, discussed below, but individuals must also take responsibility for monitoring their own behaviours and challenging those of others when required. One strategy discussed by Barb was that of the *Code Pink* (also in Namie & Namie, 2000), where nurses who witness verbal abuse or non-violent bullying occurring stand beside the victim, act as witnesses to the event. This may stop the incident. Witnesses and victim should then follow through with organizational procedures in place to respond, or they tacitly enable the next assault.

Individual nurses should also take steps to understand and respond to their own engagement in the culture of oppression. One area to create change is around the issues of names. Gordon and Grady (1995) suggest nurses insist on “symmetrical naming practices

with physicians” (p. 33). A component of symmetrical naming involves nurses identifying their last names, with the fear that this would expose nurse, generally women, to increased risk of violence from patients or other workers. However this may be a price which has to be accepted, if nurses wish to be accepted as professional colleagues.

Education

One of the most difficult challenges facing nursing schools is finding effective, yet cost efficient ways to encourage mentorship and support of nursing students by ward nurses. Yet, as Laschinger describes, senior nurses can be devastating towards students. Encouraging appropriate behaviour towards students will require a coordinated effort from educational and health care organizations. The Vancouver Island Health Authority (VIHA) (2003) has a Human Rights Policy which states “VIHA supports the principle that all employees, medical and allied staff, *students* [italics added], volunteers, patients, clients, residents and visitors are entitled to a work and service environment that is free from any form of discrimination and discriminatory harassment” (p. 1). Protocols and procedures are in place which outline what actions may be taken in the event of harassment, yet harassment of students continues to be an issue. Better education of current staff about the benefits of working with students, and the consequences of inappropriate behaviours, needs to be undertaken.

Nurse educators have a responsibility to monitor their own behaviours, and those of their colleagues, and to intervene on students’ behalf when required. Faculty organizations and education institutions need to ensure that protocols are in place to support faculty who undertake such actions.

Freshwater (2000) and Freire (1970) both discuss the role of education in maintaining a culture of oppression. Faculty who develop nursing curriculum need to be aware of the potential for students to embed the culture of subordination and horizontal violence, and work actively, not passively, against this. Current nursing curricula do include information on feminism, oppression and oppressed group behaviour, however new ways of teaching this are needed, since current nursing education is not providing students with the protection they require to avoid being eaten when entering hostile practice environments.

Practice

Laschinger (2004) identifies nurses' perception that they are respected and valued by management as a key to improving nurses' work life. She further states that "empowerment structures in the work environment were important predictors of nurses' perceptions of respect" (p. 362). Implementing changes to health care planning and administration to include frontline nurses in decision making is one action with potential to improve self esteem and moral. According to Bamford (2000) New Zealand has had success implementing a Shared Governance system in health care, resulting in increased nurse and midwife participation, commitment and morale. However, I will caution that such changes need to be sincerely undertaken, and to involve nurses and other health care workers at all levels, or feelings of betrayal and disillusionment will in fact worsen.

Self-care is another area where health care facilities, in my experience, fall short. Frontline nurses, who frequently work long shifts, often have difficulty enacting self-care even when aware that they should. Encouraging nurses to learn more about, and

undertake to self care needs to be included not only in nursing education, but in employee programs. This means developing resources, such as exercise or child care facilities, or educational opportunities, and making them available to front line nurses.

We must make sure that administrators and leaders, whether in nursing or other disciplines, at every level throughout the health care system, from unit managers to the most senior executives, are aware of the effect of conflict on workplace environments. In order to create change, it is important that health care workers know about the extent of the problem of conflict, its impact on the individual, and its impact on the system. Acknowledging and understanding the costs associated with conflict — for example, increased sick time and decreased nurse retention — is equally important in providing motivation for change as the nursing shortage and the economic strain on the health care system grow. We must establish guidelines that make it clear to all participants within the system that abuse, bullying, and other negative forms of conflict will not be tolerated towards nurses, as they are not tolerated towards any others within the system. Making conflict-resolution training available as part of both basic and continuing nursing education seems a logical first step towards developing safer, more rewarding practice environments. Such education needs to be made available to nurses, and they must be given the time and resources to integrate this skill into their repertoire.

Summary and Conclusion

Nurses experience conflict, of various types and with many different people, as an unpleasant, potentially traumatic, and all too frequent event in their working lives. In spite of the many skills that nurses bring to the workplace, few seem adequately prepared

to cope with these types of interactions, nor with the stress that results from them. Further, conflict within our professional ranks and organizations detracts from our ability to present a strong, unified voice and, thus, to participate effectively in the restructuring of health care as it occurs in both this province and this country. This study was conducted to explore nurses' experiences of conflict in the workplace, with the hope that we could start to learn about how nurses may, individually and collectively, address conflict in positive and collaborative ways.

Workplace conflict, in all its forms, is a major issue confronting the frontline nurse. My belief is that we must first acknowledge the extent of workplace conflict for nurses, and then learn ways to address nurses' unique issues around conflict, if we are to formulate a united vision and have an effective political voice in shaping health care in the years to come, to create work environments that are healthy for both patients and staff, and to maintain a healthy and growing professional body.

“Tell me the weight of a snowflake,” a sparrow asked a wild dove.

“Nothing more than nothing,” was the answer.

“In that case I must tell you a marvellous story,” the sparrow said:

“I sat on a branch of fir, close to its trunk, when it began to snow, not heavily, not in a giant blizzard, no, just like in a dream, without any violence. Since I didn’t have anything better to do, I counted the snowflakes settling on the twigs and needles of my branch. Their number was exactly 3,741,952.

When the next snowflake dropped onto the branch — nothing more than nothing, as you say — the branch broke off.”

Having said that, the sparrow flew away.

The dove, since Noah’s time an authority on change, thought about the story for a while and finally said to herself:

“Perhaps there is only one person’s voice lacking for peace to come about in the world.”

Related by Kurt Kauter, African Great Lakes Initiative Newsletter, May 10, 2004

REFERENCES

- Ahman, E. (1994). Family-centered care: The time has come. *Pediatric Nursing*, 20 (1), 52–53.
- Ahuja, J., & Marshall, P. (2003). Conflict in the emergency department: Retreat in order to advance. *Canadian Journal of Emergency Medicine*, 5(6), 429–423.
- Alavi, C., & Cattoni, J. (1995). Good nurse, bad nurse.... *Journal of Advanced Nursing*, 21(2), 344–349.
- Anderson & Parish. (2003). Report of workplace violence by Hispanic nurses. *Journal of Transcultural Nursing*, 14,(3), 237-243.
- Araujo, S., and Sofield, L. (2001). Words can hurt! Retrieved October 23, 2004, from <https://home.comcast.net/~laura08723/article2.htm>
- Archer-Gift, C. (2003a). Violence towards the caregiver: a growing crisis for professional nursing. *Michigan Nurse*, 76(1). Retrieved February 25, 2004, from the CINAHL database.
- Archer-Gift, C. (2003b). Violence towards the caregiver: a growing crisis for professional nursing. *Michigan Nurse*, 76(2). Retrieved February 25, 2004, from the CINAHL database.
- Atawneh, F.A., Zahid, M.A., Al-Sahlawi, K.S., Shahid, A.A., & Al-Farrah, M.H. (2003). Violence against nurse in hospitals: Prevalence and effects. *British Journal of Nursing*, 12(2), 102-107.
- Attridge, C.B. (1996). Analysis of powerlessness in nursing work. *Canadian Journal of Nursing Administration*, 9(2), 36–59.

- Beck, C.T. (2001). Caring within nursing education: a metasynthesis. *Journal of Nursing Education, 40*(3), 101-109.
- Beck, C.T. (2003). Initiation into qualitative data analysis. *Journal of Nursing Education, 42*(5), 231-234.
- Beech, B. (2004). Beating the bullies. *Emergency Nurse, 12*(2), 35.
- Beech, B., & Leather, P. (2003). Issues and innovations in nursing education: Evaluating a management of aggression unit for student nurses. *Journal of Advanced Nursing, 44*(6), 603-612.
- Begley, C.M., & White, P. (2003). Irish nursing students' changing self-esteem and fear of negative evaluation during their preregistration programme. *Journal of Advanced Nursing, 42*(4), 390-401.
- Bent, K.N. (1993). Perspectives on critical and feminist theory in developing nursing praxis. *Journal of Professional Nursing, 9*(5), 296-303.
- Berg, A., & Hallberg, I.R. (1999). Effects of systematic clinical supervision on psychiatric nurse' sense of coherence, creativity, work-related strain, job satisfaction and view of the effects from clinical supervision: a pre-post test design. *Journal of Psychiatric and Mental Health Nursing, 6*, 371-381.
- Blanton, B.M., Lybecker, C., & Spring, N.M. (1998). *Nurse advocate: Nurses and workplace violence*. Retrieved April 21, 2002, from <http://www.nurseadvocate.org>
- British Columbia Nurses' Union. (1998). Working too hard. *Update, 17*(3), 7-31.
- Bronner, G., Peretz, C., & Ehrenfeld, M. (2003). Sexual harassment of nurses and nursing students. *Journal of Advanced Nursing, 42*(6), 637-644.

- Brooks, A., Thomas, S., & Droppleman, P. (1996). From frustration to red fury: A description of work-related anger by male registered nurses. *Nursing Forum*, 31(3), 4–15.
- Bruce, B., & Ritchie, J. (1997). Nurses' practices and perceptions of family centred care. *Journal of Pediatric Nursing*, 12(4), 214–222.
- Buback, D. (2004). Home study program: Assertiveness training to prevent verbal abuse in the OR. *AORN Journal*, 79(1), 147–170.
- Bucknall, T., & Thomas, S. (1997). Nurses' reflections on problems associated with decision-making in critical care settings. *Journal of Advanced Nursing*, 25(2), 229–237.
- Canadian Nurses Association. (1990). *Nurse retention and quality of work life: A national perspective*. Ottawa: Author.
- Commission for Healthcare Audit and Inspection. (2004). *Summary report: Analysis of the 2003 NHS staff survey*. Retrieved November 18, 2004, from <http://www.healthcarecommission.org.uk/assetRoot/04/00/77/48/04007748.pdf>
- Cook, J.K. (2001). Exploring the impact of physician verbal abuse on perioperative nurses. *Association of Perioperative Nurses Journal*, 74.(3), 322-327.
- Coomaraswamy, R. (1995). Some reflections on violence against women. *Canadian Women's Studies*, 15, (2&3), 19-23.
- Cooper, C., & Swanson, N. (2002). Workplace violence in the health sector – State of the art. Geneva: International Labour Office/International Council of Nurses/World Health Organization/Public Services International Joint Programme on Workplace

- Violence in the Health Sector. Recovered from
<http://www.icn.ch/SewWorkplace/WPViolenceSAP.pdf>, November 16, 2004.
- Corser, W.D. (2000). The contemporary nurse-physician relationship: Insights from scholars outside the two professions. *Nursing Outlook*, 48(6), 263–267.
- Cowert, M.E., & Serow, W.J. (Eds.). (1992). *Nurses in the workplace*. Newbury Park, CA: Sage.
- Cox, H.C. (1987). Verbal abuse in nursing: report of a study. *Nursing Management*, 18(11), 47-50.
- Cox, H.C., & Kerfoot, K.M. (1990). Nursing management considerations: Changing verbal abuse into a syntonic interactive mode: The nurse manager's challenge. *Nursing Economics*, 8(6), 416–417.
- Cox, K.B. (2001). The effects of unit morale and interpersonal relations on conflict in the nursing unit. *Journal of Advanced Nursing Science*, 35(1), 17–25.
- Curley, M.A.Q. (1997). Mutuality: An expression of nursing presence. *Journal of Pediatric Nursing*, 12(4), 208–213.
- Daiski, I. (2004). Changing nurses' dis-empowering relationship patterns. *Journal of Advanced Nursing*, 48(1), 43-49.
- Davis, B., & Thorburn, B. (1999). Quality of nurses' work life: Strategies for enhancement. *Canadian Journal of Nursing Leadership*, 12(4), 11–15.
- DeSantis, L., & Ugarriza, D.N. (2000). The concept of theme as used in qualitative nursing research. *Western Journal of Nursing Research*, 22(3), 351-372.
- Deutsch, M. (1973). Conflicts: Productive and destructive. In F.E. Jandt (Ed.), *Conflict resolution through communication* (pp. 155–197). New York: Harper & Row.

- Dreher, M. (1994). Qualitative research methods from the reviewer's perspective. In J.M. Morse (Ed.), *Critical issues in qualitative research methods* (pp 281–297). Thousand Oaks, CA: Sage.
- Driedger, S.D. (1997, April 28). The nurses: Front-line care-givers are burned out. Is it any wonder? *Maclean's*, 24–33.
- Duchscher, J.E.B. (2001). Out in the real world: Newly graduated nurses in acute-care speak out. *Journal of Nursing Administration*, 31(9), 426-438.
- Dunn, H. (2003). Horizontal violence among nurses in the operating room. *Association of Perioperative Nurses Journal*, 78(6), 977-988.
- Dunst, C.J., & Trivette, C.M. (1996). Empowerment, effective helping practices and family-centred care. *Pediatric Nursing*, 22(4), 334–343.
- Early, R. (1997). Qualitative data analysis. *Nexus Consortium: Workshop for the Office of the Auditor General, February 28, 1997*. Sponsored by the Canadian Evaluation Society, pp. 1-17.
- Farrell, G.A. (1997). Aggression in clinical settings: Nurses' views. *Journal of Advanced Nursing*, 25(3), 501-508.
- Farrell, G.A. (1999). Aggression in clinical settings: Nurses' views – a follow-up study. *Journal of Advanced Nursing*, 29(3), 532-541.
- Farrell, G.A. (2001). From tall poppies to squashed weeds*: Why don't nurses pull together more? *Journal of Advanced Nursing*, 35(1), 26-33.
- Farrell, G.A., & Dares, G. (1999). Nursing staff satisfaction on a mental health unit. *Australian and New Zealand Journal of Mental Health Nursing*, 8(2), 51-57.

- Freire, P. (1970/1997). *Pedagogy of the oppressed*. (M. Bergman Ramos, Trans.). New York: Continuum. (Original work published 1970).
- Freshwater, D. (2000). Crosscurrents: Against cultural narration in nursing. *Journal of Advanced Nursing*, 32(2), 481–484.
- Frisch, N.C., & Kelley, J. (1996) *Healing Life's Crises: A Guide for Nurses*. Albany, NY: Delmar
- Gardner, D.L. (1992). Conflict and retention of new graduate nurses. *Western Journal of Nursing Research*, 14I(1), 76-85.
- Gillespie, M. (2002). Student-teacher connection in clinical nursing education. *Journal of Advanced Nursing*, (37(6), 566-576.
- Gordon, S. (2000). Necessary nursing care. *Nursing Inquiry*, 7(4), 217–219.
- Gordon, S., & Grady, E.M. (1995). What's in a name? *American Journal of Nursing*, 95,(8), 31–33.
- Haddigan, K. (1996). *Conflict resolution* (8th ed.). New Westminster, BC: Justice Institute of BC, Centre for Conflict Resolution Training.
- Haddigan, K. (1997). *Negotiation* (6th Ed.) New Westminster, BC: Justice Institute of BC, Centre for Conflict Resolution Training.
- Hall, J.M., Stevens, P.E., & Meleis, A.I. (1994). Marginalization: A guiding concept for valuing diversity in nursing knowledge development. *Advances in Nursing Science*, 16,(4), 23-41.
- Henderson, A.D. (2003). Nurses and workplace violence: Nurses experiences of verbal and physical abuse at work. *Nursing Leadership*, 16,(4), 82-98.

- Herdman, E.A. (2001). The illusion of progress in nursing. *Nursing Philosophy*, 2, (1), 4-13.
- Hrinkanic, J. (1998, November). Negotiation: A skill for nurses. *The Canadian Nurse*, 36-39.
- Hutchinson S., & Wilson, H. (1994). Research and therapeutic interviews: A poststructuralist perspective. In J.M. Morse (Ed.), *Critical issues in qualitative research methods* (pp. 301-315). Thousand Oaks: Sage.
- Institute for Safe Medication Practices. (2004a, March 11). Intimidation: Practitioners speak up about this unresolved problem (Part I). Recovered from <http://www.ismp.org/MSAarticles/intimidation.htm>, September 25, 2004.
- Institute for Safe Medication Practices. (2004b, March 25). Intimidation: Mapping a plan for cultural change in healthcare (Part II). Recovered from <http://www.ismp.org/MSAarticles/intimidation2.htm>, September 25, 2004.
- Jackson, D., Clare, J., & Mannix, J. (2002). Who would want to be a nurse? Violence in the workplace: a factor in recruitment and retention. *Journal of Nursing Management*, 10, (1), 13-20.
- Justice Institute of BC, Centre for Conflict Resolution Training. (1994). *Dealing with anger in conflict situations* (5th Ed.). New Westminster, BC: Author.
- Johnson, D., & Johnson, F. (1994). The use of power. In *Joining together: Group theory and group skills* (5th ed.), 414-429. Boston: Allyn and Bacon.
- Keen, P. (1991). Caring for ourselves. In R.M. Neil & R. Watts (Eds), *Caring and nursing: Explorations in feminist perspectives* (pp. 173-188). New York: National League for Nursing.

- Kendall, J. (1992). Fighting back: Promoting emancipatory nursing actions. *Advances in Nursing Science, 15*(2), 1-15.
- Kunaviktikul, W., Nuntasupawat, R., Srisuphan, W., & Booth, R.Z. (2000). Relationships among conflict, conflict management, job satisfaction, intent to stay, and turnover of professional nurses in Thailand. *Nursing and Health Science, 2*(1), 9-16.
- Kvale, S. (1996). *InterViews: An Introduction to Qualitative Research Interviewing*. Thousand Oaks, CA: Sage.
- Laschinger, H.K.S. (2004). Hospital nurses' perceptions of respect and organizational justice. *Journal of Nursing Administration, 7*(8), 354-364.
- Lee, M.B., & Saeed, I. (2001). Oppression and horizontal violence: The case of nurses in Pakistan. *Nursing Forum, 36*(1), 15-24.
- Lincoln, Y.S. (1998). From understanding to action: New imperatives, new criteria, new methods for interpretive researchers. *Theory and Research in Social Education, 26*(1), 12-29.
- Luborsky, M.R. (1993). The identification and analysis of themes and patterns. In J.F. Gubrium (Ed.), *Qualitative Methods in Aging Research*, pp. 189-210. Thousand Oaks, CA: Sage.
- McKenna, B., Smith, N.A., Poole, S.J., & Coverdale, J.H. (2003). Horizontal violence: Experiences of registered nurses in their first year of practice. *Journal of Advanced Nursing, 42*(1), 90-96.
- Meissner, J.E. (1986). Nurses: Are we eating our young? *Nursing, 16*(3), 51-53.
- Meissner, J.E. (1999). Nurses: Are we *still* eating our young? *Nursing, 29*(11), 42-43.

- Molzahn, A.E., McDonald, M., O'Loughlin, C., & Starzomski, R. (In press). Chinese-Canadian beliefs toward organ donation. *Qualitative Health Research*.
- Molzahn, A., & Sheilds, L. (1997). Qualitative research in nephrology nursing. *ANNA Journal*, 24(1), 13–19.
- Namie, G. (2003). The Workplace Bullying and Trauma Institute (WBTI) 2003 Report on Abusive Workplaces. Retrieved September 12, 2004, from <http://www.bullyinginstitute.org/home/twd/bb/res.html>
- Namie, G. & Namie, R. (2000). *The Bully at Work*. Naperville, IL: Sourcebooks.
- Neuman, J.H. (2000, January 28). Injustice, stress and bullying can be expensive. Retrieved September 12, 2004, from <http://www.bullyinginstitute.org/home/twd/bb/res/neuman1.html>
- Nursing90*. (1990). The nurse doctor game: Are the rules changing? *Nursing90*, 20,(6), 54.
- Nursing91*, (Eds.). (1991). The nurse doctor game. *Nursing91*, 21,(6), 60-64.
- Nursing99*. (Eds.) (1999). Nurses: Are we still eating our young? *Nursing99*, 29(11), 49–50.
- Polit, D.F., Beck, C.T., & Hungler, B.P. (2001). *Essentials of nursing research: methods, appraisal, and utilization* (5th ed.). Philadelphia: Lippincott.
- Priest, A. (1999, April 22). Who wants to be Florence Nightingale? *Monday Magazine*, pp. 8-10.
- Quine, L. (1999). Workplace bullying in NHS community trust: staff questionnaire survey. *British Medical Journal*, 318(7178), 228-232.

- Quine, L. (2001). Workplace bullying in nurses. *Journal of Health Psychology*, 6(1), 73-84.
- Randle, J. (2001). The effect of 3-year pre-registration training course on students' self-esteem. *Journal of Clinical Nursing*, 10(2), 293-300.
- Randle, J.(2003a). Bullying in the nursing profession. *Journal of Advanced Nursing*, 43(4), 395-401.
- Randle, J. (2003b). Changes in self-esteem during a 3-year pre-registration Diploma in Higher Education (Nursing) programme. *Journal of Clinical Nursing*, 12(1),142-143.
- Registered Nurses Association of BC. (2001, December). News releases: The authority of registered nurses must match the responsibilities they have in the workplace, says RNABC in a brief to government on the Health Professions Council's final report on registered nurses' scope of practice. Retrieved October 24, 2004, from http://www.rnabc.bc.ca/publicandmedia/news_releases/news/hpcregulatingdec01.htm.
- Roberts, S.J. (1983). Oppressed group behavior: Implications for nursing. *Advances in Nursing Science*, 5(4), 21-30.
- Roberts, S.J. (2000). Development of a positive professional identity: Liberating oneself from the oppressor within. *Advances in Nursing Science*, 22(4), 71-82.
- Sandelowski, M. (1986). The problem of rigor in qualitative research. *Advances in Nursing Science*, 8(3), 27-37.
- Sandelowski, M. (1993). Rigor or rigor mortis: The problem of rigor in qualitative research revisited. *Advances in Nursing Science*, 16(2), 1-8.

- Sandelowski, M. (1997). "To be of use": Enhancing the utility of qualitative research. *Nursing Outlook*, 45(3), 125–132.
- Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health*, 23(4), 334–340.
- Shor, I. (1993). Education is politics: Paulo Freire's critical pedagogy. In P. McLaren & P. Leonard (Eds.), *Paulo Freire: A Critical Encounter* (pp. 25–35). London: Routledge.
- Sieh, A., & Brentin, L.K. (1997). *The nurse communicates*. Philadelphia: W.B. Saunders.
- Sieloff, C.L., (1999, November). Staying power. *Nursing Management*, 30, 33–34.
- Skillings, L.N. (1992). Perceptions and feelings of nurses about horizontal violence as an expression of oppressed group behavior. In J.L. Thompson, D.G. Allen & L. Rodriques-Fisher (Eds.), *Critique, resistance and action – working papers in the politics of nursing* (pp.167-185). New York: National League for Nursing.
- Smith, M., Droppleman, P., & Thomas, S.P. (1996). Under assault: The experience of work-related anger in female registered nurses. *Nursing Forum*, 31(1), 22–33.
- Sofield, L. & Salmond, S.W. (2003). Workplace violence: A focus on verbal abuse and intent to leave the organization. *Orthopaedic Nursing*, 22(4), 274–283.
- Stringer, H. (2001). Raging bullies. *Nurse Week*. Retrieved October 23, 2004, from <https://home.comcast.net/~laura08723mary.htm>
- Tabone, S. (2001). TNA takes zero tolerance position on physician abuse of RNs. *Texas Nursing* 75(5). Retrieved July 8, 2003, from <http://web2.epnet.com/citation.asp>
- Tanner, C.A., Benner, P., Chesla, C., & Gordon, D.R. (1993). The phenomenology of knowing the patient. *Image: Journal of Nursing Scholarship*, 25(4), 273–280.

- Taylor, B. (2001). Identifying and transforming dysfunctional nurse-nurse relationships through reflective practice and action research. *International Journal of Nursing Practice*, 7(6), 406-413.
- Thomas, S.P. (2003). 'Horizontal hostility' Nurses against themselves: how to resolve this threat to retention. *American Journal of Nursing*, 103,(10), 87-91.
- Thorne, S., Kirkham, S.R., & MacDonald-Emes, J. (1997). Interpretive description: A noncategorical qualitative alternative for developing nursing knowledge. *Research in Nursing and Health*, 20, 169-177.
- Turnbull, J. (1995). Hitting back and the bullies *Nursing Times*, 18(3), 24-27.
- Uzon, O. (2003). Perceptions and experiences of nurses in Turkey about verbal abuse in clinical settings. *Journal of Nursing Scholarship*, 35(1), 81-85.
- von Post, I. (1998). Perioperative nurses' encounter with value conflicts. *Scandinavian Journal of Caring Sciences*, 12(2), 81-88.
- Wieck, K.L., Prydun, M., & Walsh, T. (2002). What the emerging workforce wants in its leaders. *Journal of Nursing Scholarship*, 34(3), 283-288.
- Worthington, K. (2001). Stress and overwork top nurses' concerns. *American Journal of Nursing*, 101(12). Retrieved November 18, 2004 from <http://www.nursingworld.org/AJN/2001/Dec/health.htm>
- Zelek, B., & Phillips, S.P. (2003). Gender and power: Nurses and doctors in Canada. *International Journal for Equity in Health*, 2(1). Retrieved September 25, 2004 from <http://www.equityhealthj.com/content/pdf/1475-9276-2-1.pdf>



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Appendix A

Appendixes

Human Research Ethics Board Certificate of Approval

<u>Principal Investigator</u> Stephen Bishop Graduate Student <u>Co-Investigator(s):</u>	<u>Department/School</u> HUMA	<u>Supervisor</u> Anita Molzahn	
<u>Project Title:</u> Nurses and Conflict: Workplace Experiences			
<u>Protocol No.</u> 99225	<u>Approval Date</u> 22-Jul-99	<u>Start Date</u> 22-Jul-99	<u>End Date</u> 21-Jul-00

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concludes that, in all respects, the proposed research meets appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Subjects.

Dr. J. Howard Brunt
Associate Vice-President, Research

This Certificate of Approval is valid for the above term provided there is no change in the procedures. Extensions or minor amendments may be granted upon receipt of a "Research Status" form.

99225 Bishop, Stephen

*Appendix B***Letter of Consent**

I, _____, hereby give consent for my participation in this study, entitled Nurses and Conflict: Workplace Experiences.

I understand that the person responsible for this study is Stephen Bishop, 250-721-5255, Masters in Nursing candidate at the University of Victoria, Faculty of Health and Social Development, and that the study is undertaken as his graduate thesis, supervised by Dr. Anita Molzahn, 250-721-8050.

Stephen Bishop has explained to me that this study has the following objective: To explore how frontline acute care nurses experience, perceive and understand workplace conflict.

I understand that participation in this study is entirely voluntary, and that my refusal to participate, or my withdrawal from the study at any point, will have no consequences to myself in terms of employment or in any other way.

I understand that the study will involve one or two interviews in person, lasting from one to two hours, and that there is the possibility of a third, shorter, interview by telephone. Stephen Bishop has explained to me that he will audiotape record and take notes of any interviews he conducts with me. Precautions for confidentiality will be taken by coding each interview tape numerically. The tapes will not be identified by name, and will be kept in a locked location in his home. Only Stephen Bishop will have access to the tapes, which will be destroyed following either completion of or withdrawal from his thesis. I understand that transcripts of the tapes, with all identifying information removed, will be kept for seven years following his thesis, and then destroyed. Throughout the research process, and including any discussions with Dr. Molzahn or others, a code name will be used to protect my identity. Any and all other identifying information, including but not restricted to my places of residence and work, will be removed. The confidentiality of any persons whom I discuss, whether named or not, will be similarly protected using pseudonyms and the removal of anything which might identify their community or place of work.

I understand that during the interview(s) I may decline to answer any specific questions, and that I may choose at any time to withdraw from further participation in the study. Should I choose to withdraw from the study I may request all tapes, transcripts and information arising from my participation be returned to me or destroyed, and not used in the study.

I recognize that there is the potential for me to experience some emotional distress from speaking about my experiences with workplace conflict. Stephen Bishop has discussed

this with me, and has both informed me that I may delay or stop an interview at any time, and has identified counselling services available to me if required.

If I have any questions or concerns about the study, or my rights as a participant, I can contact Stephen Bishop or Dr. Molzahn by phone, or I may ask questions at any time during an interview.

My signature below indicates that I have read and understand this letter of consent and that I am willing to participate in this study. A signed copy of this consent form will be given to me for my records.

Participant's Signature

Date

Appendix C

Questions from Method section, p. 35.

For instance, if the interview seemed stalled, and if the participant had not brought up one of these up independently, I would suggest one of the following:

- What, to you, are the key aspects of these conflict situations?
- Please tell me about another incident involving conflict, which you have experienced at work.
- Have you had any training to assist you with workplace conflict situations? If so, please describe it. Has it been useful? If so, in what ways?
- What support is available to you from your employer, professional organizations, or other sources?
- How does conflict at work affect your life, both at work and at home?
- What do you believe would assist you in coping more effectively and positively with the conflicts you experience at work?