

NEW NURSES' EXPERIENCES IN THE LATERAL VIOLENCE ZONE:

A GROUNDED THEORY

by

MARY LILLIAN HANKS

NIRMALA EREVELLES, COMMITTEE CHAIR

SUSAN APPEL

BECKY ATKINSON

KAREN MCCARTY

ALAN WEBB

A DISSERTATION

Submitted in partial fulfillment of the requirements  
for the degree of Doctor of Education  
in the Department of Educational Leadership, Policy, and Technology Studies  
in the Graduate School of  
The University of Alabama

TUSCALOOSA, ALABAMA

2017

Copyright Mary Lillian Hanks 2017  
ALL RIGHTS RESERVED

## ABSTRACT

The impact of lateral violence on nurses and the nursing profession contribute to the nursing shortage and has negative effects on patient care (Vessey, DeMarco, Gaffney, & Budin, 2009). According to the Center for American Nurses (CENTER, 2008), lateral violence and bullying are an everyday occurrence among health care professionals. Nurses must gain real world experiences to deliver quality, safe, and effective patient care (Benner, Surphen, Leonard, & Day, 2010). Unfortunately, there are experienced nurses who are unable or unwilling to help novice nurses transition into their new role. Impaired relationships among nurses can lead to absenteeism, medical errors, and poor work performance, including an unwillingness to ask questions for fear of humiliation or reprimand by a peer, and this, in turn has a negative impact on patient outcomes (The Joint Commission [TJC], 2012). Recognizing that incivility is associated with a lack of professionalism creates an opportunity for nursing academia and practice to forge a relationship to address this issue (Shephard, 2014). This qualitative study uses a grounded theory approach to examine the lateral violence encounters of 12 new nurse graduates and concludes with reflections on the role of nursing education in facilitating behaviors that support the creation and maintenance of healthy work environments for all nurses. Exploring the need to focus attention on affective-based practice methodologies to ease the burden of lateral violence in nursing can add to the science of nursing.

## DEDICATION

This dissertation is dedicated to my parents, Larry Lee and Mary Catherine Wrenn. First, I honor my father, who passed away during my first semester of graduate school. His bravery, boldness, and strength has been instrumental in molding me into the woman I am today. Second, my mother's love, patience, and unwavering belief in me made me believe that I could move mountains and heal the hearts and souls of those I would encounter. She was right. She taught me that every person I encountered deserved to be treated with respect and dignity. I love you both. I hope that I made you proud.

I would also like to dedicate this dissertation to my children, Braxton and Briana Hanks, my two heartbeats. Thank you for being patient and traveling on this journey with me. I hope it has taught you, that with a little hard work and a whole lot of faith and endurance, all things are possible.

## LIST OF ABBREVIATIONS

AACN	American Association of Colleges of Nursing
AACN	American Association of Critical-Care Nurses
ADN	Associate Degree in Nursing
ANA	American Nurses Association
BSN	Bachelor of Science in Nursing
IOM	Institute of Medicine
ISMP	Institute of Safe Medication Practices
LPN/LVN	Licensed Practical/Licensed Vocational Nurse
LV	Lateral Violence
MSN	Master of Science in Nursing
NCLEX-RN	National Licensure Examination for Registered Nurses
NCSBN	National Council of State Boards of Nursing
RN	Registered Nurse
TJC	The Joint Commission

## ACKNOWLEDGMENTS

A special thank you to Wallace and Virginia Hanks, my in-laws, for being there for my children when I could not, and to my aunts Lillie Granger and Ollie Giles for being there for my mother when I could not.

Thank you also to my dissertation committee members: Dr. Susan Appel, Dr. Becky Atkinson, and Dr. Karen McCarty. A special thank you to Dr. Nirmala Erevelles, my dissertation chairperson, who met with me throughout this process and guided me on this journey of discovery. Her encouragement and guidance made the qualitative research experience a delight. And to Dr. Alan Webb, the qualitative methodolgist genius, thank you for your expert knowledge in qualitative methodology and graciousness in answering every question I had throughout this process. I could not have done this without you.

I would like to thank the National League for Nurses Foundation for awarding me a Nursing Education Scholarship to help me complete my education and this dissertation.

Finally, I want to acknowledge all of my students and every nurse who has ever felt the sting of lateral violence. I challenge each of you to remember what it means to be a nurse and find your voice. Your patients need you and I stand with each of you.

## CONTENTS

ABSTRACT.....	ii
DEDICATION.....	iii
LIST OF ABBREVIATIONS.....	iv
ACKNOWLEDGMENTS .....	v
LIST OF TABLES .....	xi
LIST OF FIGURES .....	xii
CHAPTER ONE INTRODUCTION.....	1
Statement of the Problem.....	3
Statement of Purpose .....	4
Research Questions.....	4
Significance of Study.....	5
Limitations of Study .....	5
Delimitations.....	6
Definition of Key Terms.....	6
Overview of Literature.....	8
Methodology.....	10
Chapter Summary .....	12
CHAPTER TWO REVIEW OF LITERATURE.....	14
Lateral Violence: Workplace Violence and Bullying.....	15
The Prevalence of Lateral Violence in Nursing: What is Known .....	16

Defining Professionalism and its Role in Nursing.....	25
The Role of Professionalism and Caring in the Nursing Workforce.....	29
Promoting Professionalism in Nursing: Articulation and the Career Ladder.....	31
The Role of Care in Other Professions.....	35
Professionalism and Caring in Non-nursing Professions.....	37
Using an Ethics of Care as a Professional Model for Nurses.....	43
Nel Noddings' Ethics of Care.....	44
Joan Tronto's Ethic of Care.....	46
The Importance of an Ethics of Care in Nursing.....	48
Gaps in the Literature.....	51
Chapter Summary.....	53
CHAPTER THREE METHODOLOGY.....	54
Research Questions.....	54
Setting of Research.....	54
Participant Selection and Recruitment.....	55
Sample Selection.....	57
Methodology Selection.....	58
Data Collection.....	60
Semi-structured Interviews.....	62
Researcher-generated Documents.....	62
Data Analysis.....	63
Theoretical Framework.....	69

Validity and Reliability.....	70
Validity .....	70
Timeline of Study .....	71
Ethical Considerations .....	71
Strengths and Limitations .....	72
Researcher Positionality.....	72
Chapter Summary .....	76
CHAPTER FOUR FINDINGS.....	78
Lateral Violence as Defined by Nurse Participants: The Lateral Violence Zone.....	79
Experiencing Lateral Violence in Nursing: The Reckoning Zone.....	80
Engineered Failure.....	81
Detachment Syndrome.....	83
Wavering Foundation .....	85
Judgment Days.....	88
Culture of Lack .....	91
Self-Preservation Zone.....	92
Building Walls .....	93
Assimilation.....	95
Attrition.....	96
Affective Zone .....	96
Teaching the “Code of Ethics for Nursing” Matters .....	97
Early Introduction of Lateral Violence Across Nursing Curricula.....	100
Discerning the Good Preceptor.....	101

Zone of Silence .....	103
Role Confusion .....	103
Devaluation of Nursing.....	104
Orchestrated Unawareness.....	106
Chapter Summary .....	106
CHAPTER FIVE DISCUSSION, RECOMMENDATIONS, CONCLUSION .....	109
Discussion.....	110
How do Novice Nurses Experience Lateral Violence in the Workplace?.....	111
How do Novice Nurses Reconcile Their Commitment to Professional Care With Their Experiences of Lateral Violence in the Workplace?.....	112
What Pedagogical Interventions can be Used to Address Lateral Violence in the Workplace? .....	113
Why do Nurses Struggle to Give Voice to Affective Issues Within the Profession? .....	116
Tronto’s Ethic of Care and the Issue of Lateral Violence .....	118
Professionalism and Lateral Violence .....	123
Implications.....	126
Nursing Education, Recruitment .....	126
Recommendations.....	129
Hanks’ Bridge to Creating a Healthy Work Environment.....	129
Hanks’ Preceptor Guidelines .....	133
Limitations .....	135
Future Research .....	135
Conclusion .....	136
REFERENCES .....	138

APPENDIX A LATERAL VIOLENCE INVITATION FLYER.....	147
APPENDIX B INVITATION TO PARTICIPATE IN RESEARCH.....	149
APPENDIX C DEMOGRAPHIC SURVEY WITH LATERAL VIOLENCE DEFINITION.....	151
APPENDIX D LATERAL VIOLENCE CASE SCENARIOS .....	154
APPENDIX E INSTITUTIONAL REVIEW BOARD APPROVAL AND CONSENT FORM.....	159
APPENDIX F SAMPLE MEMOS .....	164
APPENDIX G SEMI-STRUCTURED INTERVIEW QUESTIONS .....	171
APPENDIX H EXCEPTS FROM INTERVIEWS OF FIVE NURSE PARTICIPANTS .....	173
APPENDIX I SAMPLE CODES AND THEMES DURING DATA ANALYSIS .....	183
APPENDIX J CASE SCENARIO FINDINGS ON LATERAL VIOLENCE .....	187

## LIST OF TABLES

1. Description of Nurse Participants .....	56
2. Holistic Coding for Lateral Violence Interviews.....	66
3. In Vivo Coding for Lateral Violence Interviews .....	58
4. Case Scenario 1 Responses.....	189
5. Case Scenario 2 Responses.....	190
6. Case Scenario 3 Responses.....	192
7. Case Scenario 4 Responses.....	193

## LIST OF FIGURES

1. Bridge of Nursing Professionalism and Accountability .....	130
---	-----

## CHAPTER ONE

### INTRODUCTION

Although there are debates among nurses about whether compassionate care should remain a professional construct of nursing, the fact that patients deserve quality, effective, efficient, and safe health care is not debatable. Another point of emphasis that all nurses can agree upon is that the current nursing shortage and lack of skilled, expert nurses will ultimately affect the care we give our patients [American Association of Colleges of Nursing (AACN), 2011; Center for American Nurses (CENTER), 2008; Sheridan-Leos, 2008]. There is an urgency in the nursing profession to educate, nurture, and develop nurses who are capable of gaining expertise. To be clear, this expertise is not gained in a classroom or simulation lab; it is the collaborative effect of academic and clinical practice experience that leads to what Patricia Benner termed “skilled know-how” and “ethical comportment” (Benner, Surphen, Leonard, & Day, 2010). Nurses need to learn and apply principles of evidence-based practice and gain real world experiences to deliver quality, safe, and effective patient care (Benner et al., 2010). Unfortunately, there are experienced nurses who are unable and/or unwilling to help novice nurses transition into their new role. Recognizing that incivility is associated with a lack of professionalism creates an opportunity for nursing academia and practice to forge a relationship to address this issue (Shephard, 2014).

The impact of lateral violence (LV) on nurses and the nursing profession contributes to the nursing shortage and has negative effects on our patient population. According to the Center for American Nurses (CENTER, 2008), LV and bullying are an everyday occurrence among

health care professionals. Lateral violence is defined as physical, emotional, or verbal abuse of an employee of the same rank or position. In nursing, LV is also described as nurse-to-nurse aggression. Conversely, bullying is abusive, intimidating, or insulting behavior or the abuse of power, which makes another feel humiliated, vulnerable, or threatened and may lead to stress and a decrease in self-esteem (CENTER, 2008). Bullying has a power component that incivility lacks. Nurses report feeling hurt, fearful, anxious, unable to sleep, and suffer from low-self-esteem, panic attacks, and elevated blood pressure as a result of both bullying and incivility (Freshwater, 2000; Hutchinson, Wilkes, Vickers, & Jackson, 2008; Sheridan-Leos, 2008). Organizational expenses as a result of Registered Nurse (RN) turnover and increased workload on remaining staff can range from \$22,000 to \$145,000 depending on geographic locale and specialty area (Jones & Gates, 2007). Impaired relationships among nurses can lead to absenteeism, medical errors, and poor work performance, including an unwillingness to ask questions for fear of humiliation or reprimand by a peer, and this, in turn, has a negative impact on patient outcomes [The Joint Commission (TJC), 2012; Woelfle & McCaffrey, 2007].

Typically, when one conjures up the image of a bully, memories of adolescence come into focus. Either the vision of being harassed by someone physically stronger than the victim or the thought of being the perpetrator of such acts as name-calling, teasing, or physical attack in peer group settings may flood the imagination. Bullying tends to occur most often among peer groups and is fostered by the competitive nature in US society (Hoover, Oliver, & Hazler, 1992). Although this study by Hoover et al. of adolescent bullying occurred years ago, it acknowledged a disturbing trend that still exists, albeit now in the workplace, as well. Students felt that teachers were not aware of bullying behaviors of other students but should have been; or teachers knew and did not care. According to Hutchinson and Hurley (2013), nurse administrators and

nurses in leadership roles respond to incivility and bullying in similar ways. Nurses know that uncivil behaviors occur on their nursing units, but ignore it or participate in it.

The lines between caring and incivility have become blurred on nursing units and in nursing classrooms across the country. This is troublesome for current and future nurses who provide care to patients and are responsible for cultivating a new generation of professional nurse clinicians. This is not to demonize nurses or to ignore the life-saving activities that nurses execute on a daily basis. In an excerpt from Susan Reverby's *Ordered to Care* (1987), May Ayers Burgess asserted, "A criticism of existing conditions is not necessarily a criticism of the person who is caught in those conditions." However, when nurses differ in their attitudes on caring behaviors, an essential component of the *Code of Ethics for Nurses*, and their beliefs on who should be the beneficiary of such behavior, this becomes an issue that nursing education and nursing practice must address. In *The Essentials of Baccalaureate Education for Professional Nursing Practice*, AACN proclaimed, "professionalism and the inherent values of altruism, autonomy, human dignity, integrity, and social justice are fundamental to the discipline of nursing" (2008, p. 4). Likewise, the National League for Nursing (NLN, 2010) defined professional identity with the core values of caring, diversity, ethics, integrity, excellence, holism, and patient-centeredness. Hence, if professionalism and ethics are foundational principles to nursing practice, LV is antithetical to those principles and should not exist in the midst of nurses' work environments.

### **Statement of the Problem**

It was proposed that power structures, theories of oppression, and the biomedical model play a significant role in the making of the nurse as bully (Embree & White, 2010; Freshwater, 2000; Sheridan-Leos, 2008). It was also theorized that gender plays a significant role in the

devaluation of the nursing profession (Croft & Cash, 2012). Due to gender inequalities in an androcentric health care system that restricts nurses from confronting those in positions of power, nurses have limited control over their nursing practice and project their frustrations on to other nurses (Sheridan-Leos, 2008). However, there was scant empirical evidence on how nurses in the United States perceive lateral violence. Furthermore, there was no literature that addressed a possible link between the use of LV tactics in the workplace and how nurses are educated to use professionalism and caring principles to interact with colleagues to limit LV occurrences.

### **Statement of Purpose**

The broad purpose of this qualitative research study was to explain how novice nurses define and understand LV in the workplace. In order to do this, this study (a) explored how novice nurses at the bedside interpret acts perceived to be lateral violence, (b) described how novice nurses' perceptions of professionalism and caring are interrelated, (c) analyzed how educational degree preparation informs professional role formation, and (d) identified ways in which incivility was perceived and challenged by nurses both pedagogically and in clinical nursing practice. Ultimately, this study concludes with reflections on the role of nursing education in facilitating behaviors that will support the creation and maintenance of healthy work environments for all nurses.

### **Research Questions**

The research questions for this study were

1. How do novice nurses experience LV in the workplace?
2. How do novice nurses reconcile their commitment to professional care with their experiences of LV in the workplace?
3. What pedagogical interventions can be used to address LV in the workplace?

### **Significance of Study**

Lateral violence exists in the places where nurses work (Vessey, DeMarco, & DiFazio, 2010). In nursing education and practice, novice faculty and practitioners are being harassed, belittled, and bullied by their peers (Becher & Visovsky, 2012; Clark & Davis-Kenaley, 2011; Clendon & Walker, 2012). The findings of this research benefit nursing faculty, general practitioners, and institutions that employ new nurses by informing those in positions of power to better identify, acknowledge, and negate uncivil practices. First, the research findings help nurses recognize when they are recipients and/or perpetrators of LV. The findings also offer insight into how use of an ethics of care can promote professionalism and ethical behaviors in the workplace among colleagues. Likewise, research findings aim to benefit institutions that employ nurses by making them aware of the behaviors that new nurses confront in the workplace by generating ways to detect LV and offering suggestions to reduce this behavior. Finally, the study informs nursing academia of the importance of pedagogy that addresses an ethics of care across all prelicensure nursing programs, in an effort to create and sustain healthy work spaces for nurses.

### **Limitations of Study**

Twelve nurse participants from the southeastern United States were chosen to participate in this study. All nurse participants worked in areas where there was currently a nursing shortage. Due to the small sample size and subjective nature of qualitative inquiry, the results may not be generalizable and assumptions cannot be made that all nurses with the same educational background or same years of work experience will experience and define LV in the same manner. Because the researcher has seen or witnessed episodes of LV, it is impossible to

remove all researcher bias. Due to the nature of this research study, participants were chosen purposively and not randomly.

### **Delimitations**

This study had certain delimitations. One delimitation was that novice nurses with 2 years of nursing practice or less were chosen for this study. This was because the literature suggested that these are the nurses who most commonly experience LV. Another delimitation was educational background. Only nurses with Associate and Bachelor of Science Degrees were selected for this study to determine if professionalism, ethical principles, and the concept of LV was taught in the nursing curricula of these programs. If taught, then the study sought to determine how it informed the practice of the new nurse who encounters LV in the workplace. For these reasons, experienced nurses who were victims of LV, nurses who were perpetrators of LV, nurse managers, and many others were not participants in this qualitative study.

### **Definition of Key Terms**

American Association of Colleges of Nursing (AACN) is a national accrediting agency for baccalaureate and graduate nursing education that establishes standards for nursing education and promotes public support for professional and nursing education research and practice (<http://www.aacn.nche.edu>).

American Nurses Association (ANA) is an organization that advances the nursing profession by fostering high standards of nursing practice, promoting a safe and ethical work environment, bolstering the health and wellness of its members, and advocating for health care issues that affect nurses and the general public (2015b).

Bullying is abusive, intimidating, or insulting behavior or the abuse of power, which makes another feel humiliated, vulnerable, or threatened and may lead to stress and a decrease in self-esteem (CENTER, 2008).

Care involves maintaining the world of, and meeting the needs of, ourselves and others (Tronto, 2010); denotes a relational provision for the maintenance and protection of another or the feeling of interest or concern for another (Bailey, 2009).

Code of Ethics is an outline of principles based on core values and standards for which a professional will be held accountable (ANA, 2015).

Ethics of Care or Care Ethics suggests that there is a moral significance in the fundamental elements of relationships and dependencies of human life and that caring motivation and emotion is important in moral deliberation, as well as reasoning (Lachman, 2012).

Lateral Violence and/or Horizontal Violence is defined as physical, emotional, or verbal abuse of an employee of the same rank or position (CENTER, 2008).

National League for Nursing (NLN) is an organization that represents nursing faculty across the higher education spectrum by serving to build a strong and diverse nursing workforce through faculty development, research, and public policy change (NLN, 2010).

New (Novice) Graduate Nurse is a registered nurse who is licensed to practice and graduated from a nursing program within the previous 2 years.

Profession is an entity recognized as having a systematic body of knowledge, professional authority, self-regulation and sanction, a regulatory code of ethics, and the existence of professional bodies and/or associations that control and monitor conduct and performance within the profession (Willettts & Clarke, 2013).

Professionalism elements include a unique body of knowledge, altruistic service, a code of ethics regulating practice, socialization, and the right to function autonomously (Rutty, 1998).

### **Overview of Literature**

Although the volume of literature on LV and bullying in nursing has multiplied over the last decade, there remains limited empirical inquiry on how nurses experience and resolve this phenomenon in the workplace (Gaffney, DeMarco, Hofmeyer, Vessey, & Budin, 2012). This is especially true in the United States where a culture of silence in many institutions tends to perpetuate these negative acts (Vessey et al., 2010). Nursing scholars have confirmed that the presence of LV in nursing negatively effects patient outcomes and the nursing shortage, through attrition (Hutchinson et al., 2008; Simons & Mawn, 2010). Studies have demonstrated that LV and bullying has led to an alteration in nurses' self-esteem (Clendon & Walker, 2012), attrition within the 1st year of practice (Griffin, 2004; Vessey, DeMarco, Gaffney, & Budin, 2009), loss of revenue to the organization (Lewis & Malecha, 2011), and psychological and physical distress to the victim (Sauer, 2012). Incivility in nursing culture evokes feelings of powerlessness and leads to the conception of a new generation of nurse-to-nurse aggressors who feel pressured to assimilate to the current culture to avoid becoming victims themselves (Baillien, Neyens, De Witte, & De Cuyser, 2009). Contributing factors include hierarchical management, restructuring or downsizing the organization, employees who lack empowerment, failure to enforce policies that negate LV, lack of structured organizational support, and lack of support and collaboration by senior nurses (Sauer, 2012).

The manner in which one is socialized into the world of nursing may play a significant role in the interpretation of what it means to care (Benner et al., 2010). Here, nursing education has the opportunity to facilitate how nurses should interact with patients, colleagues, and others

as one is socialized into the role of a nursing professional (Dumphily, 2014). Professionalism is a skill nursing students are to acquire and demonstrate in the classroom, clinical and simulation settings, and throughout their nursing practice (Shephard, 2014). One person's interpretation of caring behavior may be interpreted by another as incivility. However, if relational roles and development of professional behavior is clearly defined (Kirk, 2007) in nursing curricula this can aid in eliminating or minimizing the negative effects of LV. With the growing call to cease LV in nursing from such entities as the American Nurses Association (ANA, 2015a) and The Joint Commission (2012), the time has come to evaluate how it is that conceptions of care and LV co-exist in nursing culture without nurses' awareness or nurses' feigned ignorance of the two conflicting paradigms. The ANA characterized lateral violence as a direct violation to the code of ethics that guide nursing practice (ANA, 2015a), while TJC (2012) views LV as a sentinel event that causes preventable harm to patients in the health care system.

The current health care climate mandates that nurses care for the clients whom they serve and their colleagues (ANA, 2015a). Yet, due to the subjective nature of care, it is difficult to ascertain what a "caring" nurse looks like, acts like, or exemplifies. The prevailing meaning of care denotes a relational provision for the maintenance and protection of another or feelings of interest or concern for another (Bailey, 2009). The unspoken, invisible social contract that exists between nurses and society carries an expectation and obligation for nurses to show care (Reverby, 1987). In 1995, ANA clarified the definition of nursing to include a caring relationship; thereby emphasizing the role that caring has in nursing (Bailey, 2009). With this in mind, one could assume that all nurses care for all people. However, as much as nurses desire to care, the presumed existence of LV in the nursing profession demonstrates that some may lack the emotional aptitude to care for another, that nurses do not define caring interventions in the

same terms, or that all nursing academic programs are not incorporating principles of care into their curricula.

Far removed from playground bullying and hallway incivility, many students enroll in schools of nursing with the ethical ideal of wanting to care for others and heal both physical and emotional wounds. The terms “nursing” and “caring” are almost synonymous in American culture (Lachman, 2012). From an historical perspective, Reverby (1987) claimed that instead of the solidarity that sharing a common gender could have created for the nursing profession, patriarchal constraints on the administrative level and differences among women (culture, class, race, ethnicity, etc.) led to a fractured work culture. Presently, LV is an accepted, ignored, or obscured cultural practice in many academic and clinical nursing settings (Croft & Cash, 2012). If nurses believe that their actions are caring and do not perceive their behavior as violence, a discourse must be created to negotiate meaningful strategies for nurses to recognize LV and eradicate it. Although it is believed that power structures shape the cultural identity of the nursing unit and nurses’ attitudes about their work, there is scant empirical evidence on how demographics, such as educational preparation, affect those who experience LV in nursing and those who are perpetrators of LV, thus making it difficult to understand how nurses reconcile LV with the professional core value of care.

### **Methodology**

Qualitative research is a method of inquiry that uses an inductive approach to explore the meaning individuals give to a social or human phenomenon (Creswell, 2013). Munhall (2012) distinguished quantitative and qualitative research by asserting that qualitative research gives voice to the participants in the research allowing us to hear their narratives, whereas in quantitative research, the voice of the individual is silenced. Qualitative research values the

concepts of holism, situated context, seeking truth, and listening with the aim of understanding the other (Munhall, 2012). An explanatory qualitative design using a grounded theory approach was used to understand the meaning that nurses of varying educational preparation and years of experience give to their experiences with lateral violence in the workplace.

Grounded theory is differentiated from other forms of qualitative research, in that it seeks to build theory from concepts derived and developed from actual research data (Corbin & Strauss, 2015). Developed by Glaser and Strauss in 1967, grounded theory is used to construct theory from data gathered directly from interviews, documents, or observations during the research process (Dillon, 2012). Research analysis and data collection are interrelated and occur simultaneously such that data analysis drives data collection methods. Initial data analysis forms the basis for subsequent data collection and this cycle is continuous throughout the research process (Corbin & Strauss, 2015).

The substantive theory that arises from grounded theory is specific and useful to everyday practice (Merriam, 2009). In grounded theory, the researcher must provide a theoretical interpretation of identified explanatory concepts and the relationships among them (Munhall, 2012). Munhall postulated that “grounded theories are useful for directing nursing practice because they are explanatory theories of human behavior within social context” (2012, p. 226). Reasons for using a grounded theory approach for this qualitative research include (a) gaining awareness into LV in the acute care setting, (b) uncovering the belief systems that underlie the actions and reactions of nurses when encountering acts of LV, and (c) discovering how logic and emotion combine to influence how new nurses respond to and interact with acts of LV in their work environment.

Data collection, data analysis, and ethical considerations for this qualitative study design were considered. Twelve nurse participants were chosen using purposive sampling initially, and then theoretical sampling. Data gathering and analysis occurred simultaneously, as is the nature of grounded theory methodology. Joan Tronto's ethic of care was used as the theoretical framework to help frame and organize data to postulate how an ethic of care can be used in nursing academia and practice to create healthy work environments. Triangulation, member checks, researcher reflexivity, and the use of analytic memoing served to strengthen the validity of this grounded theory. The use of thick, rich description will help the reader of the study determine the transferability of the findings. Due to the nature of qualitative research, it is understood that the findings of this study may not be generalizable, but represent an abstract construction of the meaning nurses give to LV and the importance of developing professional behaviors in future nurses. Ethical considerations such as personal disclosure and privacy issues, informed consent, and Institutional Review Board (IRB) permission are addressed in the methodology chapter of this document.

### **Chapter Summary**

In the midst of a more complex health care system, some would argue that nurses no longer value care and compassion. Behaviors that for decades were constitutive as a nurse's indoctrination into the profession or so-called "rite of passage" are now labeled bullying, incivility, and violence (Hippeli, 2009). To determine how it is that the dualisms of care and violence can co-exist among nurses in the workplace, an understanding of how practicing nurses learn professional behaviors should be explored. Differing educational preparation may contribute to the meanings given to care and LV and these terms may have very different denotations for nurses from divergent social contexts. Before LV in nursing can truly be

addressed and eradicated, nursing's discourse of what it means to practice ethically and professionally should be made clear. There should be a clear understanding of what nurses experience as LV and whether the effects of LV are viewed as negative by practicing nurses. So first, we must explore nurses' attitudes toward caring, professionalism, and LV and determine the root cause of unhealthy work environments. Central to this discussion is the role that educational preparation plays in laying the foundation for professional role formation.

Equally important are the power structures, presumed or factual, that create an unfair playing field in health care settings (Baillien et al., 2009). For gendered professions in the United States, such as nursing, this can be problematic in a patriarchal structure that decides which professions are esteemed and which are not. Caring as a profession is devalued, ignored, underpaid, and transferred to those who lack economic, political, and social status (Glenn, 2010). This devaluation of care may lead nurses to feel disenfranchised and vulnerable. Some nurses may retaliate by taking their frustrations out on their co-workers; thus using coping mechanisms interpreted as LV to gain a sense of power and belonging in a system that ignores their worth. This study sought to explain the LV phenomenon from the perspective of practicing novice nurses and examine the importance of teaching professionalism and ethics across all prelicensure curricula.

## CHAPTER TWO

### REVIEW OF LITERATURE

Lateral violence (LV) and bullying are experienced by nurses in both clinical and academic settings (Vessey et al., 2009). The Center for American Nurses (CENTER, 2008) defined bullying as “persistent and systematic behavior that is offensive, abusive, intimidating, malicious, or insulting or abuse of power..., which makes the recipient feel upset, threatened, humiliated, or vulnerable” (p. 1), and undermines self-confidence causing psychological or physiologic stress. Conversely, The CENTER described LV as physical, verbal, or emotional abuse of an employee of equal status (nurse-to-nurse aggression). Lateral violence can be displayed as “nonverbal innuendo, verbal affront, undermining activities, withholding information, sabotage, infighting, scapegoating, backstabbing, failure to respect privacy and broken confidences” (Griffin, 2004, p. 254). The behavior is deemed disruptive because it interferes with effective communication among health care providers and negatively impacts performance and outcomes. Incivility and bullying, although different, must be addressed in tandem, as incivility can be a precursor to bullying behaviors.

The purpose of this review of literature is necessarily multifaceted. I begin by synthesizing the evidence on LV and bullying to disclose the nature of LV in the workplace in general, and nursing in particular, disclosing the burden it bears on patient care and the health care economy. Second, I examine the nature of professionalism in the workplace in general and specifically to nursing practice from a historical and contemporary point of reference to determine if professionalism is a valued part of nursing culture. Third, I illuminate how caring

and professionalism is presumed to be demonstrated pedagogically in associate and baccalaureate degree programs, as these are the nurses that are commonly found at the patient's bedside. Fourth, I explore the importance caring behaviors among nursing peers and non-nursing professions as presented in current literature. Fifth, I discuss the ethics of care theory as a theoretical framework for promoting professional care in nursing work environments, with special emphasis on Joan Tronto's ethic of care. Last, I explore gaps in the literature about the profile of the American nurse as a symbol of caring and the nurse as a victim and/or perpetrator of LV.

### **Lateral Violence: Workplace Violence and Bullying**

In 1997, the Workplace Bullying Institute (WBI) was founded and is currently the only US organization dedicated to the eradication of workplace bullying. Bullying is defined by WBI (2014) as a systematic campaign of interpersonal destruction that jeopardizes the health, career, and job of an individual and frequently results in emotional harm to the victim. In its most harmful form, workplace bullying causes stress-related health issues such as hypertension, autoimmune disorders, depression, anxiety and post-traumatic stress disorder (PTSD). The WBI also suggested that the rate of bullying on the job quadruples that of sexual harassment and racial discrimination, reporting that 6.5 million American workers are affected by workplace bullying.

In 2014, WBI conducted a survey on US workplace bullying. Key findings from the study included 27% of American workers have experienced abusive conduct in the workplace; 72% of the American public are aware that workplace bullying exists; 72% of employers deny, discount, encourage, rationalize, or defend bullying; and 93% of respondents support the enactment of the Healthy Workplace Bill. The Healthy Workplace Bill would provide employers with a law that prevents bullying through policies and procedures that apply to all

employees. The Bill, crafted by Suffolk University law professor David Yamada, gives employers incentives for doing the right thing. Because employers fail to acknowledge or react to the presence of workplace violence, 61% of victims targeted lost their jobs. Another important finding of the WBI study was that of those bullied, 33% reported that a coworker (not a boss or client) was the bully. The US is the last of the Western democracies to adopt a law against bullying in the workplace.

### **The Prevalence of Lateral Violence in Nursing: What Is Known**

Though workplace aggression has been recognized and studied internationally, LV in the United States' health care system remains underreported (Gaffney et al., 2012). Gaffney et al. further asserted that aggressive behaviors among nurses can cause "psychological and/or physical harm among professionals, disrupt nursing care, and threaten patient safety and quality outcomes" (2012, p. 1). Two additional concerns cited by the researchers are inadequate support among nursing colleagues and feigned ignorance among nurse administrators. LV behavior was deemed disruptive and interferes with effective communication among health care providers, which negatively impacts performance and patient care outcomes (Griffin, 2004). The consequences of LV perpetuate the nursing shortage facing the US health care system by compromising job satisfaction, increasing absenteeism, and increasing attrition rates, which inevitably increase costs (Embree & White, 2010). New graduate nurses are at greatest risk of being the victims of LV, as evidenced by higher resignation rates during the 1st year of practice (Griffin, 2004). Due to the complexity of LV in the workplace, qualitative methods should be employed to unearth the factors that support, produce, and recompense bullying behaviors (Gaffney et al., 2012).

To show that incivility in nursing includes patient safety issues, consider the following sentinel event released by The Joint Commission. In 2008, The Joint Commission (TJC) released a sentinel event alert identifying incivility and bullying as causative factors in negative patient outcomes. The Joint Commission is an independent, non-profit organization that certifies health care organizations in the areas of quality and safety performance standards (The Joint Commission website, 2016). The Joint Commission defined a sentinel event as any unanticipated event in a health care environment that results in a death or serious physical or psychological injury to a patient or patients, unrelated to the natural course of the patient's illness or disease process which signals the need for immediate investigation and change (2012). In the alert, TJC (2008) acknowledged that intimidating and disruptive behaviors contribute to medical errors, poor patient satisfaction, preventable adverse outcomes, increase cost of care, and attrition of qualified clinicians. All of this directly affects patient care and lends credence to the negative impact that LV has on the nursing profession.

In 2010, Vessey et al. reviewed the current literature on bullying, harassment, and LV. The researchers determined that LV and bullying have detrimental effects on employee satisfaction and retention rates of nurses. Vessey et al. stated that "evidence supports that bullying, harassment, and horizontal violence is the greatest problem intra-professionally within nursing, both in its prevalence and level of distress it causes" and these behaviors "encourage inter-professional bullying, harassment, and horizontal violence to flourish" (p. 134). Although quantitative data on the prevalence of LV is scarce in the U. S., Vessey et al. offer the following data on the pervasiveness of bullying, harassment, and LV. In a study conducted in Massachusetts, Simons (2008) found that 31% of registered nurses (N=511) reported being bullied and stated that bullying played a significant role in attrition. Stanley, Martin, Michel,

Welton and Nemeth's (2007) research indicated that 46% of nurses viewed LV as a serious problem (only one hospital was used in this study). The American Association of Critical-Care Nurses' (2005) study indicated that 88% of nurses (N=4,000) work with a colleague that engages in verbal abuse, gossip, and self-promotion at the expense of colleagues.

The problems with data reporting are manifold according to Vessey et al. (2010). First, it is believed that the occurrence of LV and bullying are underreported due to the stigma of being viewed as petty or weak, fear of retaliation, and the accepted culture of silence in the workplace. Additionally, LV is viewed as a normal part of the work environment and is therefore tolerated by both colleagues and those in management positions. When the perpetrator of LV has the value of technical expertise, little is done to correct negative behaviors. Furthermore, without a clear definition of what constitutes bullying, harassment, or LV, it is difficult to manage. "What constitutes bullying, harassment, and horizontal violence varies according to people's ideas and perceptions about workplace culture" (Vessey et al., 2010, p. 143). Hence, nurses need a shared understanding of what it means to practice incivility.

The current literature on LV is replete with descriptions of what workplace bullying and aggression looks like, but lacks information on specific causal relationships, predictive models, and proven interventions (Vessey et al., 2010). Furthermore, little is written about the experiences of US nurses as related to their perceptions of nurse-to-nurse relationships in the workplace (Moore, Leahy, Sublett, & Lanig, 2013) and their perceptions of LV in the workplace (Vessey et al., 2009). Understanding nurses' narratives of LV may offer a different perspective on this phenomenon and begin to shape opportunities for nursing education and nursing practice leaders to alter the effects of LV on new graduate nurses and sustain healthy (supportive and respectful) workplace environments.

One recurrent theme in the literature is viewing LV in nursing through the lens of oppression theory (Becher & Visovsky, 2012; Croft & Cash, 2012; Sheridan-Leos, 2008). In the context of oppression theory, nurses perceive themselves to have limited or no control over their nursing practice, which leads to feelings of impaired self-esteem and resentment (Freshwater, 2000; Vessey et al., 2009). Instead of confronting those in the patriarchal institutions that hold positions of power, which could lead to negative outcomes (such as disciplinary actions), nurses project their frustrations on other nurses (Sheridan-Leos, 2008). Organizations fashioned to be hierarchical in nature have not fostered a culture of professional collegiality, nor have they advanced the role of nursing which causes nurses to acquiesce to a victim mentality (CENTER, 2008). Incivility in nursing culture evokes feelings of powerlessness, reinforces the inability of nurses to find a voice to break the cycle, and leads to the conception of a new generation of nurse-to-nurse aggressors who must assimilate to the current culture to avoid becoming victims themselves (Baillien et al., 2009).

Negative attitudes tend to shape when persons are exposed to frequent hostility and incivility (Hutchinson & Hurley, 2013). Embree and White (2010) named “lack of empowerment, authoritarian leadership, oppression, learned helplessness, negative nursing unit culture, toxic work environment, suppressed anger, and low self-esteem” (p. 170) as some precursors of nurse-to nurse aggression. Griffin (2004) also cited 10 common forms of LV among nurses in the clinical setting. Among them are nonverbal innuendos, covert or overt verbal affront, withholding information, sabotage, and scapegoating. These issues can lead to negative physical and psychological problems for the abused coupled with financial decline and negative patient outcomes for the organization (Hutchinson & Hurley, 2013; Hutchinson et al.,

2008; Lee, Bernstein, Lee, & Nokes, 2014). Nurses' use of negative aggressive behaviors becomes a type of coping mechanism (Freshwater, 2000).

To gain an understanding of challenges faced by new graduate nurses, Kelly and Ahern (2008) performed a phenomenological study of a group of 13 nurses in Australia. Analysis of data revealed that the new nurses' expectations of nursing and the realities of nursing were not congruent. The participants described unfairness in workloads and schedules. The recurrent theme in the literature of "nurses eating their young" and the use of power games were noted by the authors to play a significant role in the training of the new nurse. Power games included humiliation and withholding information from the new graduates. An interesting revelation from this study revealed that older nurses with lesser education were least likely to guide the new nurses and most difficult to work alongside. Trial by fire, or what the researchers termed "thrown in at the deep end," was the method used to help most of the study participants become acclimated to the nursing profession. Six months after employment, most participants had transferred to other departments or from the facility.

Studies suggested that LV in nursing is a problem and some have even offered ways to alleviate the burden of bullying and incivility (Clark & Davis-Kenaley, 2011; Decker & Shellenbarger, 2012; Heinrich, 2010; Hutchison & Hurley, 2013; Randle, 2003). Some scholars imply that the female nature of the nursing profession causes this unwanted blemish (Croft & Cash, 2012; Crowley, 1994; Dubrosky, 2013). This is not to infer blame on females, but simply to reiterate that nurses "have internalized the norms and beliefs of the dominant group which leads to loss of professional identity and autonomy, and serves to keep nurses oppressed" (Croft & Cash, 2012, p. 228). These studies have used feminist theory to explore the gendered nature of nursing and the effects of oppression on the lateral violence conundrum.

Using a postcolonial feminist lens to deconstruct data, Croft and Cash (2012) explored the results of a mixed methods study of nurses in British Columbia. The authors identified economy and workload, lack of interpersonal skills, lack of management skills, and the hierarchical nature of nurses' work as the overarching themes that contribute to LV in nursing. The authors reported how budget cuts and lack of proper staffing affected nurses' work and self-esteem. Lack of interpersonal skills and lack of management skills play into the discourse that women do not work well with other women and have poor managerial skills which augment bullying behaviors. The findings by Croft and Cash spotlighted the oppressive and hegemonic conditions that exist in nursing across the globe.

According to Gilligan (1995), the voice of women is often silenced or unheard due to the loud and overbearing voice of patriarchal norms that render feminine experiences as unimportant and unnoticeable. Furthermore, Gilligan alleged that in an androcentric society, women are viewed in a dualism of selflessness versus selfishness. For a woman to speak on her own behalf is considered selfish if it is not aligned with the group. Enculturated since childhood to hide their emotions and internally diffuse their feelings of anger (Stanley et al., 2007), many nurses become silenced and do as they are told. An inability to confront those in positions of power leads the nurse to seek other avenues to express feelings of hurt and frustration. Typically, the victim of this frustration is a safer person of equal or lesser position within the organization (Sheridan-Leos, 2008). These aggressive behaviors may lead to impaired nursing practice and less than optimal patient care (Lachman, 2014).

Recommendations are found in the literature to abate lateral violence in nursing culture (Crowley, 1994; Gilligan, 1995; Griffin, 2004; Thomas, 2010). Most of these propositions require some form of organized education to make nurses aware that the crisis exists (Vessey et

al., 2009). This education can take place at the organizational level of the clinical setting or preferably in nursing education classrooms. Griffin (2004) suggested that students in nursing school be taught cognitive rehearsal techniques to address conflict and incivility in the workplace.

In Griffin's descriptive exploratory study of 26 newly licensed registered nurses, focus groups were used to elicit information from the participants after learning cognitive rehearsal methods. Griffin reported that use of learned ways to confront lateral violence helped the new graduates to diffuse difficult situations and improved retention rates. Some of the learned behaviors cited are respecting the privacy of others, willingness to help when asked, working cooperatively to complete a common task despite feelings of dislike toward a colleague, and avoiding conversations about coworkers with another coworker. Limitations of the study included a small sample size and inability to generalize the actions of the study participants to all nurses since only nurses from the Boston area participated.

Griffin's study and others open the possibilities of how bullying and incivility in nursing can be mitigated through LV education in nursing curricula. Through role-play, student and new graduate nurses can help to create a safe environment that empowers them to be proactive participants in promoting professionalism and not victims of verbal or physical affront. Effective communication skills, education, and empowerment of clinical staff, professional conduct and presentation, and curricula that teach and forewarn students of unhealthy work environments are strategies endorsed to prepare students and newly graduated nurses to handle incivility (Decker & Shellenbarger, 2012). Additionally, the use of post-graduation residency programs to educate preceptors, nurse managers, and newly hired nurses may help to improve unit culture and lessen the rate of lateral violence experienced by new nurses (Vessey et al., 2009). Of course, these

efforts may prove problematic if nursing incivility is prevalent in nursing education as some scholars suggest (Clark & Davis-Kenaley, 2011; Decker & Shellenbarger, 2012; Gallo, 2012; Lasiter, Marchiondo, & Marchiondo, 2012).

Though programs have been initiated to combat negativity in the workplace, “insidious cannibalism” still exist between nurse colleagues (Sauer, 2012). Sauer listed the following terms to describe the negative behaviors experienced by nurses: bullying, verbal abuse, lateral violence, horizontal violence, harassment, disruptive behaviors, and incivility. These behaviors often cause humiliation or distress to the victim. Although these behaviors are not necessarily premeditated or conscious to the perpetrator, it is the victim’s assessment that is salient, but often disregarded or devalued. The incivility seen in LV is a psychological harassment and emotional aggression that violates the workplace ideology of mutual respect and professionalism (ANA, 2015b). In a survey administered to pharmacists and nurses, nearly half of the 2,095 respondents reported that they did not clarify or question medication prescriptions due to intimidation behaviors exhibited by physicians (Institute for Safe Medication Practices [ISMP], 2009). This is consistent with findings by Longo and Sherman (2007) that indicated poor relationships among nurses led to nurses being less likely to ask for help increasing the risk of making mistakes in patient care. Nothing exists in the nursing literature that identifies how many nurses have failed to carry out patient care activities or delayed responses to patient care activities due to perceived lateral violence (withholding information, refusing to assist).

An organization’s culture can contribute to LV. Contributing factors include hierarchical management, restructuring or downsizing the organization, employees who lack empowerment, failure to enforce policies that negate LV, lack of structured organizational support, and lack of support and collaboration by senior nurses (Sauer, 2012). According to Sauer, the incidence of

LV ranges from 14.7 to 21.7%. In the United States, this rate has been reported as being between 23 to 31%. The most vulnerable populations to experience unwanted negative behaviors are students, new nurses, and nurses who are novice to the workplace. Sauer suggested the need to explore why lateral violence happens, how to prevent it from happening, and how to manage it when it happens.

Randle (2003) interviewed 56 nursing students in a grounded theory study to determine the effects of bullying on self-esteem. Through data collected at the beginning and end of the 3-year study, students identified several bullying behaviors in their preceptors. These behaviors led to feelings of insecurity and lack of confidence in the student nurses' abilities. More disturbing was the realization that many of the students admitted to exhibiting similar behaviors to fit in and successfully maneuver through the nursing curriculum and the nursing profession. Like Kelly and Ahern's (2008) study, this alluded to the idea that LV stems from within professional practice and creates opportunities for nurses to become bullies and/or victims of bullies.

Along with the previous studies, others affirmed the attrition rate of new nurses who either leave their first place of employment or abandon the nursing profession altogether as a direct result of workplace bullying. The alarming rate of incivility among nurses should be disconcerting to all parties as it affects recruitment and retention (Clark, Ahten, & Macy, 2013). Newly graduated nurses experience a culture shock when they enter the nursing environment as it really is as opposed to their conceptions of what it ought to be (CENTER, 2008). Lateral violence causes nurses to lose their voice and keep quiet. Inadvertently, this silence keeps the new nurse from asking questions, gathering information, and seeking validation of new knowledge (Griffin, 2004).

The costs of incivility in the workplace can be staggering to health care stakeholders. New nurses have been reported to resign at rates of 60% in their first year of practice (Griffin, 2004; Vessey et al., 2009). Lewis and Malecha (2011) suggested that the cost of lost productivity correlated to incivility is \$11,581 per nurse annually. Speroni, Fitch, Dawson, Dugan, and Atherton (2014) in their study of a hospital that employed 5000 nurses asserted that the estimated cost of workplace incivility was \$94,156 annually. However, the cost to patient care quality and outcome was more substantial and more difficult to quantify. The literature supported that medication errors, increases in patient falls, and delayed medication administration were impacted as a direct result of workplace violence. In the ISMP (2004) study, 7% of registered nurses admitted that intimidation had led to a medication error. Again, what was not documented was the rate of errors directly associated with LV.

### **Defining Professionalism and Its Role in Nursing**

To be recognized as a profession, certain characteristics should be apparent: a unique body of knowledge, altruistic service, a code of ethics regulating practice, socialization, and the right to function autonomously (Rutty, 1998). According to Kirk (2007), elements of professionalism include acquiring and applying a body of knowledge and skills, sharing a commitment to a group of individuals, self-regulating ability, adhering to a code of ethics, and acknowledging a social contract with society. Similarly, Willetts and Clarke (2004) summarized the criteria for a profession as having (a) a systematic body of knowledge, (b) professional authority, (c) self-regulation and sanction, (d) a regulatory code of ethics, and (e) the existence of professional bodies and/or associations that control and monitor conduct and performance within the profession. In the medical genre, professionalism is defined as an activity that involves the

distribution of a commodity and the fair allocation of a social good that is uniquely identified according to moral relationships (Applebee, 2006).

Since the 1800s, nurses have fought for and taken great strides toward being recognized as a profession. In *Ordered to Care: The Dilemma of American Nursing*, Susan Reverby (1987) chronicled the professionalization of nursing and the perils, challenges, triumphs, and unfinished business of nursing in America from 1850-1945. Reverby traced the history of the private duty nurse who had true autonomy of her practice, but was seen as a poorly educated and greedy worker who lacked the ability to care for patients and the abusive origins of the student nurse who was used as cheap labor to staff hospitals while in training. Many of the nursing laws that were passed at this time in American history occurred at a time when women in most states could not vote, allowing nurses' futures to be dictated by patriarchal forces. During this apprenticeship-style training, physicians and administrators (predominately male) controlled the spaces where nurses worked and how nurses were educated. Through many years of public and private battling, nursing education finally moved out of hospitals and into higher education institutions. The public's perception of nursing did not change from that of the doctor's helper. During the Progressive Era, Reverby asserted that nursing was the only female employment that was not subject to careful scrutiny and public investigation of working conditions. Reverby credited this lack of concern with the public's misconception of nurse's work and the poor conditions under which nurses worked. There was a misconception, by some then and now, that if one chooses care work it should be done without the benefit of earning a wage, thus reminding us that care labor is devalued in our society, reflecting prevailing beliefs, political systems, economic structures, and cultural practices (Glenn, 2010; Tronto, 1993).

The campaign to be recognized as a profession began with the transfer of training from the apprentice model in hospitals to institutions of higher education (Willetts & Clark, 2008). Willett and Clark asserted that educational preparation is seen as the defining event that led to nursing being recognized as a profession and declared that this is problematic for nursing. Current nursing research tends to focus on professional identity as it relates to academic preparation. This causes angst since nurses are educated and accepted into practice at different entry levels and most nurses are in the infancy stages of developing professional identity. Felstead and Springett (2015) emphasized the recent reports that continue to question the legitimacy of nursing as a profession. Research that focuses on the construction of nurses' professional identities through exploration of social performance as a professional activity and of the daily activities of nurses within their social work groups would offer a better worldview on the professional practice of nurses (Willetts & Clark, 2008). Furthermore, the researchers suggested using social identity theory to underscore the importance of group belongingness as a consequence of the interpersonal-intergroup continuum with the focus being on in-group behavior and self-categorization within the group. In their study, Willetts and Clark hypothesized that belongingness is an important attribute in the social and professional identity of nurses. This is true, according to the researchers, because the group dynamics of the setting in which one works shapes the social identity of the nurse.

As important as the concept of professionalism is, it is often fragmented throughout nursing curricula or introduced as an abstract concept in a foundational nursing course (Dumphily, 2014). Both the AACN (2008) and the NLN have advocated for professionalism in nursing. The AACN upheld that it is the national voice for baccalaureate and graduate nursing education. As such, AACN established standards for nursing education and promoted public support for

professional nursing education, research, and practice (2008). The American Association of Colleges of Nursing (AACN, 2008) asserted that the baccalaureate registered nurse generalist comprises several roles, one of which is to act as a member of a profession. They further declared that one of the essential roles of nursing education is to prepare the future nurse to demonstrate professionalism and fundamental values that are viewed as inherent to nursing practice: altruism, autonomy, human dignity, integrity, and social justice.

Likewise, the National League for Nursing (NLN, 2010) offered professional development, nursing research grants, and public policy initiatives while representing nursing education programs across the higher education continuum, encompassing practical/vocational, diploma, and associate degree programs, as well as graduate-level nursing programs. The core values of NLN include caring, integrity, diversity, and excellence. Integrity denotes respecting the dignity and moral wholeness of every person without bias. The NLN Associate Degree competencies specifically speak to the professional role of the graduate nurse entering practice. NLN admonished the graduate to “continually develop their professional identity” by reflecting “integrity, responsibility, ethical practices, and an evolving identity as a nurse committed to evidence-based practice, caring, advocacy, and safe, quality care for diverse patients within a family and community context.” AACN and the Institute of Medicine (IOM, 2010) called for the recognition of the baccalaureate degree as the entry level into professional practice. However, as stated previously, only 55% of nurses in the US hold a baccalaureate degree or higher (HRSA, 2013). That translates to approximately 45% of the current nursing workforce holding an associate’s degree or diploma, creating a chasm in the paradox of what it means to be a professional nurse, if education is to be our gauge.

Research detailing the effects of educational preparation on professional development and socialization are limited. In a recent study, Fisher (2014) used the 26-item Nurses Professional Values Scale-Revised (NPVS-R) to measure degrees of professionalism between diploma, associate degree, and Bachelor of Science nursing program graduates. This was the first study to compare the development of professional values within and between all types of pre-licensure programs. A total of 351 beginning and senior-level nursing students participated in the descriptive, nonexperimental study. Using ANOVA analysis and pairwise *t*-test analysis, no significant difference was noted among professional values development among ADN and BSN senior participants. Study findings were also contradictory to previous studies that examined professional values formation within groups.

As recommendations, Fisher (2014) acknowledged the need for personal values and moral education to be part of the ethical component of nursing curricula. Results of the study also suggested, according to Fisher, that the quantity and quality of pre-licensure nursing education matters. The researcher asserted that the affective domain, which is so often neglected or taken for granted, must be developed in nursing students and emphasized as much as the cognitive and psychomotor. Role modeling and role-play are some pedagogical strategies to facilitate the learning of fundamental ethical comportment principles.

### **The Role of Professionalism and Caring in the Nursing Workforce**

In 1987, Melia's seminal work on the professionalization of nursing and the role of nursing education warned of internal divisions and intra-occupational stratification that could be the unwanted result of unclear definitions on what professionalism in nursing means. Oftentimes, new nurses are taught and believe that they attain professional status upon graduation (MacIntosh, 2003) and licensure only to realize that there is more to being a

professional than merely obtaining a degree. Furthermore, the multiple entry levels into nursing and the debate over what the standard should be for professional entry-level into practice further intensifies the confusion over professionalism in nursing (Apesoa-Varano, 2007). There remains contention as to the accepted minimum educational degree in order to be eligible for registered nurse licensing and recognition as a professional nurse. Those in favor of a baccalaureate or graduate degree being the “professional standard” argued that it secures nursing’s professional status because of a liberal training and more rigorous theoretical knowledge background (Apesoa-Varano, 2007). While those who argued for the associate degree nurse submit that there is no evidence to support this claim and point to the nursing shortage, health care crisis, and demographic changes of the occupation as reasons to dismiss this never-ending debate (MacIntosh, 2003).

Professionalism denotes an ability for one to be objective, disengaged, and rational when providing expert judgments and opinions, thereby making caring attributes the antithesis to professional work (Apesoa-Varano, 2007). There continues to be tension between the scientific tenet of professionalism and the nurturing principle of care that has defined nursing since its inception. Murphy, Canales, Norton, and DeFilippis (2005) advocated for nurses to take purposeful political action to strive for congruence between professional values, practice, and policies to effect change in health care. Murphy et al. argued that policies, unlike values, can be enforced. However, Kirk (2007) argued that professionalism can be enforced if values can be conceptualized and linked to specific behaviors that are measurable. This will be discussed in more detail later in this section.

The nursing profession requires its members to care for individuals in a holistic manner. The profession mandated that through evidence-based practice principles, nurses rely on best

research practice, clinical expertise, and client preference to provide the best care possible (Harkness & DeMarco, 2016). The health of individuals is impacted by where they live, work, and spend their time, thus, nursing clientele encompasses all individuals, in all communities. In this section of the literature review, I detail the different terms used to describe nursing team members, the confusion that may create discontent among nurses in their professional roles, and how it escalates LV in the workplace. Then, I examine the definition of professionalism, and the meaning, if any, that caring plays in developing one's professional identity in nursing and other professions. I end by exploring the role that nursing education plays in fostering caring behaviors in nursing students. In the current professional doctrine that suggests that neither knowledge nor skills are needed to care (Apseoa-Varano, 2007), nursing programs may find it difficult to begin to formulate professional attributes in nursing students unless nursing leadership and stakeholders in academia and clinical practice are clear on their stance of the role that care and compassion have in formulating professional identity.

### **Promoting Professionalism in Nursing: Articulation and the Career Ladder**

In 2011, nurses quadrupled the number of physicians in health care (AACN, 2011). This section of the literature review details the different terms used to describe the nursing team members, the confusion that may create discontent among nurses in their professional roles, and suggested solutions to this dilemma. There are many “nurses” assigned to a patient’s daily care routine. Nursing assistants, also known as nurse technicians, or certified nursing assistants provide routine daily care for patients and perform their duties under the direct supervision of a licensed nurse. Licensed practical nurses (LPN) or licensed vocational nurses (LVN) are state-certified technical nurses that perform duties under the direct supervision of a registered nurse. The registered nurse (RN) or “nurse” is the manager of the patient’s plan of care. The RN works

directly with the patient, physician or physician liaison, and all other members of the health care team to ensure that best practice modalities and the patient's wishes are being carried out in a timely and cost-effective manner that lead to the best possible outcome for the patient and their family. Unlike nursing assistants who have either a high school diploma or have taken a certification exam or licensed practical nurses who have gone to junior or community college and taken a certification exam, registered nurses are educated in multiple ways.

Currently, there are three modes of entry into professional nursing practice. To clarify, professional nursing practice signifies entry into practice as a registered nurse. Although there has been a national call for the entry-level into professional practice to be recognized at the baccalaureate level (AACN, 2010; Benner et al., 2010; Institute of Medicine, 2010; NLN; 2010), multiple hurdles, including a massive nursing shortage and a decline in traditional baccalaureate nursing program enrollments (Donley & Flaherty, 2008), keeps this goal from becoming a reality. The three modes of educational preparation are diploma, associate degree, and Bachelor of Science degree. All candidates must sit for and pass the same National Council Licensure Examination for Registered Nurses (NCLEX-RN) administered by the National Council of State Boards of Nurses (NCSBN) to prove minimal competency. Once the diploma or ADN graduate has earned licensure, she or he may immediately apply for enrollment into a RN to BSN or a RN to MSN program (articulation). An articulation agreement among nursing programs provides seamless transition and transferal of course credit from one academic institution (ADN) program to another (BSN or MSN) program.

With ADNs and diploma nurse graduates competing for the same positions and salaries as BSN graduates, and few hospitals differentiating between the educational preparation of nurses, the initial move to career ladders and articulation was challenging (Donley & Flaherty,

2008). However, the growing acceptance of the nurse practitioner role, enhanced financial support for all levels of nursing education, and a growing professionalization in the nursing community encouraged more nurses to seek higher degrees (Donley & Flaherty, 2008). Donley and Flaherty also reported that multiple entry levels into nursing allow for diversity and allow high-risk students an opportunity to be successful at the community college level and further their education through an articulation program. As of 2013, 55% of all nurses held a BSN or higher degree, but the associate degree in nursing was the first degree for many of these nurses (Health Resources and Services Administration [HRSA], 2013).

Given the complexity of patient illness and the cognitive, psychomotor, and affective skills required to treat multiple comorbidities and pharmacological therapies, the current nursing workforce is undereducated (Benner et al., 2010). According to Benner et al. (2010), this lack of education is multifaceted and the answer lies in advancing education and professionalism for current and future nurses. Benner et al. (2010) made 26 recommendations for transforming nursing education and better preparing graduates for current health care trends. Among those recommendations are requiring the BSN degree for entry into clinical practice, developing articulation programs with ease of access and transition from ADN to BSN and ADN to MSN programs, improving the work environment for staff nurses, providing support for faculty development in student-directed pedagogy, and including teacher education courses in master's and doctoral programs.

As a matter of patient safety and improving patient care outcomes, nurses must graduate with the requisite knowledge to make high-risk judgments (Benner et al., 2010). These judgments require a high degree of responsibility and unlike lawyers, clergy, physicians, and engineers, nursing students have limited time to build a knowledge base that will help guide their

professional development and prepare them for the life-altering decisions they must make. “We challenge the profession to come to swift agreement about the most effective way to transform the current diverse pathways into a unified whole” (p. 217). The researchers denounced the current setup of the ADN to BSN articulation programs as a failure to help students continue their education and called for a reconstruction of the current system. One recommendation made by Benner et al. was to create more ADN to MSN programs, which would create an incentive for professional growth, and improved wages since many health care employers do not differentiate between ADN and BSN nurses. Another recommendation was to require all RNs to earn a Master of Science Degree within 10 years of initial licensure.

Interestingly, Benner et al. (2010) reported uncivil and hostile behavior from staff nurses directed toward students. This led the researchers to recommend that health care employers create healthy work environments for nurses. A zero tolerance policy for uncivil behavior toward all members of the health care team, including students, was advised and has since been adopted by the American Nurses Association (2015a). A recommendation for academia to collaborate with clinical affiliates and coach staff nurses in teaching behaviors was also suggested. Benner et al.’s (2010) study was documented 7 years ago and some of the recommendations made have been implemented and made noticeable changes in nursing. However, the one transformation that has not changed is multiple entry levels into practice. Nursing needs to continue to perform empirical studies that seek evidence to determine the amount and type of clinical experience, practice, and education that nurses need and not act out of prior beliefs and traditions (Donley & Flaherty, 2008).

## **The Role of Care in Other Professions**

Part of the problem of LV may lie in the debate about the role of caring versus professionalism in nursing practice: whether demonstration of caring behaviors is a requirement or a hindrance for those who choose nursing as a profession. Those in favor of caring behaviors argue that in order for one to be effective as a nurse, in a profession that requires constant human contact and intimate relationships, it is impossible to nurse and not care (Brett, Branstetter, & Wagner, 2014; Watson, 2009). The ANA, which describes itself as the “professional organization that represents 3.4 million registered nurses through its constituents and state nurses’ associations and organizational affiliates” (Nursing World, 2016, ¶ 1), has acknowledged LV and workplace bullying and its perceived negative influence on nursing practice. The ANA further stated that its purpose is to advocate for nursing practice by “fostering high standards, promoting the rights of nurses in the workplace, and projecting a positive and realistic view of nursing, and lobbying Congress and regulatory agencies on health care issues affecting nurses and the public” (Nursing World, 2016, ¶ 1). As an example of the caring nature of nursing, ANA has set forth a *Code of Ethics for Nurses with Interpretive Statements* to guide professional practice and create habits that cultivate morality and justice under the current biomedical health care delivery system.

In opposition to LV and bullying in the workplace, ANA (2015b) explained its belief that nurses should exhibit both professional and caring attributes in relationships among co-workers and colleagues. These beliefs are found in provision statements within the *Code of Ethics*. Provisions 1.1 (Respect for Human Dignity), 1.5 (Relationships with Colleagues and Others), and 2.3 (Collaboration) of the *Code of Ethics* detail professional nursing behavior established by ANA. Provision 1.1 suggested that respect for an individual’s “dignity, worth, unique attributes,

and human rights” (p. 7) is a fundamental nursing principle that is not merely bestowed upon the nurse-patient relationship. This provision speaks to the nurse being respectful of the values and differences of all individuals and specifically references professional relationships and settings. Provision 1.5 further expounded on the relationships between nursing colleagues and other professional relationships. In this provision, ANA asserted that nurses should “maintain professional, respectful, and caring relationships with colleagues and are committed to fair treatment, transparency, integrity-preserving compromise and best resolution of conflicts” (2015b, p. 9). ANA called for nurses to create ethical work environments and cultures of civility and kindness in interactions with colleagues, coworkers, employees, students, and others. Finally, Provision 2.3 explicated the need for nurses to collaborate and support one another. Provision 2.3 distinctively implored nurses to foster collaborative relationships with all health care professionals to preserve nursing practice. According to ANA, collaboration “requires mutual trust, recognition, respect, transparency, shared decision-making and open communication among all who share concern and responsibility for health outcomes” (p. 11) as nurses are deemed “moral agents” by ANA.

In the first study to explore the relevance of caring attributes in the work environment from the perspective of nurse educators, Brett et al. (2014) reported that nurse educators highly valued caring attributes in their co-workers. However, the researchers also reported that 19 of the 20 attributes from the Nyberg Caring Assessment Scale© (such as, “have deep respect for others,” “base decisions on what is best for those involved,” “help others grow,” and “relationships before rules”) were lacking from the current work environment. Instead, an emphasis was placed on valuing rules before relationships and this was thought to undermine the development of caring attributes among colleagues. Brett et al. suggested that other studies are

needed in this area and posit that there is a “clear conceptual link between caring and support, support and work satisfaction, and work satisfaction and recruitment and retention” (p. 365) of new nurse educators.

### **Professionalism and Caring in Non-nursing Professions**

For proponents of the opposite view, it is believed that professionalism is the element that nurses must exhibit to eradicate incivility and bullying from nursing work environments (Shephard, 2014). Shephard noted that nursing academic and clinical leaders need to forge a partnership to address the problems that exist due to a lack of training on professional behaviors. Although Shephard advocated for caring as part of professional core values, there are those who proposed that care be removed from the dynamic of nurses’ professional role. They argued that nurses seen as caring individuals add to the narrative that nursing is not a true profession and negates the relevance of other life-sustaining roles served by the nurse (Mackintosh, 2000).

Caring, though unique in nursing, is not unique to nursing and is manifested in other professions through the attainment of skills and practices consistent with beliefs about one’s professional role. According to the Kaiser Family Foundation website (2016), males comprise 66% of the physician population in the US. In 1999, the Accreditation Council for Graduate Medical Education (ACGME) required general competencies that were to be imparted during the residency or fellowship of all physicians in training. Professionalism, one of the six competencies, was described in part as a demonstration of respect, compassion, and integrity; a responsiveness to the needs of patients and society that supersedes self-interest; and accountability to patients, society, and the profession. Kirk (2007) asserted that there must be a supportive institutional culture to cultivate professionalism. Kirk further asserted that leaders have a responsibility to set expectations for professionalism, demonstrate professionalism, and

correct behaviors of unprofessionalism by giving informative feedback that is nonthreatening and does not demean another's character. This is achieved by offering insight into negative behaviors and giving instruction on how to achieve positive outcomes that are not harmful to patients.

Kirk (2007) revealed that teaching professionalism in medical school is a daunting task that involves more than a list of what it means to be a professional. Oftentimes in medical education, faculty is seen engaging in the "hidden curriculum." In the hidden curriculum, students witness unprofessional behavior by faculty that undermines the educational objectives of the curriculum. Kirk suggested moving competencies in medical professionalism from values to behaviors that are observable and measurable. Here Kirk admonished faculty to link the noncognitive skill of professionalism to distinct behaviors, such as linking the value "responsibility" to the behavior "follows through on tasks" or "arrives on time"; or the value "communication skills" to the behaviors "is not hostile, derogatory, or sarcastic," "is not loud or disruptive," or "is patient." To implement this teaching methodology, faculty must set expectations, perform ongoing assessments, remediate inappropriate behaviors, prevent inappropriate behavior, and implement cultural change, if needed. Finally, Kirk referred to the use of 360-degree evaluations by peers, nurses, patients, and other colleagues with whom the physician comes into contact instead of only by the direct supervisor. These are important to evaluate professionalism because as Kirk stated, attending physicians may not know how a resident behaves in the middle of the night when no one in a position of authority is watching. In Kirk's assessment of professionalism among medical professionals and throughout the literature, there was an expectation that members of the medical field show respect and compassion to colleagues, as well as patients (Applebee, 2006).

Gleeson (2007) considered misunderstandings that led to perceptions of unprofessional behavior among physical therapists. Much like nursing, the American Physical Therapy Association defined professionalism by a set of core values. These values are “accountability, altruism, compassion/caring, excellence, integrity, professional duty, and social responsibility” (p. 23). According to Gleeson, lack of professionalism seen in physical therapist is more likely to stem from generational differences than social or educational differences. Both clinicians and academicians in the field of physical therapy see glaring differences among generational students and clinicians in how they interpret and display elements of professionalism towards peers, patients, and those in authority. Gleeson cited Strauss and Howe’s work that distinguished the generations into Veterans (born 1901-1924), Silents (born 1925-1942), Baby Boomers (born 1943-1960), Generation X (born 1961-1981), and Millennials (birth year began in 1982).

“In a profession where differences are accepted and expected in the patients and clients we serve; we must be mindful that the differences in behaviors among our colleagues should be respected as well” (Gleeson, 2007, p. 27). Gleeson further acknowledged that while diversity and variety define the physical therapy profession, flexibility, understanding, and acceptance are its hallmark. Because of this high expectation, Gleeson implored physical therapists to celebrate differences and uniqueness among colleagues, the same as with patients. Therefore, it continues to be revealed that nursing is not the sole profession requiring compassion and altruism from its members. This caring component is not reserved only for the customers served, but for colleagues and society at large.

In a profession completely removed from the bedside, Ahadiat and Martin (2015) investigated the attributes and skills needed for success and promotion in the field of professional accounting. In their literature review, the researchers revealed that previous studies

acknowledged the need for accounting graduates to demonstrate more than technical skills to seek advancement in accounting. As an example, Stovall and Stovall (2009) conducted a survey in Western Michigan and found that local employers ranked soft skills as more valuable to success in public accounting than technical skills. Stovall and Stovall also suggested that accounting programs that did not incorporate these skills in their curricula may see decreases in enrollment.

To investigate the skills, preparation, and attributes that accounting professionals need, Ahadiat and Martin (2015) used a survey research method to collect data via electronic survey and email. One hundred ninety-eight respondents replied to the survey for a response rate of 39.6%. The researchers divided the list of attributes into two distinct groups: personal and educational. “Accounting practitioners in both public and corporate accounting felt that personal attributes such as dependability, trustworthiness . . . the ability to get along with others, knowledge of the firm’s expectations, and interpersonal skills” were significantly superior attributes when considering promoting employees than their technical or conceptual accounting skills. The researchers also noted how these findings are in contrast to earlier research in this area, which viewed oral and written communication skills as the most important (De Lange, Jackling, & Gut, 2006; Kavanaugh & Drennan, 2008). It is also interesting to note that in their study, Ahadiat and Martin found that accounting professionals continued to prefer bachelor prepared graduates for entry-level into employment.

In 2003, a group of researchers studied the Los Angeles police department to determine how to improve police training and improve police relationships with the communities they served. The researchers concluded that the first step to improving police training in the areas of use of force against citizens, search and seizure, arrest procedures, community policing, and

diversity awareness was to establish and communicate a clear definition of police professionalism (Glenn et al., 2003). Glenn et al. asserted that a police department that relied on ethical principles and integrity to inform judgment and service inherently has elements of professionalism, considering the “rights they protect are as much their own as they are those for whom they serve” (2003, p. 25). Professionalism was also seen as a common element among vocations that serve the public, although the authors explicitly acknowledge the aspects of law enforcement that make it unique from any other professional group in the world. As such, the researchers chose professionalism as the underpinning for their study.

Glenn et al. (2003) used two definitions of military professionalism for their study on law enforcement. Allan Millett identified the following six elements of a profession that are congruent to the definitions identified previously with a few notable distinctions: (a) a full-time and stable job, serving continual societal needs; (b) a lifelong calling by practitioners who identify themselves personally with their job subculture; (c) organized to control performance standards and recruitment; (d) requires formal, theoretical education; (e) has a service orientation in which loyalty to standards of competence and loyalty to clients’ needs are paramount; and (f) granted collective autonomy by the society it serves, presumably because the practitioners have proven their high ethical standards and trustworthiness. The other definition, which Glenn et al. adopted because of its brevity, was Huntington’s conceptualization of professionalism.

Huntington used three characteristics to define professionalism: corporateness, responsibility, and expertise (Glenn et al., 2003). Corporateness is the sense of unity and consciousness among members of a group apart from those outside the profession. This sense of oneness originates from the lengthy discipline and training requisite for professional competence, the connection formed by doing the same work, and sharing a unique social duty. Minimal

education and professional competence must be obtained in order to be a part of the group. Responsibility refers to the profession serving as a moral unit positing certain values and ideals, which guide its members when dealing with others. Responsibility envelops the notion that a professional is an expert who performs a service essential to the function of society and asserts that financial remuneration cannot be the primary goal of the professional. Expertise signifies the professional who has specialized knowledge and skill because of prolonged education and expertise. According to Millett and Huntington, professionalism is a goal because “no vocation, not even medicine or law, has all the characteristics of the ideal professional type” (Glenn et al., 2003, p. 28). It is the ultimate goal of professional practice. Professionalism is a goal that each member of a profession should strive to attain and maintain according to the prescribed standards of the unique profession, not that each profession should try to mimic from another profession.

The study of the LAPD by Glenn et al. (2003) continued to ask the question, is law enforcement a profession?, by looking at each aforementioned tenet. There were legitimate arguments for and against the professionalization of law enforcement. The more persuasive argument made by the investigators was against the professional status of the so-called “traditional professions” of medicine, law, and clergy. In today’s society with a multitude of government mandates and oversights, no profession truly self-regulates. As the researchers noted, all are regulated and answerable to the law. Another argument that is crucial to nursing is the concept of self-perception. Glenn et al. argued that if a vocation does not consider its members to be professionals then this can cause issues.

No vocation can be considered professional if its members do not accept the collective responsibility to maintain specialized expertise, to limit membership to those with requisite skills and who adhere to established standards, and to have a primary motivation of serving society. (p. 31)

## **Using an Ethics of Care as a Professional Model for Nurses**

To appreciate the nature and prevalence of LV in nursing, one must acknowledge the role that caring behaviors have played in nursing since its inception. As diverse as the students who seek to heal and clinicians who engage in the art of nursing, so, too, are the theoretical definitions and conceptualizations of what it means to care (Bailey, 2009). If caring and nursing are as interwoven as some believe, it is difficult to imagine that a nurse could care for some individuals, but not for others. Lachman (2012) recommended that nurses apply an ethics of care to their nursing practice to gain an understanding of caring as a feeling that leads to a physical action.

Using Carol Gilligan's and Joan Tronto's work to make her argument, Lachman (2012) also alleged that unlike an ethics of justice that relies on an impartial rationalization of one's actions, nurses rely on a certain emotional attachment or involvement with individuals. This unique relationship guides actions and decision-making. Similarly, Robichaux and Parsons (2009) recognized how an ethics of care that originated from Carol Gilligan and Nel Noddings was "more congruent with nursing because it emphasizes their inherent relational nature rather than abstract rules" (p. 204). In order to understand the process of how it is that one can desire to care for certain individuals while ignoring the needs of others, it is necessary to revisit some prevalent theories of caring.

Although there are multiple definitions and lines of thought on caring behaviors, for the purposes of this literature review, Nel Noddings' Care Ethic (2012) and Joan Tronto's Care Theory (2010) served as exemplars of how nurses ought to treat others. Most nursing theories acknowledge that nursing is interpersonal and requires that the professional nurse know the holistic needs of another (Bailey, 2009). Instead of teaching student nurses and new nurses'

basic caring principles, nursing should consider applying an ethic of care to nursing practice (Lachman, 2012). An ethic of care mandates the essential components of compassion, collaboration, accountability, and trust (Robichaux & Parsons, 2009), which are also elements of professional practice.

### **Nel Noddings' Ethics of Care**

Nel Noddings' ethics of care can be used in nursing curricula to aid in the moral education of nurses. At the center of Noddings' care ethics is the concept of a caring relationship among individuals, the carer and the cared-for (2012). Noddings' Ethics of Care has provoked the interest of some nurse scholars, such as Crowley, Robichaux, and Parsons, who advocated for an ethics of care in nursing. Fagermoen (1999) suggested that Noddings' theory is consistent with Watson's theory in that both have a relational component and both underpin who we are as persons. The focus of Noddings' care ethics has its onus in moral education. Noddings believes that caring is ontologically based and is simply a part of who we are and is dependent upon the relationships that we form with others and the context or situational aspects of those relationships (Noddings, 2010).

In a caring relation, the carer is first of all attentive to the cared-for, and this attention is receptive; that is, the carer puts aside her own values and projects, and tries to understand the expressed needs of the cared-for. (Noddings, 2010, p. 391)

In order to meet the needs of the cared-for, Noddings also contended that it is the responsibility of the carer to maintain competence in areas that the cared-for may need to be informed on, educated on, or helped with. Because the element of relationship is the epicenter of Noddings' Ethics of Care, caring cannot exist without an acknowledgement by the cared-for of the efforts of the carer (Noddings, 2010). This does not mean financial gain or any blatant attempt to pay or reward the carer for caring, but some demonstration of acceptance of care must be displayed by

the cared-for in order to name the relationship a caring one. If caring is part of the learning experience and educators are to model, dialogue, and confirm ways of caring, moral education may be a component that is missing in nursing education (Crowley, 1994) across all pre-licensure programs.

In Noddings' view of care ethics, the ethical self exists in relation to others and it is within these relationships that we gain or lose ethical comportment (Crowley, 1994). Professional comportment is defined as the expected conformity with a professional code of behavior that demonstrates and reflects respect for others and oneself (Roach & Maykut, 2010). Nursing education and practice have an opportunity to cultivate a culture of safety and empower student nurses and newly registered nurses to "confront, defuse, and refrain from adopting violent behaviors in the health care environment" (Thomas, 2010, p. 300). By learning to view the world through a relational ethic of care, one is more likely to exhibit caring behaviors such as attentive listening, therapeutic touch, and empathetic compassion (Noddings, 2012). Noddings' care theory allows for the education of all nursing students to gain an awareness of and the tools to engage in caring nursing practice. Roach and Maykut (2010) postulated that care is demonstrated cognitively, affectively, technically, and administratively through the attainment of aptitudes and practices consistent with one's professional role. According to Noddings (2010), moral education should include modeling, dialogue, practice, and confirmation of care.

At its essence, Noddings' care theory is a pedagogy of caring (Crowley, 1994). So, it is with nursing. Nursing's foundation is built on caring principles (Sawbridge & Hewison, 2015). As such, modeling care in nursing education is critical if we are to encourage and develop caring behaviors in our students and future nursing workforce. Modeling implies that the one caring (teacher) must provide an apprenticeship for the one cared for (student) so that a community of

caring individuals will evolve from nursing programs (Crowley, 1994). Nurse educators must simulate caring behaviors that are required of students. Student requests cannot be ignored but must be attended to always with regard to maintaining what Noddings referred to as the ethical ideal. Care ethics demands that all faculty encounters, courses, assignments, and learning take place within the realm of moral significance. Dialogue is the verbal representation of modeling (Crowley, 1994). In dialogue, students learn to voice and explore the ethical ideals of others and find common ground that allows them to set aside their beliefs and care for others in spite of their differences. Both modeling and dialogue could prove useful in assaying lateral violence.

In order to see the effects of modeling and dialogue on the behavior of student nurses, nurse educators must allow opportunities for practice. Experiential learning opportunities and guided practice should occur early and often within nursing curricula (Benner et al., 2010). Noddings believed that concrete experiences are necessary to develop caring behaviors in students. In today's educational arena, Noddings (2010) contended that collaborative work has become competitive and criticism of students control group dynamics. Educators must redirect students to help one another and care for one another to complete tasks. Through reflection and sharing with nurse educators or peers, students are able to recognize and adopt caring behaviors. During reflection, teacher and student are able to confirm and reinforce caring and compassion while dispelling negative behaviors, such as those seen in LV.

### **Joan Tronto's Ethic of Care**

Care work remains overwhelmingly gendered with women comprising the majority in careers such as teaching and nursing (Glenn, 2010; Zembylas, Bozalek, & Shefer, 2014). Historically, care work has been invisible, unnoticed, and consistently undervalued as it relates to material rewards and status (Glenn, 2010). Hence, an associate degree nurse and baccalaureate

degree nurse share the same paygrade and status in many institutions across the country, and a new graduate nurse can enter employment making a higher base pay than an experienced nurse at the same place of employment. In 1993, Tronto developed a political ethics of care as a theoretical framework that views care as both a practice and an activity by which the world is maintained and repaired (Zembylas et al., 2014). Tronto asserted that care ethics originates from the notion that care is basic to human existence. Tronto's ethics of care reminds us of the value of care work because care is more than a sentiment; it is a laborious endeavor, which is essential to the maintenance of human life.

Tronto's (1993) care ethics has five phases and moral elements of care that must be present and performed well in order for good care to take place. The first phase, *caring about* is the recognition that there is a need for care. *Attentiveness* is the moral element that accompanies *caring about*. The opposition of *attentiveness* is maintaining the status quo and ignoring the need for care, which leads to conditions of inequality and social injustice. The second phase, *caring for* requires ensuring that needs are met and determining how to best respond to needs. *Responsibility* is the moral element that corresponds with *caring for*. In *caring for* another, one must acknowledge and exercise the power to place another's needs before his own. *Responsibility* denotes the ability to intervene on another's behalf and care for his or her needs even when it is not consistent with established norms. *Caregiving* is the third phase of Tronto's ethic of care. *Caregiving* involves the actual work of care for people and the accompanying moral element is *competence*. Tronto saw competence as both a technical and moral quality. *Competence* implies that one has the knowledge, skills, and abilities required to perform a job to the best of his or her ability. Tronto noted that some may feign incompetence in some areas to avoid menial tasks or those deemed less than important. For instance, a Registered Nurse (RN)

may spend 15 minutes looking for a nursing assistant to place a patient on a bedpan when the RN could have completed the task within that time frame.

The fourth and fifth phases of Tronto's (1993) ethics of care are *care-receiving* and *caring with*. *Care-receiving* is the response to the care provided by the caregiver. The moral element involved in *care-receiving* is *responsiveness*. After delivering care, it is important to assess the effectiveness of the care and whether further attention is needed. This is seen as an ongoing process. Here, it is not sufficient to simply follow standards and protocols if the desired outcome is not achieved. The one caring must seek other measures to help the cared-for. The fifth and final phase is *caring with*, which refers to the formation of the moral qualities of *trust* and *solidarity*. These qualities are acquired by an ongoing process that occurs over time and must be developed through practice by relying on the caring practices of others. This fifth phase forms the social and foundational contract for healthy work environments in which all team members trust that each individual will act in the best interest of the team and not for individual gain.

### **The Importance of an Ethics of Care in Nursing**

Societies are charged with the duty to determine which social practices should be valued and honored. In order for a society to be just, Aristotle postulated that it must help to create habits that build moral character and knowledge of when to apply a set of laws or rules to a given situation (Sandel, 2009). If we imagine that the current health care system is a microcosm of American society, we might stipulate that value is placed on the accumulation of wealth more so than other social issues. Compassion remains foundational to nurses' work or so many care theorists would argue (Sawbridge & Alistair, 2015). However, colonizing practices that exist in

androcentric policies and regulations within health care systems may lead to negative feelings and instigate disruptive aggression between nurses (Croft & Cash, 2012).

For years, it has been perceived that nurses were the victims of vertical violence at the hands of physicians, patients, and administrators, secondary to the devaluation of nurses in the biomedical model (Freshwater, 2000). While this is still the case in some instances, an even more disturbing trend that has existed for at least the past 5 decades (Hippeli, 2009) is the prevalence of LV among nurses: nurse-to-nurse aggression. Student nurses and new graduate nurses are the most common casualties of this workplace phenomenon (Egues & Leinung, 2013; Griffin, 2004; Thomas, 2010;). Nurse educators, as role models and mentors of future nurses, find themselves in prime position to instill fundamental values and professional principles that will influence the behavior of the current and future nursing work force (Murphy et al., 2005).

Common themes to extract from Tronto (2010) and Noddings (2010) are the relationship-based nature of care, the willingness to set aside personal biases or desires, and the inner and outer conceptions of what it means to care. For Tronto and Noddings, care is both feeling and doing. It requires a conscientious acceptance of the role of the one caring (Lachman, 2012; Noddings, 2010). Noddings' and Tronto's conceptualizations of care emphasized the relational nature of individuals rather than abstract rules of health care entities and advocated for nurses to create a healthy work environment based on ethics rather than the financial gain today's business model requires (Robichaux & Parsons, 2009; Tronto, 2010). The business model in health care today contributes to the unhealthy work environments of care workers and continues to feed the narrative of care work as a devalued commodity (Murphy et al., 2005; Tronto, 2010; Watson, 2009).

While feminist ethics can vary in meaning depending on which theorist one chooses to subscribe, the basis for feminist ethics is one of equality, relational autonomy, and fair treatment for oppressed, marginalized, and devalued persons. According to Gilligan (1995), a feminist care ethic recognizes that women can be moral agents of care and justice. Feminist ethical practice values the social context in which all situations occur. There cannot be a universal answer to all the world's problems because each individual exists within different relational, environmental, social, and moral context (Thompson, 1998). Feminist ethics regard all as having a voice to be heard before decisions can be made; there can be no single approach to decision-making that disregards feelings and relationships (Tulloch, 2005). Additionally, feminist ethics appreciate that, in the case of care givers and care takers, decisions must be informed, truth must be maintained, and individual choices must be respected (Gibson, 2004). Other aspects of feminist ethical practice include empowering patients to be self-determining individuals and understanding that decisions cannot be disembodied from the domain in which they occur but are phenomenological in nature (Mackenzie, 2007). For these reasons, a feminist ethical practice can both inform and reform nursing education. In fact, feminist ethical practices help to lay the foundation for the American Nurses Association's *Code of Ethics for Nursing* (2015b).

*The Code of Ethics for Nurses* claims to provide a social, humanist, and feminist assessment to issues of ethical nursing practice (ANA, 2015b). Nurses need to create a work environment that promotes discussion and resolutions within an ethical climate. Robichaux and Parsons (2009) suggested that nurses are aware of the code of ethics as it relates to patient care, but may be less familiar with its application to intra- and interprofessional teamwork and sustaining healthy work environments and ethical work spaces. This unawareness leads to a failure to treat all persons with respect and expect reciprocal treatment. A contraindication of

caring behaviors is created through the use of patient satisfaction surveys, and competition among health care institutions as a measurement of good nursing care (Tronto, 2010). This discourse, in turn, pits predominately androcentric rules, regulations, policies, and administrators at odds with the compassion and affective skills of the mostly female profession of nursing (Sheridan-Leos, 2008).

Since nursing is 92% female (Dubrosky, 2013), nurses are presumed to be selfless angels of mercy. Still, nurses are criticized for not being fast enough, efficient enough, or caring enough to meet the needs of a capitalistic health care system. Administrators and medical staff give orders for nurses to carry out, decide the workload of nurses, and strip nurses of any decision-making ability in regard to the work done (Dubrosky, 2013). Enculturated since childhood to hide their emotions and internally diffuse their feelings of anger (Stanley et al., 2007), many nurses become silenced by the oppressive nature of their profession. An inability to confront those in positions of power leads the nurse to seek other avenues to express feelings of hurt and frustration. Typically, the victim of this frustration is a safer person of equal or lesser position within the organization (Sheridan-Leos, 2008). These aggressive behaviors may lead to impaired nursing practice and less than optimal patient care (Lachman, 2014). Making an ethics of care a reality in health care settings may help to eradicate incivility from nursing practice (Lachman, 2012; Watson, 2009).

### **Gaps in the Literature**

The prevalence of lateral violence within nursing is causing harm to the profession and the patients we serve. One could argue that prior to fixing a problem, the nature of the problem must be fully understood. Nursing scholars have examined lateral violence in nursing: its causes, strategies to combat it, and its victims. However, most of the available literature is international;

literature in the US on lateral violence is limited and does not examine the meanings that nurses make of this disturbing phenomenon in the workplace. The culture of silence in the US perpetuates underreporting of lateral violence and implementation of strategies that are insufficient and unproven in dealing with a concept that lacks universal definition (Gaffney et al., 2012).

This literature review has uncovered the following gaps in the literature on lateral violence. There was little empirical data on how nurses interpret and use the ANA *Code of Ethics* in everyday practice or if it is being taught consistently in nursing programs across the US. There were no studies that explored how associate degree nursing programs teach professional values and if those pedagogical methods are effective. More research is needed to understand the causative nature of lateral violence and effective ways to prevent it from happening. Demographic studies of nurses who are victims and perpetrators of LV were scarce. Research that considered how nursing management views LV and its causation was lacking; as was research that explored nurses' relationships with other nurses (specifically, positive and negative aspects of the working environment in general practice). Missing in the literature on caring was how nurses from differing educational backgrounds interpret professional care and if certain constructs, such as years of service, influence nurses to develop professional caring behaviors in clinical practice. Furthermore, it is not clear if practicing nurses adhere to the code of ethics and believe that they have to demonstrate caring behaviors in order to perform their jobs effectively and efficiently.

Also, research that examined the labor intensity of general practice nurses and its effect on nurses' ability to care are not available. All of these studies could inform nursing practice and pedagogy to create and maintain healthy workplace environments.

## Chapter Summary

Organizational structure and androcentric, capitalist policies contribute to creating hostile work environments for nurses. Nursing faculty and leaders have an opportunity to teach future nurses the value of professional care and its role in creating a healthy work environment. However, if nurses have opposing views of the three constructs that impact the emotional and professional climate of their work environment (professionalism, care, and lateral violence), then the solution to creating a healthy work environment could be more complex than the current literature suggests. This research study used a qualitative explanatory grounded theory approach to examine how nurses reconcile instances of lateral violence with their views of professionalism and caring practices. Nurses were interviewed and asked to complete a series of case scenarios to examine their experiences with lateral violence. Nurses from differing educational backgrounds and with less than 2 years of experience as Registered Nurses (RNs) were asked to share their views on the concepts of professionalism, lateral violence, and ethics in nursing. This research is important to the future of nursing and patient safety because nurses must function at their full mental, physical, and emotional capacity to ensure patient safety. The meanings that nurses in the United States give to lateral violence and care is vital to creating and maintaining healthy relationships with colleagues and patients. Nursing education is foundational in laying the groundwork to improve nurses' relationships with other nurses.

## CHAPTER THREE

### METHODOLOGY

This chapter describes the methodological framework that supports and guides this empirical study. The issue of lateral violence (LV) in nursing is an international phenomenon that has been scarcely assessed from the perspective of nurses in the United States. For the purpose of this study, a descriptive qualitative research design using a grounded theory approach was used to understand how novice nurses interpret their experiences with LV and construct their worlds to cope with this phenomenon. This approach was also used to analyze the meaning that novice nurses from differing educational backgrounds give to the American Nurses Association's *Code of Ethics for Nurses* and its value in creating a healthy work environment. According to Merriam (2009), the end result of this type of qualitative analysis is theory that emerges from the data.

#### **Research Questions**

The original research questions for this study were

1. How do novice nurses experience LV in the workplace?
2. How do novice nurses reconcile their commitment to professional care with their experiences of LV in the workplace?
3. What pedagogical interventions can be used to address LV in the workplace?

#### **Setting of Research**

The research study took place in the southeastern United States. All interviews were conducted by the principal investigator. Initial interviews of nurse participants occurred in an

office space on one of two college campuses. Both campuses were away from the nurse participants' work environment to ensure anonymity. Follow-up interviews occurred in the same office spaces as the initial interview or via telephone, at the discretion of the nurse participants.

### **Participant Selection and Recruitment**

Nurses with less than 2 years of registered nurse experience who had left their place of employment or who were considering leaving were chosen to participate in this study. These participants were chosen because the literature suggested that nurses who are new to a job, specifically new nurse graduates, are most likely to experience LV. Participants were selected based upon the highest educational degree held, Associate or Bachelor of Science.

Nurses were recruited via flier announcements (Appendix A) and announcements at professional nursing conferences in the southeastern United States. Participants were also approached via email and face-to-face notification (Appendix B). A \$25.00 Visa gift card was offered as a recruitment incentive to all participants who completed interviews in the study. Participant demographic data are depicted in Table 1 and include age, race, gender, type of degree, time on the job, nursing specialty area, and the participant's first knowledge of LV (during or after college). Only one associate degree nurse had heard the term lateral violence in nursing school, compared to two of the bachelor degree nurses, which signifies a need to introduce this concept into nursing pedagogy across nursing curricula. A total of 12 nurse participants were selected for this study.

**Table 1***Description of Nurse Participants*

<b>Time on the Job</b>		
3-6 months	8	67.7%
7-12 month	2	16.7%
1-2 years	2	16.7%
<b>Degree Earned</b>		
BSN	6	50%
ADN	6	50%
<b>Age</b>		
20-25	9	75%
26-30	2	16.7%
>30	1	8.3%
<b>Race</b>		
Caucasian	7	58.3%
African-American	5	41.7%
<b>Gender</b>		
Female	12	100%
Male	0	0
<b>First Knowledge of LV</b>		
During College	3	25%
After College	9	75%
<b>Nursing Specialty Area</b>		
Critical-Care	4	33.3%
Labor & Delivery	1	8.3%
Medical-Surgical	5	41.7%
Emergency Room	1	8.3%
Neonatal Intensive Care	1	8.3%

*Note.* 12 Total Nurse Participants

## Sample Selection

Initially, purposive sampling was used to identify participants who met the criteria for the study. Initial participants responded to fliers and called to discuss requirements for participation. Once it was determined who met criteria for the study, arrangements were made to obtain informed consent. The first three nurse participants were emailed links to the demographic survey (Table 1) and four LV case scenarios, which asked questions to determine if nurses would recognize LV and how they would respond to LV (Appendixes C and D).

Two of the initial nurse participants recommended colleagues to participate in the study. Other participants in the study were met at nursing conferences. They approached me and we arranged a telephone interview to discuss eligibility for the study. If the participant was eligible, informed consent was obtained and arrangements were made to complete a tape-recorded interview. Initially there were more associate degree nurse participants interviewed and recruited for the study. Using the theoretical sampling methodology, I wanted to interview more bachelor degree registered nurses so toward the end of the study, there were three nurse participants selected specifically because they were BSN graduates. In order to compare educational preparation and determine if BSN graduates were more prepared to navigate LV through learned professionalism, it was important to hear the experiences of these graduates.

A total of 12 nurse participants was chosen for this study based on their educational preparation and years of experience. All participants had less than 2 years of work experience as a registered nurse. Six participants held an Associate of Science Degree in Nursing (ADN) and six held the Bachelor of Science Degree in Nursing (BSN). Four had left their first place of employment and the others had thought about leaving, were in the process of working out a resignation notice, or were applying for other job opportunities at the time of our interview. All

had either experienced or witnessed episodes of LV in the workplace. Gender, race, age, and specialty area were not specific criteria for this study.

### **Methodology Selection**

According to Creswell (2013), qualitative research design is appropriate when a social issue needs to be explored to “study a group or population, identify variables that cannot be easily measured, or hear silenced voices” (p. 48). Qualitative research focuses on discovery, insight, and understanding from the perspective of those being studied and therefore offers the greatest promise of making a difference in people’s lives (Merriam, 2009). Creswell (2013) defined qualitative research as a design that “begins with assumptions and the use of interpretive/theoretical frameworks that inform the study of research problems addressing the meaning individuals or groups ascribe to social or human problems” (p. 44). Both Merriam and Creswell acknowledged that there are four essential characteristics to qualitative research: (a) the focus is on meaning and understanding from the participant’s point of view, (b) the researcher is the primary data collection and data analysis instrument, (c) the process is inductive, and (d) the data collected allows for thick, rich description of the phenomenon studied.

A more in depth assessment of the four characteristics of qualitative research gives insight into the strengths and weaknesses of using a qualitative approach. First, my overarching goal was to understand how nurses experience LV in the work environment. To communicate the perspectives of others about their experiences and the meaning they give those experiences in their social context, the researcher must understand their own worldview and biases about the phenomenon studied. Therefore, data analysis must uphold the participant’s position, not mine. Second, the researcher as the primary data instrument poses the same issue of bias. For this reason, I carefully monitored and remained cognizant of personal bias and how it shapes data

collection and interpretation. Member checks, analytic memos, and researcher reflexivity allowed me to clarify data, check with participants for accuracy of information, explore any unanticipated answers, as well as maintain an awareness of my own biases. Third, qualitative research is an inductive process that can be used when existing theory fails to adequately explain a phenomenon or there is not a theory. Gaps in the literature about the nature of LV and its interaction with the nursing profession can be extrapolated from data offering new insights into LV. Fourth, data in the form of words from interviews will allow for richly descriptive data, which are not available using quantitative methods. This method gives voice to those who experience LV and informs the social conscience of the nursing profession.

Lateral violence in nursing is an issue that must be examined in the context of nurses' work environments and how the nurse is socialized to exist within that environment. Creswell (2013) stated that one cannot always separate what one feels or says from the place where it occurs; in other words, understanding how a problem or issue is solved requires knowing the context or setting in which it occurred. Qualitative research helps us to understand why people respond as they do and how certain aspects of their life experience came to be. Nurses are bound by historic and social context that helps to shape each individual nurse's perspective on interactions within the work environment. The purpose of this study is to understand how nurses perceive LV and reconcile this phenomenon within the schema of a professional, caring work environment. By using a qualitative grounded theory approach, I aimed to (a) discover the meaning that nurses from various backgrounds gave to LV, (b) explore how different variables shaped the work environment of nurses, and (c) inform nursing practice and pedagogy of how educational preparation and years of experience may construct the professional values of nurses.

Grounded theory is differentiated from other forms of qualitative research in that it seeks to build theory from concepts derived and developed from actual research data (Corbin & Strauss, 2015). Developed by Glaser and Strauss in 1967, grounded theory is used to construct theory from data gathered directly from interviews, documents, or observations during the research process (Dillon, 2012). Research analysis and data collection are interrelated and occur simultaneously such that data analysis drives data collection methods. Initial data analysis forms the basis for subsequent data collection and this cycle is continuous throughout the research process (Corbin & Strauss, 2015).

The substantive theory that arises from grounded theory is specific and useful to everyday practice (Merriam, 2009). In grounded theory, the researcher must provide a theoretical interpretation of identified explanatory concepts and the relationships among them (Munhall, 2012). Munhall postulates that “grounded theories are useful for directing nursing practice because they are explanatory theories of human behavior within social context” (p. 226). Reasons for using a grounded theory approach for this qualitative research include: (a) gaining awareness into LV in the acute care setting; (b) uncovering the belief systems that underlie the actions and reactions of nurses when encountering acts of LV; and (c) discovering how logic and emotion combine to influence how new nurses respond to and interact with acts of LV in their work environment.

### **Data Collection**

Data collection and analysis occur simultaneously in grounded theory research. Prior to data collection and analysis, approval was received from the Institutional Review Board (IRB) as shown in Appendix E. Signed informed consent was received from the 12 nurse participants before interviews were conducted (also in Appendix E). The initial interviews were face-to-face

interviews with the nurse participants at designated areas and times. These interviews occurred August through December of 2016. Follow-up interviews and member checks occurred from December 2016 through January 2017.

During data collection, each interview transcript and case scenario document were assigned identifying notations to easily access them for analysis and write up. Each interview transcript and case scenario document were coded with a pseudonym, age, sex, race, years of employment, and educational degree tag. As new transcripts or documents were coded and placed into categories or themes, they were checked against previously coded transcripts and documents to look for like themes and to realize when saturation and redundancy of information had been reached (deductive reasoning). Analytic memos were also kept during this study. Analytic memos are reflective writings about what the researcher is learning from the data (Stake, 2006). Examples of analytic memos for this research study are available for review as Appendix F.

The most frequent type of data collected in grounded theory are from interviews and observations. However, written documents, such as memos and internal documents or recorded materials can be used as well (Corbin & Strauss, 2015). Interviews are used when behaviors or feelings cannot be observed or we need people to interpret events that have occurred in their world (Merriam, 2007). Interviews are also used when the events studied happened in the past and cannot be replicated. In semi-structured interviews, there is a list of questions to guide the majority of the interview. The primary data collection source for this study was semi-structured interviews. Two researcher-generated documents were also used to collect data, a demographic survey and case scenarios.

The researcher-generated documents include a demographic data survey and case scenarios on LV. The demographic data survey was used to collect the data displayed in Table 1 and to ascertain how new nurses defined LV. The LV Case Scenario document was created to generate information about the nurse participants' ability to identify LV in the workplace and determine how nurse participants would react to instances of LV without the perceived threat of retaliation. The following sections briefly describe each data collection method and how it was used to inform this study.

### **Semi-structured Interviews**

The primary data collection source was semi-structured interviews with the 12 nurse participants. Face-to-face or telephone interviews were conducted with nurse participants after receiving informed consent. Interviews were audio recorded with participants' consent. Open-ended questions were used in interviews that lasted approximately 30 to 45 minutes. During the interviews, a list of questions was used to guide the majority of the interview and this list was used with all participants (Appendix G). However, some interviews had additional questions depending on the nature of the answers given by the participants and the follow-up required. After the initial interviews were transcribed, each nurse participant was emailed a copy of the interview transcript to check for accuracy. Follow-up interviews with nurse participants occurred face-to face or via telephone as needed to clarify or expound on any data points. Excerpts from nurse participants' interviews are available as Appendix H.

### **Researcher-generated Documents**

The purpose of researcher-generated documents is to learn more about the demographics of nurse participants and their reactions to fictional encounters with LV. A structured demographic survey was used to collect data on nurse participants' ages, gender, years of

employment, level of formal education, race, and work specialty area. Participants were also asked to define the term lateral violence on this survey. At the initial interview, participants were given a formal definition of LV, defined as physical, emotional, or verbal abuse of an employee of the same rank or position.

The second researcher-generated document were the four case scenarios. Four LV case scenarios with multiple-response options were presented to the participants in electronic format. Questions were presented in “select all that apply” format. Participants were asked to select responses that best answered the question posed at the end of each scenario or to enter a typed response if none of the responses presented were acceptable. The purpose of these LV scenarios was to determine if novice nurses could recognize different forms of LV behavior and to assess their responses to these behaviors. The benefit of the case scenario is that (a) the novice nurses’ responses can be assessed between participants using like data, (b) it can be determined if participants view LV through the same lens, and (c) it can be assessed if nurses will respond abstractly to LV as they do in real situations.

### **Data Analysis**

Data analysis in qualitative research is a recursive process and helps the researcher make sense of the data (Creswell, 2013). Data analysis begins after the first document is collected or interview is transcribed and is done simultaneously with data collection from each subsequent document, interview, or observation. The constant comparative method allows the researcher to search for concepts within and between all data and place these concepts into categories. These categories will become the eventual themes of the qualitative research analysis.

Data analysis occurred using the constant comparative method. This method involves comparing segments of data with one another to search for similarities and differences. Data are

assimilated into smaller pieces and each piece is coded and paired together, becoming a category or theme (Corbin & Strauss, 2015). These themes allow the researcher to find patterns in the data and analyze relationships among the data (Merriam, 2009, p. 30). Throughout data analysis, analytic memos were transcribed to capture developing concepts and relationships within and between data. Each theme was developed in terms of properties and dimensions that were integrated around a core category, which became the major theme of the study. When viewed as a whole unit, the core theme and supporting themes provide the structure and foundation for the grounded theory (Corbin & Strauss, 2015).

In theoretical sampling, codes are generated through an inductive process and guide data collection (Munhall, 2012). Theoretical sampling is an open form of sampling in which there is an identified population, but data collection is otherwise flexible. The number of participants and data needed are dependent upon concept development (Corbin & Strauss, 2015). Data analysis generates concepts. Concepts guide question formation and dictate which participants are needed for further study and what questions need to be asked. Theoretical sampling was employed in this study. As an example, it was noted that more associate degree nurses were being interviewed at the beginning of the study than bachelor prepare nurses. In order to answer questions related to academic preparation and its relationship to the nurse's preparedness to handle LV, I had to sample more BSN registered nurses.

Data analysis began with the first interview and was ongoing throughout data collection. First, responses from the initial case scenarios and interviews were compared for congruency between the nurse participants' spoken and written thoughts on LV. Then, case scenarios were compared for congruency between nurse participants in their perceptions on how to respond to four instances of LV presented in each case scenario. These data were used to get a generic view

of the participants' perceptions of LV in the workplace when it did not directly affect her, whereas the interviews would give specific incidents of LV in the participant's work environment. Participants' answers were compared for similarities and differences.

Interviews were transcribed as they were collected. Coding was used to assign meaning to the data. Coding is a shorthand designation given to various aspects of data so that specific data can be easily retrieved (Creswell, 2013). Codes were analyzed, first within, and then between transcripts to assess for recurrent themes in the data. Each code was then sorted into larger categories. This represents inductive analysis. These larger categories are detailed in the data findings in Chapter Four.

In grounded theory, there is a specific process to forming *themes* or *categories*. First, data were analyzed for *concepts* that were used to build *conceptual categories*. These concepts help to describe social processes. Conceptual categories are supported by properties and dimensions that describe the qualities of each category (Corbin & Strauss, 2015). To create categories and properties, a process known as open coding was used. Open coding involves assigning a word or phrase to actions, events, processes, or statements in data that relate to the research questions (Saldana, 2016). Open coding also requires the researcher to write analytic notes during the coding phase to carefully scrutinize the data (Corbin & Strauss, 2015). Initial codes were then compared to codes identified in new data for similarities and differences. This continual comparison of data led to clarification and modification of existing codes, and emerging codes. This is useful because it allows the researcher to search for redundancy and saturation of data within and between categories. Question formation leads the researcher to the next study participant and this circular data collection process continues until saturation occurs. Saturation refers to the point in research when all major categories or themes are well developed,

show variation, and are cohesive (Corbin & Strauss, 2015). Holistic and In Vivo coding were used to analyze the interview data of the 12 nurse participants.

Holistic coding is ideal for qualitative studies that utilize multiple participants and semi-structured data gathering procedures to create a list of themes and categories (Saldana, 2016). Holistic codes served as the tools to create labels for the data sets within each of the interviews by assigning a unique term or phrase to relevant dialogue. Assigning these codes allowed me to search for relationships within and between interviews. This served the purposes of helping to identify differences and commonalities between interviews, begin to recognize larger themes from the data, and recognize when saturation and redundancy of data occurred. Holistic coding was performed manually and placed in the right-side margin of the transcripts. Manual transcription allowed me to read and re-read the transcript and re-listen to audio recordings for emphasis on certain phrases used by the participants to thoroughly analyze and immerse myself in the data analysis process. Table 2 depicts an example of the holistic coding method used to analyze data and assign codes and categories and/or themes. A partial list of codes and themes constructed during the data analysis process are shown in Appendix I.

**Table 2**

*Holistic Coding for Lateral Violence Interviews*

Interview Excerpts	Holistic Codes	Themes
<p>“But it also just really wasn’t working out at that job. I wasn’t happy there. That’s really the main reason why I left. I just didn’t like being there anymore.” Interview 1</p>	<p><i>Unhappiness</i></p>	<p><i>Detachment Syndrome</i></p>
<p>“And it has been really tough working there so far. It’s been really tough. It was nothing like I expected. It’s nothing what I had hoped for, had thought it would be. It’s been very frustrating, especially these past few weeks.” Interview 5</p>	<p><i>Culture Shock</i> <i>Helplessness</i></p>	<p><i>Detachment Syndrome</i> <i>Culture of Lack</i></p>

Table 2 (con't)

Interview Excerpts	Holistic Codes	Themes
<p>“I felt like it was very clicky at that place, more so than any other place I have ever worked. And I just felt like I didn’t fit into the click. I always kinda felt alienated from people and there was also a lot of stuff with management that was going on that I really didn’t like.”</p> <p>Interview 1</p>	<p><i>Alienation</i></p> <p><i>Isolation</i></p> <p><i>Cliques</i></p>	<p><i>Engineered Failure</i></p>
<p>“I mean like talking to doctors, or whatever is going on, I feel like they could push us into that a little bit more instead of just put us over here in this little cage, like ‘you people’. You know what I mean? And then they keep on doing their thing. And sometimes they get so busy that either they don’t want to take the time or I don’t know...maybe they do it on purpose. I really don’t know...”</p> <p>Interview 3</p>	<p><i>Isolation</i></p> <p><i>Helplessness</i></p> <p><i>Engineered Failure</i></p>	<p><i>Detachment Syndrome</i></p>
<p>“So basically because she was upset because she felt that she should have been in charge and not me, she was basically putting me down and setting me up to fail...She went behind my back talking to the nursing supervisor...”</p> <p>Interview 1 Excerpt</p>	<p><i>Engineered failure</i></p> <p><i>Lack of support</i></p> <p><i>Lack of support</i></p>	<p><i>Engineered Failure</i></p> <p><i>Culture of Lack</i></p>
<p>“Because, I don’t get any help. They give me all the hard patients. They give me admissions when I am already having a hard time. I just don’t like it.”</p> <p>Interview 4</p>	<p><i>Engineered Failure</i></p>	<p><i>Detachment Syndrome</i></p>
<p>“They were understaffed and they needed us to hurry up and get off of orientation so that they could have adequate staff.”</p> <p>Interview 3</p>	<p><i>Lack of Adequate Training</i></p> <p><i>Engineered Failure</i></p>	<p><i>Engineered Failure</i></p> <p><i>Culture of Lack</i></p>

Note. Excerpts from participant interviews.

In Vivo coding refers to a verbatim word or phrase used by the participants and originates from the qualitative data record (Saldana, 2016). Saldana (2016) maintained that In Vivo coding is appropriate for qualitative researchers who want to honor the voice of their participants, especially those who may be marginalized. Each interview in this study was analyzed using In Vivo coding after transcription. In Vivo codes were completed manually. They appeared in the right-hand margin of the transcripts in quotation marks to indicate that they were the spoken words of the participant. In Vivo codes were analyzed within and between cases to determine

similarities, differences, redundancies, and saturation. Table 3 depicts an example of the In Vivo coding method used to analyze data.

**Table 3**

*In Vivo Coding for Lateral Violence Interviews*

Interview Excerpts	In Vivo Codes	Themes
<p>“Well, it’s been, in general, I’ll say there may be times that you ask for help with something and you get the rolling of the eyes or ‘okay, give me a minute and I will see if I can help’ being said in a way that it’s obvious that you don’t want to help me.” Interview 8</p>	<p>“rolling of the eyes” “obvious that you don’t want to help me”</p>	<p><i>Judgment Days</i> <i>Detachment Syndrome</i></p>
<p>“But that first experience is the most difficult one. And, unfortunately, it was just right after I had come off of orientation as an RN. So, I’m already kind of nervous and second guessing things, trying to be as careful as I can be. So, it was just kind of startling that I had that interaction my first week as an RN. But I did what I had to do for my patient and that’s all that matters.” Interview 10</p>	<p>“difficult” “right after I had come off of orientation” “already nervous and second guessing things” “did what I had to do for my patient” “that’s all that matters”</p>	<p><i>Wavering foundation</i> <i>Culture of Lack</i> <i>Self-preservation</i> <i>Staying centered</i></p>
<p>“I feel like I am not valued or respected where I am at all. Like, it’s gotten a lot better but when I first started out, our nurse to patient ratio was one nurse to four patients and you still had the potential to get two other patients in the hallway. So, it was potentially like a 6:1 ratio which wasn’t safe. It was really stressful on me and I was actually at work a couple of months ago and my heart rate went up to 235 and I had to have an ablation done because they found out I had a birth defect. And the stress of the job made me have to have a cardiac procedure done.” Interview 11</p>	<p>“not valued or respected” “wasn’t safe” “really stressful on me” “my heart rate went up to 235” “stress of the job made me have a cardiac procedure done”</p>	<p><i>Wavering foundation</i> <i>Culture of Lack</i></p>

Table 3 (con't)

Interview Excerpts	In Vivo Codes	Themes
<p>“Well my nurse managers have been, they’ve put in a new program, like sort of a buddy system. Where they remind the older nurses to just watch us, help us, and be available to us. And I think that has been pretty helpful, like just knowing that someone else is...I know that puts extra workload on the experienced nurses but even if they were just available to us or just asked us every now and then do you have any questions. It really is helpful.” Interview 12</p>	<p>“buddy system” “watch us” “help us” “be available to us” “just asked us every now and then do you have any questions” “really helpful”</p>	<p><i>Discerning the Good Preceptor</i></p>

Note. Excerpts from participant interviews.

### Theoretical Framework

Harris (2006) suggested that a theoretical framework is a guide that helps to frame, organize or order a problem, phenomenon, or question. In this view, a theoretical framework helps to bring shape and focus to a certain experience. Kearney and Hyle (2006) proposed that a theoretical framework is a road map that is easily visualized and helps one to draw inferences into the study. Henstrand (2006) maintained that a theory is a lens used to filter data. In this definition, theory helps one to focus on meaningful data and suggests that one should view information with an unbiased eye. This assists the researcher to stay focused on the issue in question. In the realm of qualitative research, the researcher uses the theoretical framework to shape the study and form the presentation and its content so that all who read the results understand the form and direction of the researcher, or more importantly the phenomena or lived experiences of the participants. Joan Tronto’s (1993) ethics of care theory was used to frame and organize the data from this qualitative research study. Tronto’s five moral elements served as a guide to explain how nurses can use an ethics of care to create a healthy work environment.

## **Validity and Reliability**

### **Validity**

To increase the credibility, or internal validity, of this study's findings, triangulation, member checks, and reflexivity were utilized. Triangulation can occur using multiple theories to provide corroborating evidence to shed light on a theme or perspective and provide validity to data findings (Creswell, 2013). Joan Tronto's (1993) ethics of care and Huntington's (Glenn et al., 2003) characteristics of professionalism were used to validate the themes identified in this report. I also triangulated the data by comparing interview transcripts to case scenario responses of all the nurse participants.

Member checks were performed during this study. A member check is the process of soliciting feedback on emerging findings from study participants (Merriam, 2009). In order to solicit feedback from the nurse participants during data analysis, first the nurse participants were sent a copy of the original, verbatim transcribed interview. Participants were then asked to review the preliminary analysis of data from interviews and asked if they agreed with my interpretation. These transcripts were sent via email to the participants. Follow-up interviews were scheduled when clarification or more information was needed.

Later in this chapter is the researcher's positionality or reflexivity statement, which describes my biases, assumptions, and experiences with LV. Reflexivity helps to clarify biases that the researcher brings to the study. Open and honest self-reflection creates a dialogue with the reader about the researcher's background and how past experience shapes the interpretation of the study's findings.

Thick, rich, and detailed description is used to present the study findings in Chapter Four to assist the readers to determine its applicability to their practice setting. Use of descriptive

context and quotes from interviews and documents are used to submerge the reader in the evidence. By using different variants, such as years of work experience, highest degree earned, and any other variable that emerged in the study as relevant, transferability is enhanced. However, due to the nature of qualitative research, generalizability is a limitation of the study.

### **Timeline of Study**

The timeline for this research study was August 2016 through January 2017. Data collection began in August of 2016 with the initial interview of Nurse Participant One and the study ended in February of 2017 with the final data analysis. Data analysis was an ongoing process that began in August of 2016 with the transcription of the first interview. This is when analytic memoing began. The holistic and In Vivo coding process analysis began in September of 2016 and was ongoing through January of 2017. The final report was written February 2017.

### **Ethical Considerations**

It is important for the researcher to protect the participants in all research studies. Creswell (2013) suggested that researchers develop trusting relationships with participants to promote the integrity of the study, protect against misconduct and impropriety, and cope with any new problems that may arise during the course of the study. Ethical issues include privacy of participant's data, personal disclosure, researcher authenticity, and credibility of the research report. To address ethical issues that may arise, the following actions were taken.

A neutral site, one of two office spaces, was used to conduct interviews. Participants were given verbal and written information on the purpose of the study, voluntary informed consent, participant anonymity, and any rewards for participating. All data collected was coded for confidentiality. Each participant was invited and agreed to participate in member checks during the analysis phase of the study and received a copy of her interview transcript. Due to the

sensitive nature of LV and the possibility of harmful psychological effects, the participants were instructed on counseling availability. No participants requested the counseling services.

### **Strengths and Limitations**

Qualitative research has both strengths and limitations. As a strength, qualitative research is founded in real-life situations and offers a rich and holistic account of a phenomenon from the perspective of those involved. Qualitative studies offer insight and illuminate meaning that could lead to tentative hypotheses for future study. One of the most important strengths of this qualitative research is the possibility of advancing nursing knowledge and improving nursing practice as it relates to compassionate care and creating safe, healthy work environments for nurses that are free of LV. Future policies on nursing academia and clinical practice can be informed on the relevance of teaching, modeling, and reinforcing professional care principles in nursing classrooms and clinical practice settings at all levels.

Due to the small sample size and subjective nature of qualitative inquiry, the results may not be generalizable and assumptions cannot be made that all nurses with the same educational background or same years of work experience will experience and define LV violence in similar terms. Because the researcher has seen or witnessed episodes of LV, it is impossible to remove all researcher bias. Due to the nature of this research study, participants were chosen purposively and not randomly.

### **Researcher Positionality**

Researchers' backgrounds (such as work experience, cultural experiences, and history) inform their interpretation of data findings throughout a study (Creswell, 2013). This is known as researcher reflexivity. As such, our readers have a right to know "what prompts our interests

in the topics we investigate, to whom we are reporting and what we personally stand to gain from our study” (Wolcott, 2010, p. 36).

My experience as an educator started in 2011 in a rural area of the southeastern United States, not far from where I grew up. I became a nurse in 1994 and remained at the bedside until 2010. From 2010 until 2011, I was a nurse manager of a rehabilitation unit. In 1998, I had the opportunity to care for a nurse faculty. After a couple of weeks in the hospital, she asked if I had ever considered becoming a clinical instructor. I applied for an opening at her institution and worked as a part-time clinical instructor while maintaining my full-time acute care position until the birth of my second child in 2004. It is at that time that my heart fell in love with teaching because I loved the look of awe and wonder in the eyes of student nurses and the enthusiasm of wanting to “save the world” that most of them had.

In 1994, I was probably 4 months out of nursing school and still afraid of my own shadow. I was afraid to ask questions because I did not want to appear inept. At the time, I did not realize that the true foolishness lay in not asking questions that should be asked. At any rate, it was during change-of-shift report that I experienced my first encounter with what is now known as “lateral violence.” I had not adjusted a patient’s infusion pump accordingly and the nurse I was giving report to at the nurse’s station let me and every nurse, doctor, lab technician, and family member within ear shot know the error of my ways. I just knew that the patient was doomed and so was my career. As it turns out, neither was true. I called the patient’s attending physician to let him know my error. To my surprise, he was extremely kind; corrective, but kind. When I finally made it to my car, I sobbed and wondered if I was competent enough to be a good nurse or if I should quit before I actually harmed a patient.

Fortunately, I do not know what it means to quit. Growing up as the oldest child in a poor household and not wanting to return was motivation enough. We had a three-bedroom house and at any time up to three families could be living in our house. I was the first to graduate from college with a baccalaureate, or any degree for that matter. I should mention that I am female and African-American. All of my life I have been told stories of my ancestors who have had to overcome more than me, so a few tears and a few harsh words were just enough to make me want to try harder to be the nurse I knew I could be. I have tough skin, which is why I did not cry in the nurse's station. I also was not confrontational because I knew that I had done something wrong and I needed to be corrected. I just thought back then, and now, that the problem was in the way that she chose to correct the behavior. I did not think that a new nurse, or any nurse, needed to be humiliated in front of her peers to learn medication management. In my opinion, a more ethical approach would have afforded me some dignity and respected my right to, at least, private humiliation.

In the 22 years since that moment, I have witnessed and occasionally intervened on too many similar moments. These moments have occurred in the clinical practice setting and in educational settings. The victims have been persons of equal, less, or more power than the perpetrator signifying both LV and bullying behaviors. The most disturbing for me is experienced nurses interacting unfavorably with student nurses or new nurse graduates. Too soon we forget that we were once where they are and we adapt the habits of those who made us feel less than. Typically, when the victims are in positions of higher power, students are the perpetrators and teachers are the victims. I am still not sure how I feel about the terms "perpetrators" and "victims," but as these are the words used in the literature, we will use them.

The thing is, until I was a student in my current graduate program, I had never heard the term “lateral violence,” and I never equated bullying to the behaviors I had witnessed in my work environment. Therefore, this notion of LV and bullying in nursing fascinates me because I love my profession and I do not like negative connotations linked to it. However, if it exists, we need to make sure all nurses can assess it, diagnose it, treat it, and get rid of it.

As for my position, it fluctuates. On the one hand, my personal encounter in 1994 hurt my pride and my feelings. On the other hand, I credit that experience with shaping the way I decided to be a nurse. I started questioning everything that I did not know or understand. I double checked all of my labs and medications. I did not want to make another mistake because of that incident in that nurse’s station. One could argue it was the patient’s well-being that was the driving force behind my change in habit. But I am not sure. I watched that same nurse treat others similarly, and it did not change their habits. They just avoided her or dreaded having to deal with her. Some hated to work with her, which created an interesting work environment. Now I question were there other variables at play that made the work environment volatile.

As nursing researchers, we spend so much time building evidence in the cognitive and psychomotor domains of patient safety and health promotion and maintenance. I am passionate about the affective aspect of nursing. Sometimes I feel as though care and compassion either is taken for granted or is tossed aside as an unimportant commodity, as it is in everyday society. We work in a field where death and suffering are commonplace. I tell my students all the time, “Imagine if yours is the last face a patient sees or the last voice they hear before they take their last breath. What do you want their last memory to be?” I do not subscribe to the notion that people can turn compassion on and off. So it is disconcerting to me that nurses are being uncivil to each other but are thought to be caring to patients.

As a nurse educator, I feel it is my responsibility to teach and model professional values to my students. I feel that it is my responsibility to educate my students to be intellectually and socially competent, for we are intellectual and social beings. In the immortal words of Dr. Martin Luther King, “I can never be what I ought to be until you are what you ought to be.” This is an expectation that should be modeled in all professional settings: classroom, simulation lab, and clinic. It is an expectation that should be questioned when we fail to see it demonstrated among our peers in academia, on nursing units, in nursing management, and across all nursing settings. When nurses wear their uniform and wear the tag that distinguishes them as a Registered Nurse, it should mean something. All nurses in professional settings, in my opinion, should honor the *Code of Ethics for Nurses*. I believe that this requires pedagogical standards across all nursing curricula to ensure that nursing students recognize and understand the basic tenets of the ethical code to treat all persons with dignity and respect. Promoting and enforcing an ethics of care in nursing curricula would be a good place to begin.

As a researcher, I will remain open to the data and allow it to guide me to theoretical discovery. As of this moment, I am positioned in a place that leads me to believe that all nurses must be educated as ethical, professional beings who are expected to treat their fellow humans and should be expected to be treated by fellow humans with dignity, respect, and a modicum of benevolence. The mere existence of LV in our work environments suggests that there is an infestation among us that we must quickly assess, diagnose, and treat so that nurses can heal our work environments. After all, that is what we do best.

### **Chapter Summary**

This chapter outlines the qualitative methods that were used to complete this study using a grounded theory approach on nurses’ perspectives of LV in the workplace. Twelve nurse

participants were chosen using purposive, theoretical sampling. Data gathering and analysis occurred simultaneously using the constant comparative analysis method. Individual semi-structured interviews and case scenario documents were used to gather data. Triangulation, member checks, researcher reflexivity, and the use of multiple data sources served to strengthen the validity of the study. The use of thick, rich description will help the reader of the study determine the transferability of the findings as described in Chapter Four. Due to the nature of qualitative research, it is understood that the findings of this study may not be generalizable, but will represent an abstract construction of the meaning nurses give to LV and the importance of developing professional behaviors in future nurses.

## CHAPTER FOUR

### FINDINGS

This chapter presents the findings of this qualitative research study using a grounded theory approach. The experiences of 12 new nurse graduates from associate and bachelor degree granting institutions were documented to ascertain their view of lateral violence (LV) during their first 2 years of nursing practice. Excerpts of their stories help to support the themes, properties, and dimensions in this chapter. The first section describes the meaning that the nurse participants gave to the term lateral violence and documents other relevant findings from the LV case scenarios presented prior to the interview sessions. Then, initial findings are presented that answer the original research questions. Latter findings present the answer to the research question that emerged as a result of the research process. Through concept and category analysis, data were gathered and analyzed to create themes. Theoretical sampling and constant comparative analysis allowed for the creation of more focused questions as the research process continued and themes began to form and gain properties and dimensions. These data are depicted as codes and themes throughout this chapter.

The grounded theory approach was used to create themes to label how novice nurses experienced, recognized, coped with, and wished to rid the work place of LV. Using open-ended questions during interviews to collect data allowed participants to speak freely and openly about their encounters with what they perceived to be LV. It was important to allow the participants to speak uninterrupted during the interview process. Through data analysis and the open coding

process, concepts began to emerge and a new question began to take form. This new question gave way to the concepts that would formulate the core theme for this research study.

Four themes were developed as a result of using grounded theory analysis. In response to Research Question One, How do novice nurses experience LV in the workplace?, the theme *Reckoning Zone* emerged. This theme is supported by the properties of *engineered failure*, *detachment syndrome*, *wavering foundation*, *judgment days*, and a *culture of lack*. For Question Two, How does the novice nurse reconcile a commitment to professional care with experiences of LV in the workplace?, the theme *Self-Preservation Zone* was conceived. Research findings for Question Three, What pedagogical interventions can be used to address LV in the workplace?, produced the theme *Affective Zone*. Properties and dimensions that supported the *Affective Zone* were captured in (a) *the Code of Ethics for Nursing matters*, (b) *early introduction of LV across nursing curricula*, and (c) *discerning good preceptors*. Finally, findings from the question that evolved from the research study, Why do nurses struggle to give voice to affective issues within the profession?, culminated in the theme *Zone of Silence*. The properties and dimensions that supported the *Zone of Silence* are the *devaluation of nursing*, *role confusion*, and *orchestrated unawareness*.

### **Lateral Violence as Defined by Nurse Participants: The Lateral Violence Zone**

As part of the demographic survey data collection, nurse participants were asked to give a definition of the term *lateral violence*. Five out of 12 participants used the term “bully” as part of their definition. These participants described LV as “bullying,” “belittling,” “harassment,” or “acting unfriendly” toward colleagues in the work place in ways that caused “emotional or physical stress.” Others defined LV as “negative interactions,” “aggressive behavior,” or “mistreatment” of a coworker. Ten participants admitted to being victims of LV, while two

witnessed LV behaviors. All participants were able to recognize LV in the case scenarios, but responded to the scenarios in multiple ways (see Appendix J for complete results). Of significance, in Case Scenario 2 and 3, 83.3% and 50% of the nurse participants, respectively, stated that they would confront the perpetrators of LV and/or bullying behavior in the hypothetical scenarios. However, during interview sessions, nurse participants never confronted their LV aggressors.

From definitions given by the nurse participants and the case scenario findings, the *Lateral Violence Zone* was conceptualized. The *Lateral Violence Zone* encompassed the time, space, and behaviors that created a sense of apprehension, uncertainty, and self-doubt in the novice nurse. In this realm, LV behaviors are recognized and experienced and coping mechanisms are adapted to survive unhealthy work spaces. The *Lateral Violence Zone* consists of the *Reckoning Zone*, *Self-Preservation Zone*, *Affective Zone*, and the *Zone of Silence*.

### **Experiencing Lateral Violence in Nursing: The Reckoning Zone**

Nurse participants described different ways in which they experienced LV in the workplace. The transition from student nurse to registered nurse was a time wrought with excitement, insecurity, and nervousness for the participants in this study. As it related to LV, the *Reckoning Zone* described the length of time from the new nurse's first day of orientation until the moment that the new nurse gained a sense of professional competence, self-assurance, and has adequately transitioned into the role of registered nurse. The *Reckoning Zone* was characterized by feelings of being "*stressed*" and "*overwhelmed*" and the new nurse had a heightened need for professional, social, and emotional support from his or her peers. The *Reckoning Zone* was best described by the properties of *engineered failure*, *detachment syndrome*, *wavering foundation*, *judgment days*, and a *culture of lack*.

## **Engineered Failure**

*“I mean, her patient would be crashing and she would ask for help and nobody would help her. They’d let her sink.”* – Daisy, 27-year-old, Caucasian female, worked in ICU, but left after 10 months, in part due to LV behaviors.

*Engineered failure* described the effort whereby an authoritative figure, intentionally or unintentionally, sabotages the development in the clinical judgment and reasoning, psychomotor, or affective skills of a new nurse that could have harmful effects. These effects can cause harm to either the new nurse, the patient, the nursing unit, or the organization as a whole. The new graduate registered nurse orientation phase was a time of high anxiety and many questions for the nurses interviewed in this study. However, many of them felt that the nurses on their units, including those chosen to precept them into their new nursing roles, were not forthcoming with information. Some of them went on to describe instances of disorganized or disjointed orientations that set them up to fail and preceptors who did not want them to succeed.

Daisy, who went to work in an intensive care unit (ICU) after graduating from an accelerated baccalaureate degree program, said that she was not “taught how to be a critical care nurse in a real world setting” and “never really got taught anything” by her preceptor. Daisy also described an incident after her orientation when the nurse who had been her preceptor went behind her back and talked about her “to make me look like I’m not qualified.” This led Daisy to feel as though “people were turning on me” and she chose to leave the unit after being there for 10 months. Daisy’s story was not unique.

Sherry, a 23-year-old graduate of an associate degree program, recalled an incident where a new nurse, less than 6 months out of orientation was given a team of patients that was less than optimal in her ICU. At this time Sherry had been a nurse for approximately 9 months and thought the acuity level of the patient and intensity of the workload being assigned to the new

graduate would be trying for an experienced nurse, let alone a new nurse. According to Sherry, the assignment was given to the new nurse “on purpose.” “I heard them say, ‘I don’t want to take that pod (two adjoining ICU rooms). That’s two DT (delirium tremens) patients. I can’t handle it. Put it with the new girl’.” Sherry went on to explain that this was implemented by the charge nurse of the ICU. She also added, “This happens to a lot of people I work with.” The notion of *engineered failure* leads to unsafe patient assignments, according to several study participants.

Some nurse participants were living by the mantra, “you are just going to have to learn as you go,” even when patient safety is jeopardized. Several nurse participants described the experienced nurses on their units as having a “sink or swim” mentality toward the new nurses. Faye expressed that she felt that her preceptor set her up to fail as well, “And I feel like maybe somebody did it to her. And so maybe she felt like she had to pass the buck and do it to me. It was like an initiation thing.” Daisy, Sherry, Donna, Anne, and Faye shared instances of experienced nurses either withholding information from new nurses, or being unwilling to help novice nurses. Instances that they felt would have expedited patient care. None of the stories are more memorable than Donna’s account of *engineered failure*.

Donna was a graduate of an associate degree program and had been a nurse for only 3 months at the time of our interview. She worked on a medical-surgical unit that received a large influx of patients who had had total joint surgeries during the evening shift hours and she worked the 7 p.m. to 7 a.m. shift. The frustration in her voice was noticeable, but so was the disillusionment with the profession that she thought she knew and understood. Donna was seeking assistance from a colleague with more than 8 years of experience when she noticed that a patient who had had a total joint replacement no longer had a pedal pulse (an abnormality that

could lead to amputation, if not corrected immediately). She had asked the RN to come in and check the pulse to confirm her findings. Donna explained, “He told me, ‘no’ because he was in a situation before where he had to give a deposition . . . so I didn’t get any help from him.” Donna was still visibly upset by this situation as she continued to explain, “I just wanted a second opinion because you go in and I’m not getting a pulse.” Though Donna eventually received help from the house supervisor, which caused a delay in patient care, she expressed that when she had questions or needs help she no longer asked this nurse for assistance.

### **Detachment Syndrome**

*“I feel like as a nurse you care about your patient but I don’t feel like nobody cares about you, including other nurses.”* – Faye, 31-year-old, African-American female, left the job on a medical unit after 2 months because of LV treatment from her preceptor.

*Detachment syndrome* described the conflicting culture whereby experienced nurses isolated themselves from new nurses and did not establish a nurturing relationship with the new nurse to indoctrinate her or him into the professional nursing role. *Detachment syndrome* restricted the new nurse from becoming a part of the established unit culture, thereby creating a vacuum for LV to exist and persist, and is also known as the “us versus them” unit culture. Nine of the 12 participants interviewed in this study were working or had worked in fractured work environments where they “felt like they were being excluded,” “felt like they weren’t part of the group,” or were viewed as too needy.

A commonality among participants in this study was the identification of cliques on the nursing unit early in the orientation phase. “Everyone has their own little group and if you are not in that group then you will be talked about. It is very clique-y.” Many of the participants quickly realized that they did not have membership in these unit-based factions. There is a vulnerability created in the orientation period, or the months immediately post-orientation, that

creates a fear that “I’m going to be left with those nurses that don’t want to help me.” And so some new nurses start to bond with other new nurses on the unit or “nurses closer to my age” and the “us versus them” mentality is etched.

May was a 27-year-old BSN graduate who had been working on her unit for almost 2 years. Her view of her work environment was better at this point, but shortly after orientation, she had several encounters with LV that made her question her commitment to the medical-surgical unit that she eventually decided to remain on. As a new RN, she remembered asking a lot of questions and she remembered one experienced nurse who had been on the unit for several years telling her, “Don’t ask me for any more help.” At the time, May thought the RN was joking but soon realized that she was not. When I asked May how the nurse’s response made her feel, this was her reply:

Made me feel kind of low. Like, I was still new. I needed help. I don’t know everything. If a problem arises, how do I handle the situation? What am I supposed to do and who am I supposed to ask?

This sense of helplessness and vulnerability was felt by several of the participants in the study who expressed feeling as though “I was by myself,” that they “weren’t a part of the group,” and, probably most importantly, that “I didn’t know how to express myself.” Hence, they became isolated and failed to create bonds at work.

Jackie was a 24-year-old nurse who worked in the emergency department. She had worked there for 6 months. Jackie was actively searching for a new job at the time of our interview due to multiple instances of LV. On one occasion, Jackie recalled preparing to hang an insulin drip on a patient admitted with a diagnosis of diabetic ketoacidosis. Jackie noticed that the intravenous (IV) site was cold, swollen, and the patient was complaining that it was hurting her. So, Jackie agreed to start another IV. The more experienced nurse came in the patient’s

room and told her the IV was fine and that it could be used. Jackie told her that she would feel more comfortable starting a new line for the insulin.

I come out of the room and the nurse who told me the line was fine before, pulls me into a side room and starts yelling at me about how I made her look stupid. I wasn't a team player. How I wasn't advocating for the patient because I made her a pin cushion...She cornered me.

Jackie explained, "You could tell the people who heard the story from her would just look at me like, 'that was dumb'."

The antagonism that exist between experienced nurses and new nurses created a culture of helplessness in new graduate nurses. In their own words, new nurses expressed the isolation and helplessness that was felt during and shortly after orientation as a new nurse: "being excluded," "you don't matter," "outsiders," "really been tough," "don't just leave us," and "help us." The turbulent transition from student nurse to new novice nurse that was experienced in the *Reckoning Zone* is discussed next.

### **Wavering Foundation**

*"I was supported by some at first and then eventually, I wasn't. Not all the time."* –Liz, 24-year-old, African-American female, worked on a medical unit for 11 months before leaving due to long work hours and LV, especially a lack of support from more experienced colleagues.

*Wavering foundation* was the term used to describe the unpredictable nature of the orientation of the new nurse and fluctuations in behavior of preceptors during that orientation. It also referred to the time frame shortly after orientation, generally the 1st year of employment, when the novice was still asking a significant number of questions. *Wavering foundation* was characterized by shortened orientation, extreme demands on time, high patient acuity, and the persistence of *engineered failure* and *detachment syndrome* at a time when the new nurse has not

developed sufficient time management and coping mechanisms. During *wavering foundation*, the new nurse often cited feeling “overwhelmed” and “stressed” by the demands of a career.

Liz had been working as a nurse for over 1 year. She was working her second job as a registered nurse after leaving her first job due to work load and instances of LV. Liz felt like she constantly experienced the wrath of nurses who were burnt out and frustrated with their jobs and described being “overwhelmed” at her previous job. Liz’s foundation was shaken because of the insubordination of the patient care assistants and licensed practical nurses who constantly questioned her authority and left tasks undone. Because of their seniority in years of service, Liz felt that the registered nurses would side with them over her. “I was supported by some at first and then eventually, I wasn’t. Not all the time.” For Liz, she felt she knew the moment she lost the support of one of the nurses on the small unit she worked when the nurse would constantly “hammer me with questions” during change-of shift report. “I would meet with the other ones (nurses). They would be like, well she didn’t do that to me so I don’t know if it’s like something personal against me or what.” Liz left that job after 11 months.

Most of the participants in this study shared Bea’s viewpoint, “if it wasn’t for some of my coworkers, I would be completely happy with my job.” This “love the work, hate the environment attitude” was consistent with the statements “it has nothing to do with the patients,” “I love my job,” and “I love the patients.” The problem with experiencing LV lies in the sense that “you have to learn on your own,” and being “overwhelmed” and “stressed” that 11 out of 12 participants felt during their orientation as new nurses. This is problematic because it was directly connected to a sense of *detachment syndrome* and *engineered failure* authored by experienced nurses who the new nurses thought were there to make their transition to nursing

practice smooth and safe for the patients. “It is overwhelming if people don’t show you the right way to be a nurse and patient’s lives are on the line.”

The study participants described many areas of the new nurse orientation process that could easily promote a culture of LV. Participants described orientations that were shortened because the unit was “understaffed and they needed to get us off orientation.” Some participants were assigned either multiple preceptors, inexperienced preceptors with less than 1 year of nursing experience, or a combination of the two. One preceptor had only been a nurse for “3 months.” Faye described a scene of confusion on her first day on her unit.

My first day showing up, I didn’t know where to go, who I was supposed to talk to. The girl who was supposed to be my preceptor didn’t show up that day...I got put with a nurse...who had only been on the floor for 3 months.

Once the preceptor learned that Faye had been an LPN, the preceptor decided “just to fall back and let me see how it feels. I didn’t know anything about this particular hospital. She just kinda, sorta just pushed me out there.”

During the initial orientation period, and the subsequent months after, there was “a lot to take in as a new nurse” and the study participants felt as though they were not prepared to handle the patient load that was assigned to them without a safety net, the assurance that an experienced nurse would be there if a “situation arises.” Instead of a fond remembrance of the orientation process, most study participants shared the sentiment that “this whole orientation process has been an absolute nightmare” and “it was just terrible.” As one put it,

I mean, I’m new to all of this. I mean, you’re not taught how to grow up at 22. You’re just not used to how to be a new nurse. You know what you are supposed to do and you are taught professionalism but you are not taught how to deal with doctors, how to deal with each other.

For these new nurses, they depend on experienced nurses and preceptors to teach, guide, mentor, and show them how to be a nurse. However, disjointed and disorganized orientation periods laid an unsteady foundation for the study participants that left them feeling unsure of their nursing abilities when placed on their own.

### **Judgment Days**

*“When I ask questions at work, sometimes I get looked at like I’m stupid. And I really just don’t know...But, I’m taking care of somebody and it’s important for me to know.”* – Donna, 23-year-old, African American female, remained on the job but planned to leave after 1 year of experience to pursue Travel Nursing; cited LV as her reason for not wanting to stay.

*Judgment days* was the term used to describe the fear of professional judgment incurred by the new nurse. Each nurse interviewed expressed the desire to be seen as a competent nurse who had completed a rigorous nursing program and passed the required licensure exam. Each presumed that as a new graduate, mastery of nursing was not the expectation and asking questions was part of the expected learning curve that would be anticipated by their experienced counterparts. For a few, their questions were met with enthusiasm and a genuine willingness to share years of knowledge gained through experience. For most, their questions were met with a perceived condescending judgment that left the nurse participants feeling “silly or dumb for asking a question.”

June, a 23-year-old BSN graduate, who had been on the job for 3 months at the time of this interview, worked in an intensive care unit. June explained being overwhelmed as,

I guess, just so many new things being thrown at me. And a lot of people either expect you to know everything . . . I mean other nurses expect you to already know everything and already know how things work. Um . . . so it’s hard when you have to interrupt them a lot and ask questions and get clarification.

Bea’s frustration comes from feeling as though the management on the unit is not supportive of new nurses and that there is a lot of “gossip” on the unit about new nurses in public

spaces. Bea spoke of one new RN on the unit who she had heard the nurse manager and team leader talk about on multiple occasions. I asked Bea had the other nurses on the unit taken any steps to try and improve the new nurse's skills and abilities. This was her response,

They help sometimes, but then they will come back and talk about her like she is really incompetent behind her back instead of talking to her and I don't like that. I mean if you are going to help somebody, you shouldn't talk about them.

Gossiping was a constant theme with the majority of participants in this study. As Anne put it, "Let me just say that everybody talks about everybody behind their back."

A persistent theme in the interviews was the unfavorable tone and mannerisms that were expressed when new graduates would ask questions of experienced nurses. As Donna shared, "Some nurses hate to . . . you can tell from the expressions on their face, they hate to see me come. The expression on their face is like, I don't have time for you." Anne confirmed this feeling: "When you ask questions, you get looks." Anne continued, "You are ignored . . . you roll your eyes at me" or at times nurses "say ugly words at me." Anne described a story of trying to check tube placement in a neonate in the neonatal intensive care unit before a scheduled feeding. Although she knew the practice was to use a 3 milliliter (mL) syringe to insert 1 mL of air to test for proper placement of the feeding tube, she had depleted her supply of 3 mL syringes and was attempting to use a 1 mL syringe to insert air. When she asked an experienced nurse to assist her, the nurse said, "Well, you're not going to hear shit with that 1 cc syringe."

In an attempt to evade judgment, the new nurse retreated into a safe haven and chose not to question unit norms or scrutinize policies and/or procedures for fear of being judged by more experienced peers. Although most experienced nurses answered the new nurses' questions, too often the new nurse left the conversation with the perception that she had been subjected to a verbal affront; "I felt stupid," "they make you feel dumb," or "made me feel like I didn't know

anything.” There did seem to be some incongruence in the severity of these perceived slights dependent upon the nurse participants’ degrees. The nurses who graduated with associate degrees were more likely to correlate the experienced nurses’ behaviors as being offensive than those with bachelor’s degrees. The nurse participants with bachelor’s degrees were more apt to search for other causative factors for the experienced nurse’s response. As an example, Jackie explained, “you are not always going to see eye to eye with every nurse. Nursing is a stressful environment. So, if someone is disrespecting you and it’s a moment of high stress, don’t take it personal in that moment.” Jackie went on to explain the high-stress environment of a patient undergoing a cardiopulmonary arrest and the emotions that may flare during such an intense episode. She advised that cooler heads should prevail after the patient had been stabilized. Jackie also suggested that the negative interaction in LV is a two-way interaction, “Like you have to be able to differentiate between caring and frustration and people being angry at you. You have to not be a jerk when that happens, too. You can be frustrated, but don’t be a jerk.”

Carrie, who was a graduate of a baccalaureate program and worked on a cardiac intensive care unit had a similar perspective on asking questions and the negative connotation that may accompany the new nurse’s need to question everything. “I always take help if I need it and I’m not afraid to ask for help. You can’t be afraid to ask for help. Even if you ask the same person a million questions, you know, ask one more.” Carrie went on to comment,

It is the most important thing that I have learned as a nurse. There are always going to be things that you don’t know. You are going to have to be able to ask a question or something bad could happen.

The fear of being judged, as it relates to LV, is a personality trait that may necessitate more resolution on the part of the new nurse, than the experienced nurse.

## Culture of Lack

*I feel like they took us off way too early from orientation. They should be like this is how much time you are supposed to be in orientation and you are going to get your whole time that you need. And, I feel like they could reach out more to the newer nurses.* – Sherry, 23-year-old, Caucasian female, worked in critical care and cited systemic LV on her unit, had remained on the job for over 1 year but was currently placing applications to seek other job opportunities because of the toxic unit culture, which she believed to be organizational.

*Culture of lack* referred to how new nurses experienced LV due to an absence of necessary components, proper management surveillance, properly trained preceptors, adequate training time, and adherence to a professional ethics of how nurses should treat nurses. The seeds of LV are sewn in the orientation period and nurtured in the months immediately following due to this lack: lack of professional support, lack of proper training, lack of adequate preceptors and/or preceptorship length, lack of nursing management involvement or awareness, and a fundamental lack of concern for the ethical behavior of nurses towards other nurses.

Daisy recalled,

I was a brand new nurse when I started there. I got four weeks of orientation in critical care before I got out on my own. And I, even during my orientation, I was pushed around from person to person.

She continued, “It was kinda like, you just go figure it out for yourself kind of atmosphere. I didn’t really feel like I got the support that I needed to really be successful there.” Sherry conveyed this recurring scenario on her unit,

Sometimes, I would have two ventilators and, like a psych (psychiatric) patient in 4-point restraints. Just stuff that was not, in my opinion, safe. And especially not well thought out for a new graduate because you’re still learning like how to operate the ventilator, how to work on certain things.

Sherry was supposed to have 3.5 months in orientation for the intensive care unit. She was out of training in 1.5 months according to her because, “they were understaffed and they needed us to hurry up and get off of orientation so that they could have adequate staff.”

“I went on my own kinda early. I wasn’t ready to be on my own.” Donna said she expressed to her nurse manager that she was not ready to be placed on her on, but that her manager insisted that she come out of orientation. Donna had completed her student nurse preceptorship on the same unit and the nurse manager felt that Donna would not need the regular time allotted for new hire orientation, so Donna’s time was shortened. Donna said that her nurse manager simply replied, “‘It’s normal to stay over. It’s normal to have problems. It gets better with time’. And she would expect me to stay over some mornings to finish charting and finishing up what I needed to finish up.”

Others recalled what they perceived as a lack of support from their peers. May told of her days shortly after the orientation period, “Because of all the stress. Thinking about the times that I didn’t get to eat lunch. Times I just felt like I struggled. I felt like I didn’t know anything. Sometimes the lack of help on the job.” June was with her preceptor in the ICU during the 2nd week of orientation when she had the opportunity to call report on a patient. The patient had a hypoglycemic reaction that June had treated but did not follow the hospital protocol to recheck the patient’s blood glucose within the specified time frame. June said that while on the phone, the nurse “explained it to me, not in a nice way.” Basically, the nurse receiving the telephone report was rude. And I wanted to tell her, “I’m sorry, that I was new, and that this was like my second week and I didn’t even know where to look to see all of these protocols.” June said that she guessed her preceptor forgot to mention to her that there was a protocol that she should be following because she did not. The patient was unharmed.

### **Self-Preservation Zone**

The next section presents the theme, *Self-Preservation Zone*, and properties extrapolated from participants as it relates to reconciling the ability to care in the midst of LV. The *Self-*

*Preservation Zone* was defined as a reconciliatory avenue that the new nurse can take to maintain licensure and employment as a registered nurse in the midst of LV behaviors. This need may be to provide financially for self and family, to fulfill one's lifelong desire of being a nurse, or to pursue future career endeavors, such as advanced nursing practice. The *Self-Preservation Zone* allowed the new nurse to accept, ignore, evade, report, or adapt to incidents of LV because the new nurse must sustain employment in order to meet life goals. For these nurses, the culture of the unit "is what it is" or they "knew it was going to happen" because "you just have to go through it" and "there isn't anything that can be done" to change it. If conditions were unsustainable, the nurse would seek alternative employment opportunities within the same health care facility or elsewhere.

The 12 nurse participants in this study found multiple ways to cope with LV or offered suggestions as to how they thought their colleagues should cope with instances of LV. The properties that came from data analysis and support the *Self-Preservation Zone* theme are *building walls*, *assimilation*, and *attrition*. For most participants, more than one reconciliatory mechanism can be enacted to meet the demands of a "stressful" work environment.

### **Building Walls**

*"Since then, one of the nurses, the one that was mocking me, I have not spoken to, not made eye contact with her. I avoid her like the plague."* –Jackie, 24-year-old Caucasian female, worked in the Emergency Department but wanted to leave after 6 months on the job due to LV behaviors including mocking and feeling unvalued and disrespected by both colleagues and the organization.

*Building walls* referred to a coping mechanism whereby the new nurse attempted to ignore LV behaviors. Jackie presented an example of a nurse who remained at her job for financial reasons, although she was actively seeking to go to another facility because of the lack of support in the emergency department. Jackie had accumulated student debt as an out-of-state

student and felt trapped in her current employment situation. As she explained it, “I am in a place financially that I can’t even change my job if I wanted to . . . I’m stuck in a place where I am unhappy.” Instead of confronting those who mocked and berated her on her unit, she chose to avoid them whenever she saw them walking in her direction. Most participants in the study chose to ignore LV behaviors because they did not want “to make anybody upset.”

Tina gave a general suggestion on how to handle LV: “Don’t get involved with the backtalk or the talking behind people’s back because it doesn’t lead to anything good.” Tina went on to elaborate, “Keep your opinions to yourself and if you have something that you feel is a danger to other patients, you need to discuss it with that person.” In Case Scenario 3, when presented with an opportunity to speak up for a colleague who was a victim of LV, one participant responded that she tried “to stay out of other people’s business.” Another participant responded in the same scenario that she would only speak up for the colleague if the nurse manager directly asked her about the situation.

The ubiquitous nature of LV caused some participants to build walls that would not allow coworkers to damage their fragile professional ego. Bea described the culture on her unit, “It’s a negative energy all the time. Yes, sometimes we get busy and sometimes it does suck . . . But just, shut up and do your job.” Bea went on to describe her frustration with LV,

It makes me get more distanced from them. I see you go help this person and you’re smiling and talking to them, but then when you get back to your friends you’re talking like . . . they’re not going to do that to me. I’ll figure it out on my own.

Donna’s view corresponded with Bea’s assessment. Donna had two colleagues that she had experienced LV with. “Til this day, I don’t really care for that nurse. I don’t talk to her.” For the other nurse, Donna acknowledged, “I don’t ever want to ask him another question. I’ve worked with him twice since then and if I have a problem, I just don’t ask.” Anne did not like

conflict, but tried to maintain relationships. “Well, I try to avoid conflict because that is just who I am. So, I try to be understanding and still be caring.”

Although Donna had applied for a job at another facility, she was contemplating staying at her current place of employment in the hope that she could gain a year of experience and become a travel nurse. Two other participants in this study suggested that they were considering travel nursing as an alternative, while others expressed a desire to become a nurse practitioner, nurse anesthetist, and nurse educator in the future. Only 3 out of 12 nurses in this study would consider remaining at the bedside. Although it was understandable that nurses would want to maintain employment after years of arduous training, *building walls* could morph into another form of reconciliation that could breed LV, *assimilation*.

### **Assimilation**

*“I’m sorry to say this but she asked me to help her do something, and I didn’t do it.” – Donna*

*Assimilation* occurred when the new nurse took on the attitudes, rituals, and culture of the experienced nurses that she once ridiculed. This behavior required the new nurse to maintain the status quo and blend in to the unit so the nurse must start to exhibit the behavior that she once shunned. *Assimilation* also referred to accepting the other nurse’s behavior as part of the nurse’s personality or “that’s just how she is.” This allowed the experienced nurse to continue to behave in ways that were antagonistic and unsettling to a healthy work environment while asking others to adapt to the nurse’s negative behaviors instead of requiring the nurse to adapt to a culture that was better suited for a healthy work environment.

May learned to adapt to a coworker as she worked alongside her. “I think the more experience I got and the more I worked with her, the relationship got better. But, yeah, it’s kind

of part of her personality.” May learned to accept the experienced nurse’s behavior and thought it to now be socially acceptable since it was a personality trait.

### **Attrition**

*“I am actively searching out a different hospital to work at because I am not really happy with where I work . . . I feel like I am not valued or respected where I am at all.”* –Jackie

*Attrition* described transferring to another nursing unit within the same health care facility, transferring to a different nursing facility, or leaving the nursing profession altogether. At the writing of this chapter, four of the participants had left their first job and were working in another health care facility. Four were actively seeking employment in other facilities, and four decided to remain on their current units. Two of the four who decided to remain had been on their units for over 1 year. One of those two had applied for jobs in other facilities, but conceded that she could not leave her current job for personal reasons. The other, May, finally learned how to “fit-in” on her unit.

After being a constant victim of LV and witnessing nurses talking about other nurses, Anne said, “It made me want to leave that unit, that facility. It has made me think about finding a completely different career.” Donna felt as though the new nurses on her unit were being treated differently than others, “I wanted to leave. I wanted to quit.” Liz left her job for several reasons; LV was one of those reasons. Daisy left her first job as a registered nurse after 10 months. “I wasn’t happy there. That’s really the main reason why I left. I just didn’t like being there anymore.” She stated, “I felt that the way they were treating their nurses in general just wasn’t really good.”

### **Affective Zone**

Everyone deserves to work in a space that allows them to perform their daily duties in the absence of incivility. Professions, such as nursing, that involve high stress, life-altering, and

split-second decisions need to actively work to create environments that are healthy and supportive to those who occupy those spaces. In this section, the nurse participants responded to questions that helped us ascertain how nurse pedagogy can be instrumental in shaping such work environments. Not surprisingly, an increased emphasis on affective knowledge and skills, which included didactic and simulated experiences involving the *nurses' code of ethics* was warranted. This led to the creation of the *Affective Zone*. Nurse participants also suggested *early introduction of LV across nursing curricula*, as some had not heard the term until they started working and/or had actually experienced the phenomenon. Finally, the nurse participants felt that it was important to “*discern good preceptor*” qualities and train those who were chosen to help the new nurse transition into practice.

### **Teaching the “Code of Ethics for Nursing” Matters**

*“Stressing being respectful and being kind to your people is just as important as patient safety because when we are kind and compassionate to each other we take care of our patients better.”* – Tina, 23-year-old Caucasian female, BSN graduate, had been on the job for 6 months and was beginning to gain confidence and build trust in her colleagues due to the “Buddy System” that her unit employed.

Though the nurse participants agreed that the American Nurses Association’s *Code of Ethics* was the standard bearer for how nurses should treat others, most were uneasy when asked to recall the ethical principles learned during their course of study. Once assured that this was not a test of their “smartness,” the participants became more relaxed but admitted they could not recall a lot about the code of ethics. For the nurse participants, the ethical principles taught in nursing school often shared three commonalities: (a) brevity in content, (b) didactic in nature, and (c) mainly patient-centered.

The participants viewed the ethical principles as patient-centered concepts, as opposed to comprehensive human-centered principles. Respect, compassion, autonomy, veracity, advocacy,

fidelity, do no harm, and beneficence were the nucleus of conversation for the majority of the nurse participants. These principles were typically taught in a lecture hall setting, early in the program, and in the context of how the nurse should treat the patient. After further questioning, it was obvious that the study participants viewed respect and a universal care for all persons as a necessary component of their professional comportment; however, it did not come to them as naturally as the concern for patient rights. May thought that this is because these principles were things that professors think that all of us “should already know.”

Tina, a BSN graduate, recalled the code of ethics in a more general sense that included interprofessional relationships: “I just feel like it was, sort of, trying to create a culture of healthy, compassionate nurses. Do no harm and . . . I don’t know.” The notion of “do no harm” to patients was extended to coworkers in Tina’s mind. For Tina, and other nurse participants, victims of LV could inadvertently cause harm to patients due to stress, lack of confidence in abilities, or failure to thrive as a nurse because of improper training.

Jackie recalled that “you have to advocate for the patient, and do no harm. You have to have veracity and tell the truth to your patients. You don’t lie to them. You have to have autonomy.” More important than recounting these principles learned in nursing schools, the nurse participants reported that these were the principles that they tried to apply to their current nursing practice on a daily basis as they built their careers. In addition to the patient, Jackie noted,

You definitely have to respect the people around you . . . But you also have to respect them that they don’t know what they are doing, to be able to approach them in a respectful manner and not make them feel little.

Jackie believed that the manner in which nurses treated each other were a direct reflection of the work environment.

You have to care about the people you work with because just like health care for a person, it's holistic. If you are not caring for a person you work with, you are not respecting the work environment to begin with.

It is significant to note that all of the nurse participants began their statements on ethical principles in relation to patients and the realization that nursing's ultimate contract was with the health and wellbeing of the patient. The BSN graduate nurses went on to link the principles to their coworkers more often than the ADN graduates. Carrie, who was a BSN graduate presented another example.

The main ethical principles I adhere to are beneficence, to do good to all people and veracity, to tell the truth and be honest about what's going on. With beneficence, not only doing good to my patients but also to my coworkers.

Carrie expressed a desire to do good to "all people all the time," but to be cognizant that the patient remained the center of all action and interactions of the team. From Carrie's perspective, it was difficult to care for patients well in the absence of respect and care for one's colleagues.

I think that you have to have respect for other people in your profession . . . In the same way as I care for my patients, I care for them too. I think that builds a good team, offering up your assistance . . . I don't want anyone to feel like they are abandoned so I try to offer my assistance. Coworkers feel like they can trust me.

For Bea, being honest and treating others with dignity and respect were ethical principles that she remembered from nursing school and she tried to emulate in her daily practice. "And with your coworkers, if you say that you are going to help them out, then help them and being honest in the conversations that you have at work. Don't help and then talk about them after." Because this ethical principle was important to Bea, when it was violated by those on her unit, it caused her to build walls and not want to engage in building healthy work relationships with some of her coworkers. Bea was an ADN graduate who recognized that there must be respect shown to the patient and colleagues to demonstrate professionalism. For the patients and their families, "I need to respect these people and the people who love them in the way that I carry

myself and the way that I take care of their needs to reflect that I am aware of that responsibility.” And for her colleagues, it was not just about respecting registered nurses and those in positions of authority, but all members of the team.

But to go in and respect these people, PCAs (patient care assistants) who may not know why they are doing certain things and you have to explain things to them in a manner that doesn't make them feel dumb or beneath you.

This statement by Bea was relevant because, too often, new nurses feel like they are dumb or beneath those who are supposed to help them grow into their professional practice.

### **Early Introduction of Lateral Violence Across Nursing Curricula**

*“They would just kind of say that in nursing, nurses eat their young and that it is just something that you are going to have to deal with basically.” –Jackie*

The nurse participants felt that the phrase “lateral violence” should be introduced during nursing school. Some participants thought that though their nursing professors taught them concepts of conflict in the workplace and they were introduced to the phrase “nurses eat their young,” the terminology “lateral violence” was not used. Participants also suggested simulation in the form of “role play” and/or incorporating clinical opportunities as a means of integrating LV discussion into nursing pedagogy. This would allow nurses to identify LV and learn techniques to manage LV in professional settings.

When asked if they had learned about LV while in their nursing program, Tina answered, “I don't think so. Not from my memory. Maybe we did, but it might have only been once because I don't remember.” Carrie remembered learning about LV “in college during leadership classes and less clinical work, but more the lectures that we sat down in.” Bea summed up the general consensus of most nurse participants when she stated, “I don't feel like we ever directly talked about it or used that term. But we definitely talked about attitudes in the clinical setting. And that's a lot of the reason why I don't react sometimes.”

## Discerning the Good Preceptor

*“They helped me, supported me, and treated me, even though I was new, treated me like a friend and a peer and a fellow nurse and not someone that was beneath them or unknowledgeable just because I don’t know it all and I’m new with very little experience.”* – June, 23-year-old Caucasian female who had worked in the ICU for 3 months, experienced LV more as a student than in her current position; described the supportive, nurturing environment that she believed was responsible for her role transition.

According to the nurse participants, there was a clear delineation of what a “*good preceptor*” should be. A good preceptor possessed qualities of a teacher, mentor, and coach. The *good preceptor* was a good listener who was willing to answer questions, and actually anticipated the needs of the new nurse. She asked questions or probed the new nurse to help build clinical judgment and clinical reasoning skills. The *good preceptor* helped to welcome the new nurse to the unit by introducing her to team members, creating a “buddy system,” “showing” her how the unit was run, and “being available” at all times, but especially in times of crisis. For new nurses, having a *good preceptor* was a critical component to creating a healthy work environment and having a successful transition into practice that helped to mitigate LV.

Anne drew a comparison between her last preceptor, who she considered to be a “good preceptor” and her first preceptor who she felt lacked the necessary teaching skills to be an adequate preceptor for new nurses.

Like she will say, this is how I communicate with the doctor or this is what I say when I call pharmacy. Whereas my other preceptor would be like, here’s the phone. Well, I don’t want to sound stupid when I talk to the doctor for the first time. I don’t know what to say.

Anne went on to explain that, “I felt comfortable asking her questions. Whereas, the first preceptor made me feel like if I ask questions, then you’re dumb.”

The “good preceptor” also validated accomplishments in the new nurses’ cognitive, psychomotor, and affective skills, and offered verbal encouragement to the new nurse. The

words “supportive” and “encouraging” were used as attributes to describe the “good preceptor.” As one participant noted, “If I do something good, she is like, ‘Well, that was great’ or ‘Keep going’.”

Tina explained a process used on her unit to help new nurses transition through the orientation period. “They’ve put in a new program, like sort of a buddy system. Where they remind the older nurses to just watch us, help us, and be available to us.” In this “buddy system” instead of the new nurse approaching the experienced nurse to ask questions, the system had a built in comfort zone for the new nurse. It allowed the experienced nurse to periodically ask the new nurse if she had any questions or needed help with anything. “When they ask me, ‘Do you need anything’, then it opens up for me to just ask them things.”

For other nurse participants, it was important to know that the preceptor would be available if they needed them. As Anne explained, “She stands by the bedside with me or she is right outside the door if I need her.” Faye used the word guidance to explain an encounter with an experienced nurse who helped her when her own preceptor “disappeared.”

Guidance and I . . . I don’t know what word to use . . . I would say understanding . . . one of the other seasoned nurses on the floor went with me and she showed me so many things about that and how you can give a piggyback of antibiotic and keep from losing any of the medicine while flushing the air from the tubing. I think I learned more from her in twenty minutes than I had learned those few shifts with my preceptor.

Sherry gave a summation of how most new nurses feel on their 1st week of orientation and the preceptor they hoped to have,

She took the time to teach me, to show me stuff . . . At one point, you don’t even know how to call the doctor. You don’t know how to find numbers. You don’t know how to get anything because you are just there . . . I’m like here I am. I’ve graduated, but I don’t know what to do now. That’s how I felt. She took the time; you know? To walk me through.

## **Zone of Silence**

The final theme that came from data analysis was the *Zone of Silence*. This theme emerged from the voices of the nurse participants as they spoke of feeling devalued at work, not knowing whether or not they were members of a profession or how to define what a professional nurse should be, and having to live in the midst of LV behaviors when no one else seems to notice. The *Zone of Silence* represented the nursing profession's inability or unwillingness to diagnose its own ailments and its continued tone deafness on issues of lateral violence, nursing professionalism, and the devaluation of nursing. In the shadow of the *Lateral Violence Zone*, the *Zone of Silence* represented the place where LV behaviors breed and go unnoticed, unquestioned, and uncontested despite their harmful outputs to the profession of nursing and the patients. Inadvertently, the *Devaluation of Nursing*, *Orchestrated Unawareness* (inability to acknowledge the need for affective-based relationships), and *Role Confusion* (confusion about which nurses are professionals and which are not) added to the contentious nature of LV by creating work environments that did not share the same professional and, therefore, ethical culture. The properties of *Role Confusion*, *Devaluation of Nursing*, and *Orchestrated Unawareness* support the *Zone of Silence* and are discussed below.

### **Role Confusion**

*“Being competent, being respectful. Having some sympathy. Dependable. Trustworthy.”* – Faye

*Role confusion* simply referred to unclear professional role expectations. *Role confusion* contributed to LV in the workplace because nurses viewed their roles and professionalism through different lenses. In fact, most nurse participants were unable to state the criteria for professionalism or what makes a nurse a professional. Furthermore, some nurse participants had to stop and think when asked if nursing was a profession.

The nurse participants were asked to share their thoughts on what they believed made a nurse a professional. Though one participant noted outward appearance and punctuality as qualities of the professional nurse, the majority of the participants cited intangible traits as the criteria of nursing professionalism. Daisy stated, “I think that it doesn’t matter how you feel about a situation; you still have to act professional in it. I think that doing your work efficiently and respecting others is what makes a nurse a professional.” Liz viewed professionalism in nurses as “how we carry ourselves . . . in a bad situation.” As Sherry put it, “There’s a way you act about things. That you have to control yourself. Even though you have personal beliefs, you kind of go into that mode.” Sherry explained, “I try to treat them with respect, too. Even though I don’t always agree.” Donna, Faye, and Jackie all used the words *respect* and *care* to describe their definition of a professional nurse.

Jackie’s definition of what it means to be a professional was more detailed than the others and stressed the importance of valuing others and taking pride in one’s work. Jackie stated

I think what makes a nurse a profession and what makes her a professional is the way that she cares about her patient, the way she cares about their well-being. Not just the body, but holistically. How they feel respected, how they feel valued as a person, and how the nurse herself feels that pride in her work and feels the need to make herself better and further her education and not just stop at being good enough. But she keeps going to make it better for herself, for her patient, for her community, for every one that’s involved in health care.

### **Devaluation of Nursing**

*“There has to be a relationship that is established if you are going to get through this first year of nursing. I cling to the nurses that are my age because I have more in common with them. But I also look up to those older nurses and take everything they say into consideration.”* – Carrie, 23-year-old Caucasian female, BSN graduate; 6 months on Cardiac Intensive Care Unit, speaking about the value found in all nursing relationships on the unit.

The *devaluation of nursing* referred to the lack of recognition of the importance that nurses serve as members of the health care community. This lack of value can come from

management, physicians, patients, or other nurses. Nurse participants felt that it was important for experienced nurses to “value new nurses” and develop relationships” by “integrating new nurses into the family.” Some nurse participants felt that this would help to build confidence in the new nurse and create a sense of unity that comes from being a member of a shared profession. However, for most of the participants in this study that sense of unity was missing and that sense of “pride in the profession” was lacking. A lack of “pride” in their job was cited as a perceived reason that experienced nurses were unhappy with their jobs. That unhappiness led to LV behaviors toward new nurses.

Although May had been at her place of employment for almost 2 years and stated that “the nurses are overworked and stressed,” she did not feel that she had been employed long enough to determine if her organization valued her as an employee. Donna shared how she perceived experienced nurses in her organization,

Experienced nurses, they don't want to be there. They hate their job. They hate how it's run. They come into work and they're there because, I got to be there. I gotta work because I got bills and I got stuff to do. They take it out on the nurses underneath them.

Tina expressed the importance of valuing one's profession. The socialization of new nurses on Tina's unit was a smooth process and there was a “buddy system” in place that was conducive for them to become integrated into their new workplace. She had benefited from this system and stated,

I think, appreciating their profession. The nurses that I work with, they love what they do. When other people come in, they want to teach them because they appreciate what they do. And they know the value of what they do and so they love teaching. I think that's a good foundation for them.

### **Orchestrated Unawareness**

*“I think it is hell. And I think it's just torture. Well, people say that you need experience. I just think it's hell that all new nurses have to go through.” – Donna*

*Orchestrated unawareness* had dual meaning. First, *orchestrated unawareness* was the term used to describe a concerted effort to ignore, disguise, or deny the presence of an undesirable attribute. Failure to address this attribute can cause harm to the community and have long-lasting consequences. Second, *orchestrated unawareness* was used to define the intentional act of valuing certain principles, ideas, or concepts at the expense of others. *Orchestrated unawareness* created an active environment for incivility and bullying to thrive when those in positions of power chose to ignore the presence of these detrimental behaviors. The mere notion that “all new nurses have to go through” a period of lateral violence as a form of initiation reinforces that there is an awareness that nurses engage in LV behaviors. However, many of the participants in the study were not aware of the term “lateral violence”. Moreover, they were not aware that LV is a negative behavior that can lead to negative patient outcomes.

### **Chapter Summary**

The 12 nurse participants in this qualitative study have all experienced lateral violence, either as a victim or witness. Each provided a definition of lateral violence that did not necessarily differentiate LV and bullying, but conjoined the two. Using a grounded theory methodology, four themes emerged from data analysis of the nurse participants lived experiences inside the *Lateral Violence Zone: Reckoning Zone, Self-Preservation Zone, Affective Zone, and Zone of Silence*. Whether they experienced LV as *engineered failure, judgment days, wavering foundation, detachment syndrome, or a culture of lack* within the *Reckoning Zone*, each nurse participant found a coping mechanism that would allow her to continue in the profession of nursing. The *Self-Preservation Zone* offered methods to reconcile LV with the new nurses caring need and abilities. Some chose *attrition*, in which they sought employment opportunities at other institutions. Some chose *assimilation* that required them to adapt qualities that

mimicked those of the culture on their nursing units. Unfortunately, others decided to *build walls* which could stunt their growth as nurses and potentially place their patients in harm's way. Most justified these coping mechanisms as ways to help them remain focused on the reason they became nurses in the first place—the patient.

Managing conflict is never easy, as demonstrated by the participants in this study. The case scenario findings would suggest that it is much easier to confront LV in theory than in real-life situations. The participants offered meaningful ways in which nursing pedagogy and nursing practice could help alleviate nursing of the negative effects of LV to avoid the need for confrontation. The following recommendations, which are situated in the *Affective Zone*, were made by the nurse participants: (a) *teaching the “Code of Ethics for Nursing” matters*, (b) *early introduction of lateral violence across nursing curricula*, and (c) *discerning the good preceptor*.

Conscientiously focusing on the affective aspect of nursing education, as much as the cognitive and psychomotor phases, will be imperative in order for nursing faculty to help improve relationships among nurses in nursing practice. For this reason, the *Zone of Silence* must be addressed. Nurse participants suggested that the orientation period for new nurses is a vulnerable time. Role transition and the role that the preceptor plays are vital so clearly delineated role expectations should be known to all involved, to dispel any *role confusion*. New nurses and experienced nurses must be taught and expected to act in professional and ethical ways. Nurse participants believed that the *devaluation of nursing*, beginning with nurses not valuing their profession, was a primary cause of many LV behaviors. Finding a means to enlighten all to the value of nursing is paramount to building healthy work environments. Finally, *orchestrated unawareness* or the inability to acknowledge the presence of LV or any other blemish in nursing must be rectified in order to begin the healing process. We must own

our truths in order to build a culture of mutual respect and accountability among nursing students, nursing professionals, nursing units, and organizations.

## CHAPTER FIVE

### DISCUSSION, RECOMMENDATIONS, CONCLUSION

The issue of lateral violence (LV) in nursing, or incivility in health care in any form, is its potential negative effect on patient care outcomes. Labeled as a sentinel event by The Joint Commission (2008) and recognized as a threat to patient safety by the American Nurses Association (2015a), as well as a direct dissent from the nurses' code of ethics, the presence of LV is unquestionable and its effects are felt by novice nurses in differing forms. Internationally, nursing scholars have offered theories as to why LV exists and possible solutions. Yet here in the United States, there are limited qualitative data on the direct effects of LV on nurses in their formative years of practice, the first 3 years, and how LV influences their professional development. The findings of this study attempts to give meaning to how new nurses recognize, experience, and cope with LV in the workplace.

According to Benner et al. (2010), new nurses must develop and learn skillful ways to move from a lay person's knowledge to "exercising flexible judgment and taking astute, context-dependent action in an underdetermined situation" (p. 179). This shift in thought process from novice nurse to competent practitioner is dependent upon the support of nurse educators, preceptors, nursing management, organizational support, and most importantly, every peer interaction that the novice nurse has throughout her or his formative years. The aim of this study was to answer three questions surrounding LV and its effects on nursing through the experiences of nurses in their first 2 years of practice. Over the course of the study, a fourth question

emerged from data gathering that was more profound than the original questions. Why do nurses struggle to give voice to affective issues within the profession?

### **Discussion**

Knowledge of what nurses do remains a mystery to some in mainstream America. In 2015, nurses were still being accused of carrying doctors' stethoscopes. The life-saving practice of clinical nurses somehow gets relegated to the duties of an angel of mercy whose purpose is merely to hold hands, serve as a shoulder to cry on, empty bedpans, give shots, or take "orders" from physicians without any thought to the consequences of enacting those instructions. The cognitive abilities that are required for a nurse to notice subtle warning signs in a patient, whose condition would not be known to a physician who is not present unless the nurse makes him or her aware, goes unnoticed by public entities. In acute care settings across the nation, nurses are administering life-sustaining medications and questioning the legitimacy of prescriptions to make sure that the correct patient is receiving the proper medication. Nurses are running Code Blues by beginning chest compressions, placing automated external defibrillator pads, and pushing intravenous medications to keep patients alive. Nurses are inserting nasogastric tubes, urinary catheters, and cleaning wounds while preventing the spread of infection that could cause detrimental harm to patients. Care work is a legitimate enterprise, and nursing research in the areas of cognitive and psychomotor function abound. However, to successfully acknowledge the legitimacy of nurses as valued members of the health care team, we cannot ignore the social climate that allows LV to persist in the spaces where nurses work. The experiences of nurses who perform care work must be recognized as important and these experiences used to create opportunities in nursing to make a safer, more efficient environment for patients and nurses.

Using qualitative data findings from the 12 participants in this study, we begin to understand the relevance of teaching nurses within the affective domain.

### **How do Novice Nurses Experience Lateral Violence in the Workplace?**

Considering the significance of the work that nurses do and the effect that it has on humankind, it would be almost elementary to suggest that a certain level of expertise or competence should be expected of those who are registered nurses. However, novice nurses are experiencing LV in the workplace in ways that threaten patient safety because it directly threatens building competence and expertise in the new nurses cognitive, psychomotor, and affective skills. Too often it is assumed that new graduate nurses should graduate from a college or university setting with expert knowledge on how to enact the role of a registered nurse. Half of the nurses in this qualitative study held an associate degree in nursing which gives them minimal skills in nursing practice. In other words, they have basic nursing knowledge in caring for patients, which means they require an abundance of experiential, supervised tutelage in the clinical practice setting to learn the complex art and science of nursing.

According to the data in this study, nurses experience LV in the *Reckoning Zone* as *engineered failure, wavering foundation, detachment syndrome, judgment days*, and a *culture of lack*. Within the *Reckoning Zone*, the nurse participants experienced a lack of support from their more experienced peers, inadequate training hours, overwhelming patient assignments, fear of shaming and failure due to lack of knowledge and guidance, verbal affront, and mocking as forms of LV. Nonverbal innuendo was especially prevalent in this study for the nurse participants as indicated by “eye rolling” or nurses looking at them “like I was dumb” when questions were asked. An example of verbal affront occurred when an experienced nurse used profane language to explain to one nurse participant that she was using the incorrect equipment

to check gastric tube placement. Similarly, Sauer (2012) cited lack of structured organizational support and lack of support and collaboration by senior nurses as factors that contribute to LV behavior. Griffin (2004) listed verbal affront, nonverbal innuendo, sabotage, gossiping, withholding information, and backstabbing as forms of LV behavior that can lead to a disruption among health care professionals and cause negative outcomes. Spector, Zhou, and Che (2014) recognized insensitive and rude remarks and serious verbal abuse as the most prevalent form of LV behavior.

According to the nurses interviewed, their experienced peers expected them to know answers to questions that they lacked the experiential knowledge and repetitive occurrences to answer. Some experienced nurses would become insolent when responding to the novice nurse. These *judgment days* caused many in the study to build walls and retreat to a safe place where it was best not to ask questions for fear of being judged or harshly reprimanded. The pressures of being a new nurse were “overwhelming” for all the nurse participants, but the *wavering foundation* of having their mentor criticize them or turn their backs on them shortly after orientation was the most confusing encounter of LV for some of the nurse participants. Whether reality or perception, the mere thought that a nurse participant in this current study would think that a new nurse would have a patient “crashing” and go to experienced nurses and ask for help, but not receive it, is dumbfounding. When the health and wellbeing of patients are in peril, LV has become more than an annoyance to our profession. It is the sentinel event that The Joint Commission (2008) labeled it and must be challenged by nursing professionals at all levels.

### **How do Novice Nurses Reconcile Their Commitment to Professional Care with Their Experiences of Lateral Violence in the Workplace?**

Data revealed that at least four of the nurse participants in this study left their first place of employment secondary to LV within their 1st year of practice. Others were seeking to leave

or trying to complete 1 year of experiential training so that they could become travel nurses. Supported by studies such as Hutchinson et al. (2008) and Simons and Mawn (2010), LV in the workplace leads to *attrition* for some nurses. Some nurse participants attempted to *build walls* and distance themselves from the negative effects of LV. They reported feeling “hurt,” ashamed, and fearful to ask questions necessary to provide patient care. One nurse participant reported an exacerbation of a cardiac condition that led to an accelerated heart rate, for which she had to be hospitalized, while she was working. She blamed LV behaviors directed toward her for this change in her physiologic status. Sauer (2012) suggested that LV leads to both psychological and physical stress in those who are victimized. Sauer also noted that victims of LV are left feeling disregarded and devalued, feelings which Longo and Sherman (2007) indicated could lead to poor relationships among nurses, causing the new nurse to be less likely to seek help when needed, which increases the risk of making patient care errors.

Some nurses may reconcile LV behaviors by *assimilation*. Assimilation refers to taking on the behaviors, practices, or culture of the unit. In Donna’s case, she assimilated to the culture of the unit in retaliation to what she perceived as unfair treatment by two senior nurses who refused to help her. When one of those nurses later approached Donna and asked for help with a patient, Donna stated, “I didn’t help her. She didn’t help me when I needed help.” According to Ballien et al. (2009), nurses assimilate to unit culture to avoid becoming or remaining targets of LV themselves. Assimilation only serves as a breeding mechanism for the culture of LV to continue.

### **What Pedagogical Interventions can be Used to Address Lateral Violence in the Workplace?**

For the nurse participants in this study, the American Nurses Associations’ *Code of Ethics for Nurses with Interpretive Statements* was the bible for ethical principles for nursing

practice. However, articulating the words within the code and giving meaning to implementing those ethical principles, proved to be a challenge. Further complicating this dilemma for the nurse participants was the belief for most participants that these rules need only apply to nurse-patient and/or family relationships. Compound this with the absent or limited exposure to the concepts contained within the *Code of Ethics* during the nurse participant's academic preparation, and it becomes clear why some tended to struggle to build interprofessional relationships that honored social justice and mutual respect for all. The ANA *Code of Ethics with Interpretive Statements* stipulated that nurses are to maintain respectful relationships with their colleagues while respecting each other's values and differences, collaborating with one another to foster healthy work environments guided by principles of trust, transparency, open communication, and respect. In order for this ethical space to exist, ANA acknowledged a culture of civility and kindness must be the expectation of those involved in nursing practice. One of the problems with dedicating nursing instruction to the subject of nursing ethics, other than the time constraints and breadth of information that already exists for nursing students to master, is what one nurse participant phrased as the belief that nursing faculty "think we should already know how to treat each other." This preconceived assumption that nursing students or all people know how to treat others ethically is a dangerous premise because it discounts the significance of affective knowledge in nursing pedagogy.

Study participants also conveyed that LV is not being taught consistently in nursing pedagogy. Several had never heard the term "lateral violence" while in nursing school, but were well aware of the behaviors labeled as "LV." They had heard the term "nurses eat their young," but had come to view this as a normal part of nursing and something that "all nurses have to go through." Scholars suggested that creating an awareness of LV through formal education helps

to alleviate its effects (Griffin, 2004; Vessey et al., 2009). Griffin (2004) reported using learned cognitive rehearsal methods to help new graduate nurses confront and diffuse LV situations. In Griffin's (2004) study, the retention rates of 26 newly licensed registered nurses were improved through role play, effective communication, and empowerment exercises that were taught to help the new nurse confront instances of bullying and incivility. Griffin (2004) suggested that these skills be introduced during nursing school. Teaching both ethical principles and negative behaviors in nursing school that could require conflict management would help the novice recognize acceptable versus unacceptable professional behaviors and learn healthy coping mechanisms.

Finally, nurse participants described the value of a "*good preceptor*" in helping them transition from the role of student nurse to new graduate nurse, or what Benner (1984) would describe as the advanced beginner to the early stages of competence. According to nurse participants, the "*good preceptor*" must possess the ability to teach, mentor, and coach. In addition to these qualities, a good preceptor must be available and willing to answer questions and demonstrate patience, and show a willingness to help, support, and guide the new nurse through times of uncertainty and self-doubt. A study by the American Association of Critical-Care Nurses (2005) found that 88% of nurses worked with colleagues that engaged in verbal abuse, gossip, and self-promotion at the expense of colleagues, instead of promoting positive relationship development and sustainment. Another issue reported by Vessey et al. (2009) was the stigma attached to LV, which led to underreporting for fear of being viewed as weak, fear of retaliation, and the accepted culture of silence in the workplace. This acceptance leads nurses, such as the participants in this study, to learn from preceptors who are unwilling, unprepared, or

lack the proper resources to help the novice transition into the role of nurse. This also keeps the novice quiet because they fear losing their job or being labeled as incompetent by their peers.

The “*good preceptor*,” as well as the health care organization and nursing management, needs to understand the level of preparation that the new nurse graduate brings to the job. Benner (1984) suggested that instructors formulate principles or guidelines to help the advanced beginner become acclimated to practice. Even more importantly, advanced beginners need support in the clinical setting from their assigned preceptors to help them discriminate between which aspects of patient care are routine and which are priority. In a hostile work environment laced with LV, advanced beginners may find it difficult to navigate to the competence level, and never reach the level of expertise. According to Benner’s theory, competence is signified by having been “on the job in the same or similar situations two to three years” (p. 25) and the nurse can visualize the patient’s plan of care in current and long-term goals. The competent nurse has mastered clinical nursing and can comfortably cope with the multiple contingencies of the clinical day. Efficiency and organization, which are lacking in the advanced beginner, is the hallmark of the competent nurse. This delay in cognitive and psychomotor development secondary to LV stunts the professional growth of novice nurses. Ultimately, patient care outcomes are jeopardized.

### **Why do Nurses Struggle to Give Voice to Affective Issues Within the Profession?**

It is imperative that nurses examine nursing science and the totality of what it means to be a nurse in today’s health care climate. Pedagogically, nurse faculty must be willing to honor the affective domain of nursing education, as we do the cognitive and psychomotor domain. Professionally, nurses must admit that social justice issues and the ways in which nurses respect and honor all humans matter. Therefore, all registered nurses must understand the significance

of professionalism that is expected and hold all who would enter into our profession accountable within the realm of professionalism. Ethically, if all nurses honor the professional realm of nursing and understand professionalism in its truest form, recognizing nursing's ethical boundaries will make negative conditions, such as LV, easy to recognize and better equip us to combat it. Scholarly, as we use our research to investigate and create new nursing knowledge that adds to evidence-based practice, we would be remiss to ignore the importance of affective-based practice in nursing and the impact it has on the health care of our nation and our world. Just as the cognitive and psychomotor principles of nursing are founded in evidence, so too, is affective practice as the evidence in this study postulates.

**Assess.** So, why do nurses struggle to give voice to affective issues within the profession? Lateral violence exists in nursing because we are afraid to acknowledge its presence. Like a disease, we hope that if we do not own it, it will disappear. We create an *orchestrated unawareness* and turn a blind eye or refuse to give voice to a real issue. But in order to prevent the spread of a disease or illness, we must admit that signs and symptoms are present, determine what is causing those signs and symptoms, and ascribe it a name or diagnosis. Assessment of the literature concluded that LV exists and its presence has been further evidenced by the 12 nurse participants in this study. Lateral violence in nursing is real.

**Diagnose.** The symptoms of LV are common and easily recognizable: gossip, withholding information, sabotage, refusal to answer questions, isolation from new nurses, eye rolling, verbal affront, and the list continues. It is difficult to diagnose a dysfunction if you are unaware of its existence and those who know about it try to disguise it as a natural occurrence. In order to recognize LV, we must begin to learn about it in nursing school. Lateral violence must be taught in all nursing curricula since new nurses and student nurses are the likely victims.

Once behaviors of LV are described and nursing students are able to recognize it in the classroom, simulated experiences in the form of role-play can be created to allow students to diagnose it and prevent them from succumbing to its effects.

**Intervene.** Lateral violence is antithetical to the principles in nursing that dictate how we treat others. For this reason, it has no place in the spaces where nurses work and nurses must confront it. Here Nel Noddings' (2012) modeling and dialogue can be used in simulation and classroom settings to facilitate the expression of ethical ideals. Dialogue is the verbalization of modeling that allows students to express what should happen in a given situation. Using ethical principles to assuage LV behaviors and find common ground, while setting aside personal preferences, would allow nursing students to model management of conflict that may arise in the clinical setting; thus, preparing them to confront LV. Also, if LV is witnessed in the clinical setting, students can have real-life opportunities to model and dialogue ethical behavior.

We must identify a treatment regimen that nursing can implement, evaluate, and make adjustments to if the treatment is not working. By educating new nurses on the relevance of an ethic of care that supports social justice principles for all humans and teaching principles of professionalism, nurse educators empower new nurses to fulfill the role of the professional nurse. While Nodding's (2012) modeling and dialogue provided a means to teach nurses how to confront LV, Joan Tronto's (1993) Ethic of Care and Huntington's (Glenn et al., 2003) definition of professionalism laid the foundation for creating sensible principles for nurses to exercise affective-based practice and maintain healthy work environments.

### **Tronto's Ethic of Care and the Issue of Lateral Violence**

Proactive and reactive actions are needed to create optimal working environments in nursing. This may seem like a redundancy, but often there is a failure to act that leads to LV

behaviors. Both the data in this study and current literature associated inaction on the part of nurse educators, nurse leaders, nurse managers, student nurses, new nurses, and experienced nurses as a contributing factor that leads to an accepted culture of bullying and/or uncivil behavior that is viewed as the norm. Tronto's (1993) ethic of care offered moral tenets that help establish an action plan for nursing academics and nursing practice to mitigate the profession of unhealthy working relationships among its members. These moral elements are *attentiveness*, *responsibility*, *competence*, *responsiveness*, and *trust and solidarity*.

**Attentiveness.** In the first phase, *caring about*, the nurse must recognize that there is a need to care (Tronto, 1993). For LV to be contested, the nurse must first recognize that such a phenomenon exists. Therefore, the nurse must be attentive to the social and political environment in order to engage in *caring about* (Zembylas et al., 2014). *Attentiveness* is the moral element that accompanies *caring about* (Tronto, 1993). If not attentive, the nurse continues to function in the status quo and ignores the need of the other, which leads to conditions of inequality and social injustice. When conditions of LV, such as withholding information, are prevalent on the unit, patient care can become compromised and lead to an unsafe care environment. For the participants in this study, *engineered failure*, *detachment syndrome*, *a culture of lack*, and *wavering foundation* themes were displayed when their nursing peers ignored, isolated, and left them feeling helpless at a time when the participants needed their peers' attention and support.

The ability to create working spaces where nurses are attentive to the needs of each other, especially the most vulnerable of the population (student and new nurses), would fulfill the moral tenet of *attentiveness*. Tronto implored us to be aware of both the political and social climate. As nurses, we have to pay attention to the organizational climate so that we do not

become victims of oppression or hierarchical norms (Becher & Visovsky, 2012; Croft & Cash, 2012; Freshwater, 2000; Sheridan-Leos, 2008). Nursing education and health care organizations should work in tandem to create seamless transitions for new nurses to enter into nursing practice, considering the high-risk nature of our profession. Patient safety should be the determining factor for all of our actions and interactions. Nurse residency programs (NRPs) that allow for a better transition to practice for new graduate nurses should be the rule, not the exception, to introducing nurses into their new employment roles. Nurse residency programs have been found to better prepare nurse graduates as evinced by improvements seen in their clinical reasoning skills, communication skills with health care providers, and ability to prioritize patient care (Blevins, 2016). Additionally, studies supported that NRPs help novice nurses cope with the stressors faced in their first year of practice (AL-Dossary, Kitsantas, & Maddox, 2014). The *attentiveness* given to the new nurse and that is built in to NRPs should be modeled by all facilities who hire and train new nurses.

**Responsibility.** The second phase, *caring for* requires a response to the LV episode. If the nurse is a victim of LV or witnesses another nurse being victimized, the onus is a moral obligation to intervene. *Responsibility* is the moral element that corresponds with *caring for*. Although Tronto (1993) used the notion of *privileged irresponsibility* to describe the manner in which majority groups “fail to acknowledge the exercise of power, thus maintaining their taken-for-granted positions of privilege” (p. 121), this *privileged irresponsibility* could be used to describe the manner in which nurse managers or nurse executives fail to intervene when LV and bullying occur on nursing units. In a greater sense, it underscores the nursing profession’s role in finding ways to intervene in the global LV phenomenon. The *culture of lack* that exists within the *Reckoning Zone* is a direct result of organizational and/or management failures to ensure that

policies are followed to create an environment where the new nurse has the tools and guidance to succeed. Shortened orientation periods, lack of trained preceptors, and a lack of collaboration from experienced nurses creates a space for irresponsible behaviors to thrive. Experienced nurses who are the majority fail to recognize the power they hold to create a better learning experience for the novice nurse and by extension, a safer environment for patients. Nurse managers who are in position to serve as change agents sometimes allow the nurse's skill level to override their LV behaviors and do not intervene (Vessey et al., 2010). A zero tolerance policy must be expected by every member of the team (ANA, 2015a) and all must be held accountable to form a healthy workplace.

**Competence.** *Caregiving* is the third phase of Tronto's (1993) ethic of care and *competence* is its corresponding moral element. *Caregiving* involves action. It is the actual knowledge, skills, and abilities required to prevent and competently correct LV. Tronto submitted that one must be competent in order to effectively perform this duty. Tronto noted that some may feign incompetence in some areas to avoid tasks deemed as negligible (Zembylas et al., 2014). If nurses do not think that showing care and respect toward colleagues is an important component of professional practice, then they are less likely to respond actively against LV. Failure to acknowledge LV and to explicitly honor the nurses' *Code of Ethics* creates a veil of incompetence within the *Affective Zone* of nursing care. Although ethical practice is seen as a prominent component of professional practice, ethical behaviors are not a part of nurses' competencies and the manner in which nurses treat nurses is not held in high esteem. As one nurse participant noted, "You say something bad to a patient, you can lose your job or your license. There is no consequence for saying something bad to a new nurse. No one cares." Measurable, specific competencies of affective behavior are needed.

**Responsiveness.** The fourth phase of Tronto's ethic of care is *care-receiving*. *Care-receiving* represents the response to the intervention provided by the victim of LV or the nurse who intervened on the victim's behalf. The moral element linked to *care-receiving* is *responsiveness* (Tronto, 1993). After intervening, it is important to assess the effectiveness of the intervention and whether further attention is needed (Zembylas et al., 2014). This is seen as an ongoing process. Does the perpetrator continue the behavior with the same victim or another victim? If so, is another intervention undertaken or is the behavior ignored? According to Tronto's (1993) theory, it is not sufficient to follow standards and protocols if the desired outcome is not achieved. The one caring must seek other measures to help the cared-for. As an example, the "good preceptor" identified by the nurse participants in this study, has a responsibility to not only teach the new nurse but to monitor the response of that teaching. If the teaching was not effective, instead of labeling the new nurse as unteachable, difficult, or incompetent, the "good preceptor" would seek alternative methods to elicit the desired result. Responsiveness is reciprocal and requires the new nurse to engage in honest dialogue about her or his needs and the effectiveness of how those needs are being met.

**Trust and Solidarity.** The fifth and final phase is *caring with*, which refers to the formation of the moral qualities of *trust* and *solidarity* (Zembylas et al., 2014). These qualities are acquired by an ongoing process that occurs over time and must be developed through practice by relying on the caring practices of others. This fifth phase forms the social and foundational contract for healthy work environments in which all team members trust that each individual will act in the best interest of the team and not for individual gain. This is also significant because nursing is a team profession that relies on the knowledge, skills, and abilities

of others. Without trust and solidarity, it would be difficult to have a healthy work relationship and LV could easily manifest.

With trust comes the need for accountability. Every member of the profession has the obligation to hold each member accountable. In an ethical framework, if a nurse is seen demonstrating LV behaviors, it is acceptable for another nurse to intervene and remind her that LV is not tolerated within the framework of nursing. Solidarity suggests that we are all in this together and have one shared vision: the best possible outcome for the patient and society as a whole.

### **Professionalism and Lateral Violence**

Scholars use different terms to define professionalism. However, there are three components of professionalism that are consistent throughout all definitions: (a) sharing the same body of work, (b) having expert knowledge in a field of study, and (c) the presence of values and ideals to guide the moral judgments of the members within the profession. Huntington used three words to describe these attributes: corporateness, expertise, and responsibility (Glenn et al., 2003). Teaching nurses the basic tenets of professionalism and the responsibility that each has as a member of a shared profession beginning at the collegiate level is necessary to instill affective-based practice principles.

**Corporateness.** Huntington described corporateness as the sense of unity and consciousness among members of a group that originates from the discipline and training requisite for professional competence, formed by doing the same work and sharing a unique social duty (Glenn et al., 2003). Corporateness is decidedly the easiest of the professionalism traits to attain and, on a simplistic level, coincides with Tronto's (2010) solidarity. All nurses must attend nursing school and successfully pass a national licensure examination to become a

registered nurse; although there are multiple entry levels to becoming a registered nurse including diploma, associate, and baccalaureate education. It is the other two stipulations that need to be addressed more extensively as a means for nursing academia and practice to address professionalism.

**Responsibility.** Responsibility, according to Huntington's definition of professionalism (Glenn et al., 2003), refers to the moral unit of a profession that advances certain values and ideals. These ethical principles serve as a guide to its members when dealing with others. To partake in professionalism, one must be well versed in these values and ideals. The American Nurses Association (2015b) has set forth a *Code of Ethics for Nurses with Interpretive Statements* to serve as a guide for its members that define social justice and the ethical treatment of all persons. Updated in 2015, the *Code of Ethics* specifically speaks to the LV epidemic and its paradoxical nature to nursing science. It is the responsibility of nursing as a profession to ensure that its members have the obligatory knowledge to uphold its ethical ideal, especially among its members. The *Code of Ethics* must be taught as a foundational component of how nurses should treat all persons, including nurses, and how nurses should honor the profession. Lost in the noise of LV is the notion that current and future nurses should be charged with a duty to honor, maintain, and sustain nursing's future. Engaging in LV behaviors will not build nursing's future, but contribute to its attrition and limit our contributions to society.

**Expertise.** Huntington recognized expertise in the individual who has specialized knowledge and skill because of prolonged education and experience (Glenn et al., 2003). Likewise, Benner believed that "experience is a requisite for expertise" (1984, p. 3). This basic idea posited by Huntington and Benner is monumental to the foundation of building healthy work environments. Specialized knowledge, in the form of nursing education, is needed to gain

expertise in any field. However, without experience and situated context, novice nurses cannot gain the expertise needed to care safely for patients in contemporary health care environments.

Typically, novice nurses enter into new nurse orientation with an assigned preceptor, a nurse who is responsible for their training. If, during the course of this training, the experience that is gained is laced with *engineered failure*, *judgment days*, *detachment syndrome*, and a *culture of lack*, gaining the ability to make complex clinical judgments and interpret data into useful information becomes painstakingly difficult for the new nurse, and potentially harmful to patients. The notion that experienced nurses would refuse to assist a new nurse who has asked for help in assessing a patient's deteriorating condition seems incomprehensible; however, Donna's experience of an 8-year seasoned nurse refusing to enter the room of a patient who had an absent pedal pulse is only one example of *engineered failure* that is experienced by nurses. This limits their ability to gain competence, let alone expertise.

For professionalism to overtake LV behaviors, the concepts of corporateness, responsibility, and expertise, along with an ethics of care should be introduced to nursing students in nursing curricula. Principles of professionalism and ethical treatment of others should be highlighted in the nursing profession as foundational and critical components, on which other nursing standards and norms are based. It is essential that this information not remain hidden in textbooks or preserved for those who seek graduate-level degrees. Ethical and professional treatment of all individuals should be taught at the foundational level of all nursing programs as an expectation of how nurses value social justice and the humanity of each individual. The merit of our profession must first be acknowledged by those within the profession before we seek the approval of those without. We must learn to value each new member of nursing by showing and expecting respect and dignity to all. The relationship must

be reciprocal and not unilateral. The following implications and recommendations use evidence from this and other studies to submit solutions to LV for nursing pedagogy and practice and the value of teaching affective-based practice principles.

## **Implications**

### **Nursing Education, Recruitment**

Nursing education plays a huge role in alleviating the nursing workforce of LV.

Institutions cannot directly care for anyone; people must do the caring-for. However, institutions and large groups can create the conditions under which caring-for can flourish, and their attempts to do so should be guided by the spirit of caring laid out in care ethics. (Noddings, 2010, p. 392)

Although previous studies advocated teaching about LV and prevention methods (Griffin, 2004; Vessey et al., 2009), there is another pedagogical opportunity for nursing educators. Nursing students should be encouraged to practice professional and caring behaviors toward colleagues, as well as patients. Nursing programs have an opportunity to educate future nurses to care for patients and to care for one another through focused instruction in the areas of ethics and professionalism.

One can deduce that in order to “continually develop professional identity,” as the NLN (2010) admonished associate degree nurses to do, this process must be initiated in nursing curricula. Nevertheless, the divide between what is considered professional practice and what is technical may present difficulties for the nursing profession. Nursing finds itself in a conundrum because of multiple entry levels into practice that do not necessarily focus on the same competencies or devote time to developing certain aspects of nursing, such as professionalism. In baccalaureate programs, curricula are designed to value and place emphasis on professionalism and behaviors deemed to be professional, whereas in associate degree programs, the technical aspect of nursing is at the forefront of the curriculum. Even the nurse participants

in this study who graduated from baccalaureate programs appeared to have a more nuanced understanding of professionalism and the role of ethics in interprofessional relationships than did their associate degree graduate counterparts. Yet, both sets of graduates needed more practice opportunities in the *Affective Zone* of nursing.

**Articulation Programs and Nurse Residency Programs.** Due to the continued nursing shortage that exists in certain parts of the United States, there remains a need for the associate degree nurse. The IOM, AACN, and NLN have clearly stated that this entry into nursing practice cannot be the gold standard and that nurses must continue to further their education. Pedagogically, articulation programs exist that allow associate degree and diploma nurses to have a seamless transition into bachelor of science or master of science nursing programs. A more sophisticated level of critical thinking and clinical reasoning skill is needed at the bedside in acute care health facilities. Nursing students should enter the profession with the expectation that the associate degree or diploma is a starting point. To persist in nursing, nurses should be required to continue their education with the support of their employers.

Nursing schools initiate the cognitive, psychomotor, and affective development of the novice nurse. Nursing organizations must support that growth and development throughout the nurse's professional lifespan. Today's nursing graduates are being hired into specialty units such as critical care, emergency care, neonatal, and labor and delivery units, without the experiential knowledge that comes from years of clinical practice. Without mandates in place that specify that nurses must spend a predetermined amount of time on a medical unit prior to entering a specialty area, it will be crucial that entities such as nurse residency programs, continuing education programs, professional development, and articulation programs (aided with financial assistance through employers) support the cognitive, psychomotor, and affective growth of new

graduate nurses who are minimally prepared to care for the complex patients that await them in their new role. Nursing leadership must find their voice and help organizations understand that patient safety becomes an issue when nurses are ill-prepared to care for them due to improper training and development. That development includes affective-based practice.

**Future of Bedside Nursing: Recruitment and the Travel Nurse.** Recruitment efforts to keep nurses at the bedside are stymied by the effects of LV. However, many nurses enter into nursing with thoughts of bypassing the bedside before they have begun nursing school. Only two of the nurse participants in this study planned to remain at the bedside prior to entering nursing school. The participants either wanted to become nurse practitioners, nurse anesthetists, or become travel nurses after spending the minimum required time at the bedside. With this new trend in nursing, keeping nurses with expertise at the bedside is challenging. The nursing profession must look for ways to shift its recruiting mechanisms to sustain a safe environment for patients. If one subscribes to Benner's (1984) theory that it takes a minimum of 2 years to become competent at one's craft, then the minimum of 6 months to 1 year that it takes a nurse to become a travel nurse should be alarming to the profession. What does allowing nurses with minimal training and experience to care for patients mean for nursing's future? Quality and not quantity should be the standard for nursing experience. Organizations need to create incentives to keep nurses at the bedside for more than 1 year or 2. Creating a culture of civility that supports nurses in their efforts to care for patients is imperative. At the forefront of this movement is the creation and maintenance of nurturing work environments founded on professional and ethical principles. Other incentives could include monetary incentives (such as seen in travel nursing) or educational incentives that support nurses efforts to further their

education. This will help to create a proficient and expert nursing workforce in the place where patients need them the most, at the bedside, in the acute care setting.

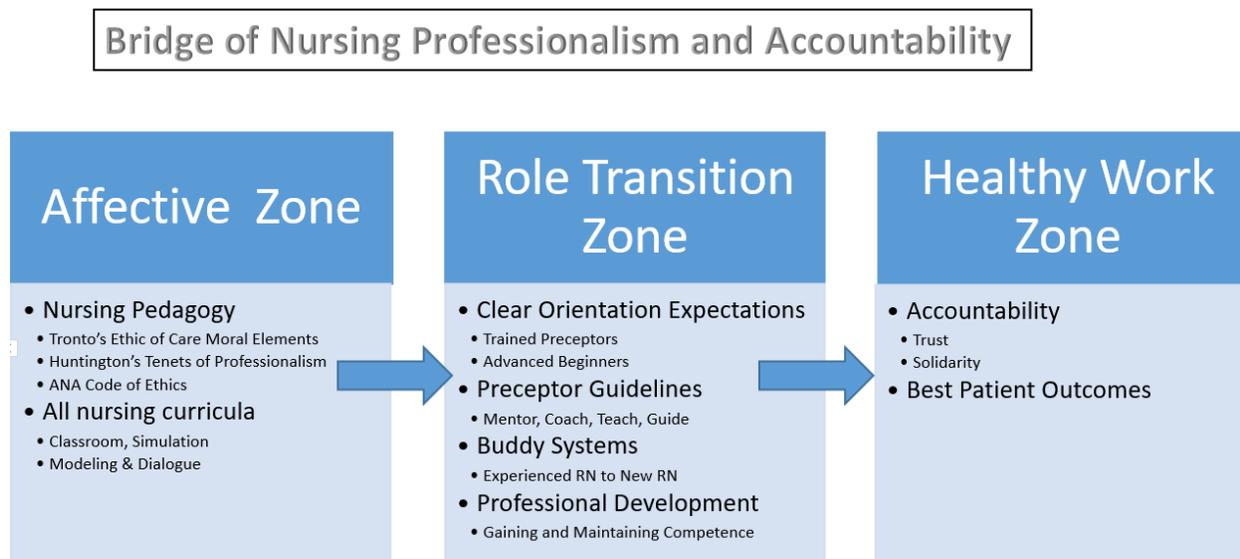
### **Recommendations**

Sawbridge and Hewison (2015) discussed the responsibility of organizations to create compassionate cultures with approaches to support staff who engage in emotional labor. The invisibility of emotional care work leads to feelings of detachment and disenfranchisement, leaving nurses unsupported in their work. Compassion must be cultivated and nurtured and therefore is the responsibility of individuals and organizations. Instead of the impetus being that incivility is failure on the part of the individual nurse to be compassionate, incivility should be viewed as organizational failure to nurture an environment and culture that breeds, expects, and rewards compassionate behavior while having a zero-tolerance policy toward bullying and uncivil treatment of others.

### **Hanks' Bridge to Creating a Healthy Work Environment**

The focus of incivility and uncaring behaviors should be on the wider health care system and internal, external, or systemic failures to provide professional growth and not lay the burden of the crisis at the feet of individual nurses. "Compassion requires a purposeful and systematized approach" (Sawbridge & Hewison, 2015, p. 195) that requires systemic buy-in. Sawbridge and Hewison (2015) further asserted that in the absence of support systems that help nurses replenish their emotional bank account, nurses may suppress feelings of hurt, fear, and anxiety, which over time lead to burn-out, feelings of detachment, and acts that are labeled as incivility. "When staff is cared for, they can fulfill their calling of providing outstanding professional care for patients" (p. 196). Figure 1, Bridge of Nursing Professionalism and Accountability, is a conceptualization

for creating a healthy work space for nurses to fulfill their cognitive, psychomotor, and affective potential based on the data from this study.



*Figure 1.* Bridge of nursing professionalism and accountability. (Based on the data collected in this study and using principles conceived by Tronto, Huntington, Benner, and Noddings, the Bridge of Nursing Professionalism and Accountability represents a framework to combat lateral violence in nursing by teaching affective-based practice in nursing pedagogy and throughout the nurse's professional career.)

**Affective Zone.** The affective zone is important to build and maintain when creating healthy work environments for nurses. The construction of the affective zone must begin in nursing classrooms and continue throughout the nurse's professional career through continuing education and professional development opportunities. Though there are multiple ways of teaching and knowing about ethics and professionalism, as exemplars I recommend the five moral elements introduced in Tronto's (1993) Ethic of Care and use of the American Nurses Association's (2015b) *Code of Ethics for Nurses with Interpretive Statements* as a means to lay the foundation for the ethical treatment of colleagues and creation of a healthy workspace. On the subject of professionalism, I recommend Huntington's (Glenn et al., 2003) use of

corporateness, expertise, and responsibility as laying a brief and concise means of understanding what professionalism means. New nurses, in truth all nurses, should understand what professionalism is and how each should contribute to sustaining the nursing profession. More important than whose methodology is used to teach professionalism and ethics in nursing is the conviction to teach it throughout all nursing curricula and reinforce it in the nurse's professional environment.

**Role Transition Zone.** The most compelling argument to be made in completing this research is that the transition period from new graduate nursing student to novice nurse is an overwhelming time psychologically and emotionally for the novice nurse. Arguably, it is also the time when their cognitive, psychomotor, decision-making, clinical-judgment, and beginning competence as a nurse is starting to take form, making this the most crucial time in the professional life of a nurse. To compound this fragile moment in their lives with unwarranted intimidations and fears is unconscionable. The role transition zone should be free of as many obstacles as possible to create a path for the new nurse graduate that has clear expectations during orientation. All organizations should have a set of pre-established orientation expectations. These expectations can exist as guidelines or procedures. Each member of the orientation process should know their role and how to seek assistance in case of unclear or undefined expectations. In order for this to be a seamless process, one truth must be known to all involved: New nurse graduates are not fully competent and they do not know all the answers.

The two most important roles in the orientation process of the new nurse are undoubtedly the new nurse and the preceptor. The new nurse should be accepted as what Benner (1984) recognized as an advanced beginner. As an advanced beginner, expectations of the new nurse's knowledge, skills, and abilities should be set at that level and the preceptor should proceed to

coach, mentor, teach, and guide the orientation process from that realm. Likewise, preceptors should be trained in the role of one who is expected to coach, mentor, teach, and guide. Nurses should be hired and trained by organizations with the mentality that one day, you will serve as a preceptor to nursing students or new nurse hires. As a member of a profession it is our duty to sustain the profession. The creation of a “buddy system” for new nurse hires to be paired with experienced staff that can continue to mentor them after the orientation process is also useful to the role transition process. The “buddy system” ensures that the new nurse will not become isolated from other nurses on the unit and will always have a safe person or persons to ask questions of or seek guidance from when needed. Finally, organizational support in the form of professional development opportunities to gain and/or maintain competence in cognitive, psychomotor, and affective nursing knowledge are paramount.

**Healthy Work Zone.** The healthy work zone represents the space where nurses within the unit have achieved a sense of trust and solidarity. They rely on accountability to achieve the common goal of obtaining the best possible patient outcomes. Nurses trust that their nursing colleagues, whether experienced or novice, all have the same goal in mind. That goal is to produce the best patient outcomes and the only way to achieve that goal is for all to work collaboratively as a team, sharing knowledge, information, and experiences in a culture of mutual respect. Tronto’s fifth moral element of *trust and solidarity* underpins the relational interdependence of nurses within the healthy work zone. Nurses rely on each other to fulfill their duty to their patients and to society. Forming bonds that are cemented in respecting the individual rights, dignity, and self-worth of all persons, including nurse colleagues, will help to strengthen the solidarity of the nursing unit and stifle spaces where LV would attempt to exist.

Accountability carries an expectation that all nurses should respect others and expect similar treatment. Accountability, in the healthy work zone, also reiterates the nurse's role as an autonomous being who has the power to make decisions and speak in opposition against forces that are deviant to nursing professionalism. Nurses must appraise for the ethical treatment of all individuals when assessing interactions between nurses intra- and interprofessionally. When we see behaviors that are deviant, such as those seen in LV, we must find the voice to speak up in a manner which respectfully reminds our colleague that the negative treatment of another human being is not to be tolerated within nursing. As nurses, we treat the physical, emotional, and psychological needs of others; we cannot inflict these wounds. Nursing units and organizations that employ nurses must create a culture that welcomes these healthy interactions between nurse colleagues. As an example, the following guidelines serve as a set of recommendations for helping a new preceptor initiate the role.

### **Hanks' Preceptor Guidelines**

#### *The Good Preceptor*

The following guidelines can be used in nursing clinical settings, in higher education, or in health care organizations to facilitate new nurse orientation or student preceptorships, residencies, or internships.

1. ***Recruit a Preceptor.*** Recruit preceptors who meet certain criteria. The preceptor must be willing to teach, mentor, and coach while accepting the added responsibility of having a new nurse or student working alongside and shadowing every professional move. Each preceptor should be encouraged to recruit a nurse to serve as preceptor to a new generation of nurses, remembering that the future of our profession is the new nurse.
2. ***Commit to Maintaining and Supporting a Healthy Work Environment for all Nurses.*** The preceptor should be committed to creating a nurturing and supportive relationship with the new nurse or student nurse.
3. ***State Clear Expectations for all Participants in the Preceptor/Orientation Process.*** It is acceptable to have clear organizational, management, preceptor, new employee, and/or student nurse expectations spelled out. The preceptor should carefully review these expectations with the new nurse or student on day1 of orientation. This will negate any gray areas and everyone will know their responsibilities in the training process. These

expectations should include cognitive, psychomotor, and affective responsibilities. If a conflict exists between the preceptor and the new nurse and/or student, there should be guidelines as to how to handle the conflict. If the unit is committed to creating a healthy work space for all employees, these instances should be worked out between the two participants involved without further incident. Having rules so that everyone understands their value and understand that their voices will be heard needs to be clearly stated.

4. ***Be Willing and Prepared to Answer Questions.*** After each patient round, ask the new nurse or student if there are questions about the patient's condition, medications, new prescriptions, etc. If not, ask questions that you think should have been asked.
5. ***Introduce.*** Introduce the new nurse or student to important players on the unit (other nurses, physicians, pharmacists, physical therapists, etc.). This initiates the team building process and begins to shed the "outsider" mentality of the new nurse or student.
6. ***Show and Tell.*** In clinical situations that are complex or that the new nurse or student has not had hands-on experience with, explain to the patient that you are going to perform the procedure together this time. Teach the new person by talking and coaching them through the procedure. Next time, let the new nurse or student perform the procedure while you watch.
7. ***Scavenger Hunt.*** Give the new nurse or student a list of commonly used items. Allow them a designated amount of time to find the items without your assistance. Tell them it is acceptable to ask others on the unit for help if they get stuck. This will allow them to meet new colleagues and learn their new unit.
8. ***Calling the Physician.*** Calling the physician, or anyone, for the first time can be a nerve-racking, earth-shattering experience for the new nurse. If it is not an emergency situation (in which case the preceptor should be making the call anyway), role-play with the new nurse prior to calling by pretending to be the physician. Ask questions and make sure that all of the necessary information is in the nurse's hand before the call is made. This can help ease the anxiety level. Each phone call will get better. The more opportunities the new nurse has to practice phone calls in orientation with you listening, guiding, and coaching, the better.
9. ***Practice Makes Perfect Practices.*** Without overwhelming the new nurse or student, allow them to take on the role of a nurse in practice. By week 2 or 3 in the orientation experience, depending on your organization's and specialty area's policies, the new nurse should be ready to perform the duties that you perform as a nurse, but under your constant guidance and supervision. This is when the preceptor earns the title of mentor and coach. In accordance with your facility's policies, allow the new nurse to take the patient assignment. However, you **MUST** remain visible and present to answer questions and troubleshoot should a problem arise. Here is also when you start to teach the new nurse time management and management of care skills.
10. ***Don't be a Polar Bear.*** It is believed that polar bears are now among the animals that eat their young. If the new nurse or student has a question or is having time management or

other rookie issues, simply whisper to yourself, “that was me once,” and rescue them. It is our ethical responsibility as nurses to care for those who cannot care for themselves. Our patient’s lives are dependent on how well you, as the preceptor, train the new nurse.

Let us build competent nurses, healthy work environments, and do what nurses do best, SAVE LIVES.

### **Limitations**

Limitations of this study included the small sample size due to the qualitative nature of the study. Only nurses with 2 years of experience or fewer were interviewed. This limitation did not allow for nurses with more experience to express their views on LV in the workplace. Also, the study was performed in the southeastern United States. The participants represented two states from the southeast and four different nursing facilities. Only female nurses were interviewed. No nurses over the age of 40 were interviewed. This study did not examine the experiences of those nurses who were thought to be instigators of LV behaviors.

### **Future Research**

Research in the area of professionalism, ethical practice, and social justice issues in nursing is needed. How do we measure affective competence to ensure that behaviors, such as those seen in LV, do not persist on nursing units? How do nurses self-regulate their behavior to ensure that ethical treatment of all persons is implemented in nursing practice? Research that examines the usefulness of affective-based practice and operationalizes affective practice into measurable components will be needed. Nurses’ relationships with other nurses are important to the overall work environment, yet little research focuses on this issue. Healthy work environments are essential to nursing satisfaction, recruitment and retention efforts, and safe and effective patient care delivery. However, no empirical studies exist that explore staff nurses’ perceptions regarding positive and negative aspects of nurse-to-nurse relationships (Moore et al., 2013) and how these relationships affect the nursing profession. Current recommendations for

combating lateral violence focus on teaching conflict resolution techniques (reactive approach). Research studies that explore the outcomes of integrating professionalism and ethical behavior development in undergraduate nursing curricula or studies that explore ways to enhance professional development in clinical practice would help to inform nursing leadership on how to best assure nurse professionalism and ethical behavior among its members from a proactive stance.

### **Conclusion**

It is ironic that nursing, an ethical ideal, birthed in caring and altruism, has an issue with lateral violence. Nursing must now conscientiously forge a merger between professional practice and caring that is frowned upon by some in a capitalist market who would rather we denounce the caring nature in our profession, which makes it unique and a model for other professions to emulate, and focus on efficiency and outcomes connected to financial gains (Watson, 2009). For those who believe that nurses are asked to show compassion due to gender differences or the nature of nurse's work, the literature supported that other professions have an ethical responsibility to show altruism (unselfish concern for the welfare of another), care, and compassion. For those who think that care and professionalism are not qualities that deserve the attention of nursing academia and nursing practice, the findings of this qualitative study using a grounded theory analysis provide a strong argument to support that ethical training is needed across all nursing curricula and should be extended into nursing practice areas, as well.

Traditionally, nurses have been ranked in Gallup Polls as the most ethical and trustworthy profession since being placed on the survey in 1999 (ANA, 2015c). The sole year that nurses were not ranked number one was in 2001, following the September 11 attacks. That is an indication as to how those outside of nursing see us. However, caring and civility are only

important if the group, in this case, nurses, acknowledge them as important. Social identity theory espouses that an individual's sense of self-worth is reflected in their evaluation of the groups in which they belong (Willettts & Clark, 2008). In other words, nurses are who we say we are. We should choose to be professional, ethical beings who seek the fair and just treatment of all those we serve, our patients and our colleagues.

The best means of effecting change in the nursing profession is to promote collaborations between nursing academia and practice (Andrew, 2012). Teaching professional, caring, ethical principles in nursing academia and ensuring its nurturance in nursing practice can mitigate LV in nursing. Caring relationships need not always lead to friendship, nor is friendship development necessary (Engster, 2005). What is necessary is a conscientious understanding that respect, dignity, and social justice are basic human rights that all nurses should be expected to honor.

## REFERENCES

- Ahadiat, N., & Martin, R. M. (2015). Attributes, preparations, and skills accounting professionals seek in college graduates for entry-level positions versus promotion. *Journal of Business and Accounting*, 8(1), 179-189.
- AL-Dossary, R., Kitsantas, P., & Maddox, P. J. (2014). The impact of nurse residency programs on new nurse graduates' clinical decision-making and leadership skills: A systematic review. *Nurse Education Today*, 34(6), 1024-1028.
- American Association of Colleges of Nursing. (2008). *The essentials of baccalaureate education for professional nursing practice*. Retrieved from <http://www.aacn.nche.edu/education-resources/BaccEssentials08.pdf>
- American Association of Colleges of Nursing. (2011). *Nursing fact sheet*. Retrieved from <http://www.aacn.nche.edu/media-relations/fact-sheets/nursing-fact-sheet>
- American Association of Critical Care Nurses. (2005). *American Association of Critical Care Nurses' standards for establishing and sustaining healthy work environments: A journey to excellence*. Retrieved from <http://www.aacn.org/wd/hwe/docs/hwestandards.pdf>
- American Nurses Association. (2015a). *American Nurses Association position statement on incivility, bullying and workplace violence*. Retrieved from <http://www.nursingworld.org/MainMenuCategories/Policy-Advocacy/Positions-and-Resolutions/ANAPositionStatements/Position-Statements-Alphabetically/Incivility-Bullying-and-Workplace-Violence.html>
- American Nurses Association. (2015b). *Code of ethics for nurses with interpretive statements*. Retrieved from <http://Nursesbooks.org>
- American Nurses Association. (2015c). *Nurses rank as most honest, ethical profession for 14th straight year* [Press release]. Retrieved from <http://www.nursingworld.org/2015-NursesRankedMostHonestEthicalProfession>
- Andrew, N. (2012). Professional identity in nursing: Are we there yet? *Nurse Education Today*, 32, 846-849. <http://dx.doi.org/10.1016/j.nedt.2012.03.014>
- Apesoa-Varano, E. C. (2007). Educated caring: The emergence of professional identity among nurses. *Qualitative Sociology*, 30, 249-274. <http://dx.doi.org/10.1007/s11133-007-9069-6>

- Applebee, G. (2006). A brief history of medical professionalism and why professionalism matters. *Contemporary Pediatrics*, 23(10), 53-64.
- Bailey, D. N. (2009). Caring defined: A comparison and analysis. *International Journal for Human Caring*, 13(1), 16-31.
- Baillien, E., Neyens, I., De Witte, H., & De Cuyser, N. (2009). A qualitative study on the development of workplace bullying: Towards a three way model. *Journal of Community and Applied Social Psychology*, 19, 1-16. <http://dx.doi.org/10.1002/casp.977>
- Becher, J., & Visovsky, C. (2012). Horizontal violence in nursing. *Medsurg Nursing*, 21(4), 210-213, 232.
- Benner, P. (1984). *From novice to expert: Excellence and power in clinical nursing practice*. Menlo Park, CA: Addison-Wesley.
- Benner, P., Surphen, M., Leonard, V., & Day, L. (2010). *Educating nurses: A call for radical transformation*. San Francisco, CA: Jose-Bass.
- Blevins, S. H. (2016). Nurse residency programs: Supporting nurse graduates. *Medsurg Nursing*, 25(5), 367-368.
- Brett, A. L., Branstetter, J. E., & Wagner, P. D. (2014). Nurse educators's perceptions of caring attributes in current and ideal work environments. *Nursing Education Perspectives*, 35(6), 360-366. <http://dx.doi.org/10.5480/13-1113.1>
- Center for American Nurses. (2008). *Lateral violence and bullying in the workplace* [Position statement]. Retrieved from Center for American Nurses website: [http://www.centerforamericannurses.org/positions/lateral violence.pdf](http://www.centerforamericannurses.org/positions/lateral%20violence.pdf)
- Clark, C. M., Ahten, S. M., & Macy, R. (2013). Using problem-based learning scenarios to prepare nursing students to address incivility. *Clinical Simulation in Nursing*, 9(3), e75-e83. <http://dx.doi.org/10.1016/j.ecns.2011.10.003>
- Clark, C. M., & Davis-Kenaley, B. L. (2011). Faculty empowerment of students to foster incivility in nursing education: A merging of two conceptual models. *Nursing Outlook*, 59, 158-165. <http://dx.doi.org/10.1016/j.outlook.2010.12.005>
- Clendon, J., & Walker, L. (2012). Being young: A qualitative study of younger nurses' experiences in the workplace. *International Nursing Review*, 59, 555-561.
- Corbin, J., & Strauss, A. (2015). *Basics of qualitative research: Techniques and procedures for developing grounded theory* (4th ed.). Los Angeles, CA: SAGE.
- Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). Los Angeles, CA: SAGE.

- Croft, R. K., & Cash, P. A. (2012). Deconstructing contributing factors to bullying and lateral violence in nursing using a postcolonial feminist lens. *Contemporary Nurse*, 42(2), 226-242.
- Crowley, M. A. (1994). The relevance of Noddings' ethics of care to the moral education of nurses. *Journal of Nursing Education*, 33(2), 74-80.
- De Lange, P., Jackling, B., & Gut, A. M. (2006). Accounting graduates' perceptions of skills emphasis in undergraduate courses: An investigation from two Victorian universities. *Accounting and Finance*, 46(3), 365-386.
- Decker, J. L., & Shellenbarger, T. (2012). Strategies for nursing faculty to promote a healthy work environment for nursing students. *Teaching and Learning in Nursing*, 7, 56-61. <http://dx.doi.org/10.1016/j.teln.2010.12.001>
- Dillon, D. R. (2012). Grounded theory and qualitative research. In *The encyclopedia of applied linguistics*. <http://dx.doi.org/10.1002/9781405198431.wbea10486>
- Donley, R., & Flaherty, M. J. (2008). Promoting professional development: Three phrases of articulation in nursing education and practice. *The Online Journal of Issues in Nursing*, 13(3). <http://dx.doi.org/10.3912/OJIN.Vol13No03Man02>
- Dubrosky, R. (2013). Iris Young's five faces of oppression applied to nursing. *Nursing Forum*, 48(3), 205-210.
- Duphily, N. H. (2014). Simulation education: A primer for professionalism. *Teaching and Learning in Nursing*, 9, 126-129. <http://dx.doi.org/10.1016/j.teln.2014.03.003>
- Egues, A. L., & Leinung, E. Z. (2013). The bully within and without: Strategies to address horizontal violence in nursing. *Nursing Forum*, 48(3), 185-190.
- Embree, J. L., & White, A. H. (2010). Concept analysis: Nurse-to-nurse lateral violence. *Nursing Forum*, 45(3), 166-173.
- Engster, D. (2005). Rethinking care theory: The practice of caring and the obligation to care. *Hypatia*, 20(3), 50-74.
- Fagermoen, M. S. (1999). Humanism in nursing theory: A focus on caring. In S. Kim & I. Kollak (Eds.), *Nursing theories: Conceptual and philosophical foundations* (pp. 135-159). New York, NY: Springer.
- Felstead, I. S., & Springett, K. (2015). An exploration of role model influence on adult nursing students' professional development: A phenomenological research study. *Nurse Education Today*. <http://dx.doi.org/10.1016/j.nedt.2015.11.014>

- Fisher, M. (2014). A comparison of professional value development among pre-licensure nursing students in associate degree, diploma, and bachelor of science in nursing programs. *Nursing Education Perspectives*, 25(1), 37-42.
- Freshwater, D. (2000). Crosscurrents: Against cultural narration in nursing. *Journal of Advanced Nursing*, 32(2), 481-484.
- Gaffney, D. A., DeMarco, R. F., Hofmeyer, A., Vessey, J. A., & Budin, W. C. (2012). Making things right: Nurse's experiences with workplace bullying-a grounded theory. *Nursing Research and Practice*, 2012, 1-10. <http://dx.doi.org/10.1155/2012/243210>
- Gallo, V. J. (2012). Incivility in nursing education: A review of literature. *Teaching and Learning in Nursing*, 7, 62-66. <http://dx.doi.org/10.1016/j.teln.2011.11.006>
- Gibson, S. (2004). The problem of abortion: Essentially contested concepts and moral autonomy. *Bioethics*, 18(3), 221-233.
- Gilligan, C. (1995). Hearing the difference: Theorizing connection. *Hypatia*, 10(2), 120-127.
- Gleeson, P. B. (2007). Understanding generational competence related to professionalism: Misunderstandings that lead to a perception of unprofessional behavior. *Journal of Physical Therapy Education*, 21(3), 23-28.
- Glenn, E. N. (2010). *Forced to care*. Cambridge, MA: Harvard University Press.
- Glenn, R. W., Panitch, B. R., Barnes-Proby, D., Williams, E., Christian, J., Lewis, M. W., . . . Brannan, D. W. (2003). *Training the 21st century police officer: Redefining police professionalism for the Los Angeles police department*. Santa Monica, CA: RAND.
- Griffin, M. (2004). Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *The Journal of Continuing Education in Nursing*, 35(6), 257-263.
- Harkness, G. A., & DeMarco, R. F. (Eds.). (2016). *Community and public health nursing: Evidence for practice* (2nd ed.). Philadelphia, PA: Wolters Kluwer.
- Harris, E. L. (2006). Mary Douglas's typology of grid and group. In V. A. Anfara, & N. T. Mertz (Eds.), *Theoretical frameworks in qualitative research* (pp. 129-154). Thousand Oaks, CA: Sage.
- Health Resources and Services Administration. (2013). *The U.S. nursing workforce: Trends in supply and education*. Retrieved from <http://bhpr.hrsa.gov/healthworkforce/reports/nursingworkforce/index.html>
- Heinreich, K. T. (2010). An optimist's guide for cultivating civility among academic nurses. *Journal of Professional Nursing*, 26(6), 325-331. <http://dx.doi.org/10.1016/j.profnurs.2010.07.002>

- Henstrand, J. L. (2006). Seeking an understanding of school culture: Using theory as a framework for observation and analysis. In V. A. Anfara, & N. T. Mertz (Eds.), *Theoretical frameworks in qualitative research* (pp. 1-22). Thousand Oaks, CA: Sage.
- Hippeli, F. (2009). Nursing: Does it still eat its young, or have we progressed beyond this? *Nursing Forum*, 44(3), 186-188.
- Hoover, J. H., Oliver, R., & Hazler, R. J. (1992). Bullying: Perceptions of adolescent victims in the Midwestern USA. *School Psychology International*, 13, 5-16.
- Hutchinson, M., & Hurley, J. (2013). Exploring leadership capability and emotional intelligence as moderators of workplace bullying. *Journal of Nursing Management*, 21, 553-562.
- Hutchinson, M., Wilkes, L., Vickers, M., & Jackson, D. (2008). The development and validation of a bullying inventory for the nursing workplace. *Nurse Researcher*, 15(2), 19-29.
- Institute for Safe Medication Practices. (2009). *Results from ISMP survey on workplace intimidation*. Retrieved from <https://www.ismp.org/Survey/surveyResults/Survey0311.asp>
- Institute of Medicine. (2010). *The future of nursing: Leading change, advancing health*. Washington, DC: National Academies Press.
- The Joint Commission. (2008). *Behaviors that undermine a culture of safety*. [Issue brief]. Retrieved from [https://www.jointcommission.org/assets/1/18/SEA\\_40.PDF](https://www.jointcommission.org/assets/1/18/SEA_40.PDF)
- The Joint Commission. (2012). *Comprehensive accreditation manual for hospitals*. Retrieved from [www.jointcommission.org](http://www.jointcommission.org)
- The Joint Commission website. (2016). <http://www.jointcommission.org>
- Jones, C., & Gates, M. (2007). The costs and benefits of nurse turnover: A business case for nurse retention. *Online Journal of Issues in Nursing*, 12(3), 2.
- Kavanaugh, M. H., & Drennan, L. (2008). What skills and attributes does an accounting graduate need? Evidence from student perceptions and employer expectations. *Accounting and Finance*, 48(2), 279.
- Kearney, K. S., & Hyle, A. E. (2006). A look through the Kubler-Ross theoretical lens. In V. A. Anfara, & N. T. Mertz (Eds.), *Theoretical frameworks in qualitative research* (pp. 109-128). Thousand Oaks, CA: Sage.
- Kelly, J., & Ahern, K. (2008). Workplace issues in nursing: A phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing*, 18, 910-918.

- Kirk, L. M. (2007). Professionalism in medicine: Definitions and considerations for teaching. *Baylor University Medical Center Proceedings*, 20(1), 13-16.
- Lachman, V. (2012). Applying the ethics of care to your nursing practice. *MedSurg Nursing*, 21(2), 112-115.
- Lachman, V. D. (2014). Ethical issues in the disruptive behaviors of incivility, bullying, and horizontal/lateral violence. *MedSurg Nursing*, 23(1), 56-60.
- Lasiter, S., Marchiondo, L., & Marchiondo, K. (2012). Student narratives of faculty incivility. *Nursing Outlook*, 60, 121-126. <http://dx.doi.org/10.1016/j.outlook.2011.06.001>
- Lee, Y. J., Bernstein, K., & Nokes, K. M. (2014). Bullying in the nursing workplace: Applying evidence using a conceptual framework. *Nursing Economics*, 32(5), 255-267.
- Lewis, P. S., & Malecha, A. (2011). The impact of workplace incivility on the work environment, manager skill, and productivity. *The Journal of Nursing Administration*, 41(1), 41-47. <http://dx.doi.org/10.1097/NNA.0b013e3182002a4c>
- Longo, J., & Sherman, R. (2007). Leveling horizontal violence. *Nursing Management*, 38(3), 34-37, 50-51.
- MacIntosh, J. (2003). Reworking professional nursing identity. *Western Journal of Nursing Research*, 25(6), 725-741.
- Mackenzie, C. (2007). Feminist bioethics and genetic termination. *Bioethics*, 21(9), 515-516.
- Mackintosh, C. (2000). Is there a place for “care” within nursing? *International Journal of Nursing Studies*, 37, 321-327.
- Melia, K. (1987). *Learning and working: The occupational socialization of nurses*. London: Tavistock Publications Ltd.
- Merriam, S. B. (2009). *Qualitative research: A guide to design and implementation* (3<sup>rd</sup> ed.). San Francisco: Jossey-Bass.
- Merriam-Webster. (n.d.). *Professionalism*. In Professionalism. Retrieved from <http://www.merriam-webster.com/dictionary/professionalism>
- Moore, L. W., Leahy, C., Sublett, C., & Lanig, H. (2013). Understanding nurse-to-nurse relationships and their impact on work environments. *MEDSURG Nursing*, 22(3), 172-179.
- Munhall, P. L. (2012). *Nursing research: A qualitative perspective* (5th ed.). Sudbury, MA: Jones & Bartlett Learning.

- Murphy, N., Canales, M. K., Norton, S. A., & DeFilippis, J. (2005). Striving for congruence: The interconnection between values, practice, and political action. *Policy, Politics, & Nursing Practice*, 6(1), 20-29. <http://dx.doi.org/10.1177/1527154404272145>
- National League for Nursing. (2010). *2010 Nurse educator shortage fact sheet*. Retrieved from <http://www.nln.org/governmentaffairs/pdf/NurseFacultyShortage.pdf>
- Noddings, N. (2010). Moral education in an age of globalization. *Educational Philosophy and Theory*, 42(4), 390-396.
- Noddings, N. (2012). The language of care ethics. *Knowledge Quest*, 40(4), 52-56.
- Nursing World. (2016). <http://nursingworld.org>
- Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing*, 43(4), 395-401.
- Reverby, S. M. (1987). *Ordered to care: The dilemma of American nursing, 1850-1945*. Cambridge, United Kingdom: Cambridge University Press.
- Roach, M. S., & Maykut, C. (2010). Comportment: A caring attribute in the formation of an intentional practice. *International Journal for Human Caring*, 14(4), 22-26.
- Robichaux, C., & Parsons, M. L. (2009). An ethical framework for developing and sustaining a healthy workforce. *Critical Care Nursing Quarterly*, 32(3), 199-207.
- Rutty, J. E. (1998). The nature of philosophy of science, theory and knowledge relating to nursing and professionalism. *Journal of Advanced Nursing*, 28(2), 243-250.
- Saldana, J. (2016). *The coding manual for qualitative researchers* (3rd ed.). Los Angeles, CA: SAGE.
- Sandel, M. J. (2009). *Justice: What's the right thing to do?* New York, NY: Farrar, Straus and Giroux.
- Sauer, P. (2012). Do nurses eat their young: Truth and consequences? *Journal of Emergency Nursing*, 38(1), 43-46. <http://dx.doi.org/10.1016/j.jen.2011.08.012>
- Sawbridge, Y., & Hewison, A. (2015). Compassion costs nothing: The elephant in the room. *Practice Nursing*, 26(4), 194-197.
- Shephard, L. H. (2014). It takes a village to assure nurse professionalism. *i-manager's Journal on Nursing*, 3(4), 1-5.
- Sheridan-Leos, N. (2008). Understanding lateral violence in nursing. *Clinical Journal of Oncology Nursing*, 12(3), 399-403.

- Simons, S. (2008). Workplace bullying experienced by Massachusetts registered nurses and the relationship to intention to leave the organization. *Advances in Nursing Science*, 31(2), 48-59.
- Simons, S. R., & Mawn, B. (2010). Bullying in the workplace: A qualitative study of newly licensed registered nurses. *American Association of Occupational Health Nurses Journal*, 58(7), 305-311. <http://dx.doi.org/10.3928/08910162-20100616-02>
- Spector, P. E., Zhou, Z. E., & Che, X. X. (2014). Nurse exposure to physical and nonphysical violence, bullying, and sexual harassment: A quantitative review. *International Journal of Nursing Studies*, 51, 72-84.
- Speroni, K. G., Fitch, T., Dawson, E., Dugan, L., & Atherton, M. (2014). Incidence and cost of nurse workplace violence perpetrated by hospital patients or patient visitors. *Journal of Emergency Nursing*, 40(3), 218-228. <http://dx.doi.org/10.1016/j.jen.2013.05.014>
- Stake, R. E. (2006). *Multiple case study analysis*. New York, NY: The Guilford Press.
- Stanley, K. M., Martin, M. M., Michel, Y., Welton, J. M., & Nemeth, L. S. (2007). Examining lateral violence in the nursing workforce. *Issues in Mental Health Nursing*, 28, 1247-1265.
- Stovall, D. C., & Stovall, P. S. (2009). Professional accountants: Void of soft skills? *The Business Review, Cambridge*, 14(1), 99-104.
- Thomas, C. M. (2010). Teaching nursing students and newly registered nurses strategies to deal with violent behaviors in the professional practice environment. *The Journal of Continuing Education in Nursing*, 41(7), 299-308.
- Thompson, A. (1998). Not the color purple: Black feminist lessons for educational caring. *Harvard Educational Review*, 68(4), 522-554.
- Tronto, J. C. (1993). *Moral boundaries: A political argument for an ethic of care*. New York, NY: Routledge.
- Tronto, J. C. (2010). Creating caring institutions: Politics, plurality, and purpose. *Ethics and Social Welfare*, 4(2), 158-171. <http://dx.doi.org/10.1080/17496535.2010.484259>
- Tulloch, G. (2005). A feminist utilitarian perspective on euthanasia: from Nancy Crick to Terri Schiavo. *Nursing Inquiry*, 12(2), 155-160.
- Vessey, J. A., DeMarco, R., & DiFazio, R. (2010). Bullying, harassment, and horizontal violence in the nursing workforce: The state of the science. *Annual Review of Nursing Research*, 28, 133-157.

- Vessey, J. A., DeMarco, R. F., Gaffney, D. A., & Budin, W. C. (2009). Bullying of staff registered nurses in the workplace: A preliminary study for developing personal and organizational strategies for the transformation of hostile to healthy workplace environments. *Journal of Professional Nursing, 25*(5), 299-306. <http://dx.doi.org/10.1016/j.profnurs.2009.01.022>
- Watson, J. (2009). Caring science and human caring theory: Transforming personal and professional practices in nursing and health care. *Journal of Health and Human Services Administration, 31*(4), 466-482.
- Watson, J., & Smith, M. C. (2002). Caring science and the science of unitary human beings: A trans-theoretical discourse for nursing knowledge development. *Journal of Advanced Nursing, 37*(5), 452-461.
- Willetts, G., & Clarke, D. (2013). Constructing nurses' professional identity through social identity theory. *International Journal of Nursing Practice, 20*, 164-169. <http://dx.doi.org/10.1111/ijn.12108>
- Woelfle, C. Y., & McCaffrey, R. (2007). Nurse on nurse. *Nursing Forum, 42*(3), 123-132.
- Wolcott, H. F. (2010). *Ethnography lessons: A primer*. Walnut Creek, CA: Left Coast Press.
- Workplace Bullying Institute. (2014). 2014 WBI U.S. workplace bullying survey. Retrieved from <http://www.workplacebullying.org/wbiresearch/wbistudies/>
- Zembylas, M., Bozalek, V., & Shefer, T. (2014). Tronto's notion of privileged irresponsibility and the reconceptualisation of care: Implications for critical pedagogies of emotion in higher education. *Gender and Education, 26*(3), 200-214. <http://dx.doi.org/10.1080/09540253.2014.901718>

APPENDIX A

LATERAL VIOLENCE INVITATION FLYER



Do No Harm Refers to Nurses Too

## RESEARCH STUDY ON LATERAL VIOLENCE

### Do you feel a lack of emotional and professional support in your workplace?

Lateral violence in nursing can lead to absenteeism, attrition, poor work performance, and an unwillingness to ask questions for fear of humiliation or reprimand by a peer, and this, in turn has a negative impact on patient outcomes. This study will focus on new nurses' perspectives on lateral violence in the workplace and their thoughts on the role of professionalism and caring behaviors as a means to mitigate uncivil behavior.

**\$25 GIFT CARDS TO ALL PARTICIPANTS  
WHO COMPLETE INTERVIEWS.**

Participation is voluntary.

UA IRB Approved Document  
Approval date: 7/20/14  
Expiration date: 7/19/2017

### RN Participants Wanted

#### Eligibility Criteria

New RN that has left (or plans to leave) the job within 1 to 2 years because of lateral violence

Graduate of an Associate Degree or Bachelor Degree of Nursing Program

Willing to take an online survey and participate in a face-to-face interview

**For more information, please contact Mary Hanks.**

#### MARY HANKS, MSN, RN

Principal Investigator  
University of Alabama  
Doctoral Candidate  
Department of Education

[mlgiles@crimson.ua.edu](mailto:mlgiles@crimson.ua.edu)

(205) 242-8824  
July-October, 2016

APPENDIX B  
INVITATION TO PARTICIPATE IN RESEARCH

Invitation to participate in the research project titled:

“Incivility or Unprofessionalism: Nurses’ Perspectives on the Contradictions of Caring Behaviors in Their Work Environment”

Dear Registered Nursing Colleagues,

I am conducting interviews as part of a research study to increase our understanding of how lateral violence is perceived and experienced by new graduate nurses in practice to determine if it is causing them to leave their jobs. If you are a new nurse who has left your job in the first year or two of practice or you are thinking about leaving because of uncivil behavior where you work, you are in an ideal position to give valuable firsthand information from your perspective.

The interview takes around one hour and is very informal. I am simply trying to capture your thoughts and perspectives on being a nurse in your particular work environment and the encounters you have had with incivility. Your responses to the questions will be kept confidential. Each interview will be assigned an alphanumeric code to help ensure that personal identifiers are not revealed during the analysis and write up of findings.

After participation in the interview and a follow-up interview to ensure that I have recorded your thoughts accurately, a \$25 gift card will be given to each participant. Your participation will be a valuable addition to this research study and findings could lead to greater understanding of lateral violence and ways to prevent it from occurring in nursing. Participation is voluntary and you do not have to answer any questions that make you uncomfortable.

If you are willing to participate, please suggest a day and time that best suits you and I will do my best to be available. If you have any questions, please do not hesitate to ask.

Thanks for your consideration,

Mary Hanks, MSN, RN, CNL, CNE  
mlgiles@crimson.ua.edu  
(205) 242-8824

APPENDIX C

DEMOGRAPHIC SURVEY WITH LATERAL VIOLENCE DEFINITION

## Professionalism and Incivility Demographics Survey

1. What is your gender?

- Female
- Male

2. What is your age?

- 19 to 24
- 25 to 34
- 35 to 44
- 45 or older

3. What is the highest nursing degree you have received?

- Associate degree
- Bachelor degree

4. Which category best describes your years of employment as a Registered Nurse?

- less than 2 years
- greater than 2 years

5. Which race/ethnicity best describes you? (Please choose only one.)

- American Indian or Alaskan Native
- Asian / Pacific Islander
- Black or African American
- Hispanic
- White / Caucasian
- Multiple ethnicity / Other (please specify)

6. What does the term lateral violence mean?

APPENDIX D  
LATERAL VIOLENCE CASE SCENARIOS

1. A new nurse graduate has been out of orientation for two weeks and the charge nurse has assigned her four patients, two of which are very demanding and time-consuming. The other nurses on the unit each have six patients and their beds are at capacity, but the acuity of their patients is much more stable than the new nurse's. You already know that two patients are scheduled to come to the new nurse's two empty beds, which will give her two new admissions requiring even more of her time. The new nurse comes to you to express her discomfort with the acuity level of the four patients and the fear that she may get two more patients. How do you respond to this situation? Select all that apply.

- Tell the new nurse that we all had to go through this at some point and that she will just have to manage the best she can.
- Offer to help the new nurse when the new admissions come if time will allow.
- Go to the charge nurse and see if something can be done to assist the new nurse with her current patients and redirect the new admissions.
- Listen to the new nurses concerns and offer emotional support.
- Tell the nurse that this is the way the organization is run and that complaining will only make matters worse.
- None of these.

Other (please specify)

2. Dr. Brown is in a foul mood because the night shift nurse forgot to call him to report the morning lab results on a patient's prothrombin time and now the patient's surgery must be delayed. Joanne has just clocked in for the dayshift and is assigned to the patient. Dr. Brown turns to you and demands to see the "incompetent nurse that didn't call me". You are aware that the night shift nurse has already left and you know that Joanne tries to avoid conflict. Joanne is a good nurse who manages her patient's care well. How would you handle this situation? Select all that apply.

- Go and tell Joanne that Dr. Brown would like to discuss a patient's lab results.
- Explain to Dr. Brown that mistakes happen and that the night shift nurse has left.
- Confront Dr. Brown about his behavior at the nurse's station and tell him that it is unacceptable.
- Find the charge nurse and have her intervene.
- None of these

Other (please specify)

3. Two nurses are gossiping on the unit about one of your co-workers and how they hate to follow him after a shift because he is lazy and always leaves work for them to do. You have received change-of-shift report from the same nurse and find the opposite to be true. The nurses say that they are going to report him to Kim, the nurse manager on the unit, and make sure that she "gets rid of him". The two nurses always take smoke breaks together, are slow to respond to patient call lights, and never offer to help other nurses on the unit. They graduated from nursing school with the nurse manager and she always praises them in front of patients, families, and colleagues. What action would you take in this situation? Select all that apply.

- Confront the two nurses and tell them that you disagree with their assessment of your co-worker.
- Go to the nurse manager and defend the co-worker that the nurses are gossiping about.
- Do nothing because it really doesn't concern you.
- Tell the co-worker what the two nurses are saying about him.
- None of these.

Other (please specify)

4. A student nurse is assigned a preceptor on your unit. The preceptor is great with her patients and allows the student to perform tasks, but does not engage the student outside of patients' rooms. You notice the student sits off by herself when the preceptor is interacting with doctors, pharmacists, physical therapists, and family members. The student often is sent to eat lunch alone. The preceptor does not allow the student to participate in change-of-shift report and does not notify the student when she takes low census days. Would you intervene in this situation? Select all that apply.

- Yes. The preceptor should do more to help socialize the student nurse to the culture of the nursing unit and other disciplines on the unit.
- No. It is the student's responsibility to become more involved if she wants to be.
- No. It is the preceptor's responsibility to teach the student how she sees fit.
- None of these.

Other (please specify)

APPENDIX E

INSTITUTIONAL REVIEW BOARD APPROVAL AND CONSENT FORM

July 20, 2016

Mary Hanks  
Dept. of Education  
Box 870302

Re: IRB#: 16-OR-255-ME "Incivility or Unprofessionalism: Nurses's Perspectives on the Contradictions of Caring Behaviors in their Work Environment"

Dear Ms. Hanks:

The University of Alabama Institutional Review Board has granted approval for your proposed research.

Your application has been given expedited approval according to 45 CFR part 46. Approval has been given under expedited review category 7 as outlined below:

(7) Research on individual or group characteristics or behavior (including, but not limited to, research on perception, cognition, motivation, identity, language, communication, cultural beliefs or practices, and social behavior) or research employing survey, interview, oral history, focus group, program evaluation, human factors evaluation, or quality assurance methodologies

Your application will expire on July 19, 2017. If your research will continue beyond this date, complete the relevant portions of the IRB Renewal Application. If you wish to modify the application, complete the Modification of an Approved Protocol Form. Changes in this study cannot be initiated without IRB approval, except when necessary to eliminate apparent immediate hazards to participants. When the study closes, complete the appropriate portions of the IRB Request for Study Closure Form.

Please use reproductions of the IRB approved stamped consent forms to provide to your participants.

Should you need to submit any further correspondence regarding this proposal, please include the above application number.

Good luck with your research.

Sincerely,

THE UNIVERSITY OF ALABAMA

Informed Consent to be in a Research Study

**You are being asked to take part in a research study.** The study is called "Incivility or Unprofessionalism: Nurses' Perspectives on the Contradictions of Caring Behaviors in Their Work Environment". Mary Hanks, a doctoral student at the University of Alabama, is conducting this study. Ms. Hanks is being supervised by Dr. Nirmala Erelles who is a professor at the University of Alabama.

**What is this study about?**

The impact of lateral violence on nurses and the nursing profession could add to the nursing shortage and have negative effects on our patients. There is no literature that addresses a possible link between the use of lateral violence tactics in the workplace and how nurses are educated to use the professionalism and care in everyday practice with their coworkers. The purpose of this qualitative research study is to examine how nurses define and understand lateral violence in the workplace.

**Why is this study important?**

This study is important because the literature supports that lateral violence is a cause of physical and psychological distress in nurses. This leads to attrition from the profession, increases in absenteeism from the job, low self-esteem in some nurses, elevated employer costs, and patient safety issues.

**Why have I been asked to take part in this study?**

You are being asked to take part in this study because you are a registered nurse who has witnessed lateral violence, been a victim of lateral violence, or enacted lateral violence toward a coworker.

**How many people will be in this study?**

The investigator is seeking at least ten participants to be a part of this study. Additional participants are welcome.

**What will I be asked to do in this study?**

If you agree to participate in this study, you will complete one survey. You will then be asked to respond to four different case scenarios using pencil and paper or by entering your responses on the computer. You may be asked to participate in a face-to-face interview that will be audio recorded.

**How much time will I spend being in this study?**

The survey will take approximately five minutes to complete. The four case scenarios should take a total of 30 minutes to complete. Interviews will last about one hour each.

UNIVERSITY OF ALABAMA IRB  
CONSENT FORM APPROVED: 7/20/16  
EXPIRATION DATE: 7/19/2017

**Will being in this study cost me anything?**

The only cost is your time.

**Will I be compensated for being in this study?**

In appreciation of your time, participants who complete interviews will receive a \$25 VISA gift card.

**What are the risks (problems or dangers) from being in this study?**

Though the risks of participating in this study is small, there is a risk that recalling a painful memory may lead to feelings of anxiety or distress. If this occurs, we will stop the interview immediately and you can decide if you wish to continue. If you wish, I will put you in touch with a mental health counselor.

**What are the benefits of being in the study?**

There are no immediate benefits to you as a participant in this study. However, being in this study will improve awareness of the effects of lateral violence in the nursing profession and possible solutions to dealing with this problem in the future.

**How will my privacy be protected?**

The only place your name will appear in connection with this study is on this informed consent form. The primary investigator will collect the consent forms. They will be placed in a sealed envelope. The envelope will be locked in a file drawer in the investigator's home office.

**How will my confidentiality be protected?**

All participants will answer their surveys and case scenarios in a classroom area away from your workplace. You will not include your name on the survey or scenarios. Paper copies of the information provided will be kept in a locked file cabinet by the investigator. The information you provide in the survey and case scenarios will be kept confidential.

The interviews will be recorded for coding purposes. The recordings will be destroyed by erasure after the research study has been completed. Your identification in association with the interviews will remain anonymous.

The investigator will use the data from this study to write a dissertation. In addition, the data may be used to write research articles and make professional presentations. All participant identities will remain anonymous.

Participants will only be identified as "nurses in the southeastern United States" and designated by years of employment, degree type, and other demographics such as age, gender, or race.

**What are the alternatives to being in the study?**

The alternative to being in this study is not to participate.

UNIVERSITY OF ALABAMA IRB  
CONSENT FORM APPROVED: 7/20/16  
EXPIRATION DATE: 7/19/2017

**What are my rights as a participant?**

Taking part in this study is voluntary. It is your free choice. You can choose not to be in the study at any time. If you start the study, you can stop at any time.

The University of Alabama Institutional Review Board (IRB) is a committee that protects the rights of people in research studies. The IRB may review study records from time to time to be sure that people in research studies are being treated fairly and that the study is being carried out as planned.

**Who do I call if I have questions or problems?**

If you have questions about this study right now, please ask them. If you have questions at a later time, please call Dr. Nirmala Erevelles at 205-348-6060 or email her at nerevell@ua.edu. If you have questions or complaints about your rights as a research participant, please call Ms. Tanta Myles, the Research Compliance Officer of the University of Alabama, at 205-348-8461 or toll-free at 1-877-820-3066.

You may ask questions, make suggestions, or file complaints and concerns through the IRB Outreach website at [http://osp.ua.edu/site/PRCO\\_Welcome.html](http://osp.ua.edu/site/PRCO_Welcome.html) or email the Research Compliance office at [participantoutreach@bama.ua.edu](mailto:participantoutreach@bama.ua.edu).

After you participate, you are encouraged to complete the survey for research participants that is online at the outreach website or you may ask Ms. Tanta Myles for a copy of it and mail it to the University Office for Research Compliance, Box 870127, 358 Rose Administration Building, Tuscaloosa, AL 35487-0127.

\_\_\_\_\_ Yes, I agree to be audio-recorded during interviews.

\_\_\_\_\_ No, I do not wish to be audio-recorded during interviews.

I have read this consent form. I have had a chance to ask questions. I agree to participate.

\_\_\_\_\_  
Signature of Research Participant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Investigator

\_\_\_\_\_  
Date

UNIVERSITY OF ALABAMA IRB  
CONSENT FORM APPROVED: 7/20/16  
EXPIRATION DATE: 7/19/2017

APPENDIX F  
SAMPLE MEMOS

MEMO

September 2016

Sherry's Interview

*Engineered Failure, Sabotage, and the Emotional, Psychological, and Professional Effect of Lateral Violence*

*"They just screwed me and they know it."*

*"And then they would make jokes about it."*

*Warned of potential problems with nurses' negative attitudes but, "you can't feel it, until it happens to you"*

*"It definitely hurts."*

*"Puts a damper on your viewpoint because you have to deal with so much more."*

Lateral violence is emotionally *harmful* and *stressful*, adding to the stress of a job that is inherently inundated with stressors throughout the course of a nurse's daily shift. Having the emotional support of colleagues is uniquely beneficial to a nurse's professional environment and plays a direct role on patient care outcomes when one considers the interdependence of new nurses on their seasoned counterparts. Much like Daisy, Sherry is dismayed by the *lack of support* from the experienced nurses on her unit for the new nurses. Both Daisy and Sherry work in intensive care units. Both have witness and been a victim of lateral violence in the form of engineered failure, in which colleagues have assigned new nurses difficult assignments and did not help them when they need it. Unlike Daisy, Sherry believes some of the acts on her unit were intentionally done to cause harm or humiliation to the new nurse. This causes an emotional harm to the new nurse expressed as "*hurt*" and causes some of them to *build walls* and *isolate* themselves from all unit activities.

New nurses rely on seasoned nurses to learn the layout of the unit and locate important items (e.g. supplies, telephone numbers, and equipment) to carry out their responsibilities to their patients. Seasoned nurses are a treasure trove because they know the routines and inner nuances of the unit, such as when health care providers make rounds, what special equipment should be available for certain procedures, what information should be relayed during calls to health care providers, and so forth. The wealth of knowledge that an experienced nurse on a nursing unit has to offer and potentially share with a new nurse is boundless because of real-life knowledge that is not bound in the pages of a manual or textbook, and cannot be searched on Google. The willingness to share this knowledge and expertise in an *ethical manner* should be unbound, as well. A community of professionalism must be forged wherein lies a healthy, respectful exchange of ideas that exists simply for the betterment of humankind, the communities that we serve. As interactions between nurses and patients are shaped by *respect* and *care* and we are mindful of our tone and communication techniques with our patients, so too this should extend to colleagues. Our most vulnerable colleagues are the new nurses who find themselves in new nurse *orientation* experiences, some in cultures more accepting than others. What does a good orientation or a good preceptor look like?

MEMO

October 2016

Orientation Issues for the New Nurse and the Need for Preceptor Guidelines: The Good Preceptor

The *orientation process* for these new graduate nurses is brutal. Here is when the attrition process begins, because it is here that they feel the brunt of bullying and/or lateral violence behaviors. At this point, I don't see a need to differentiate between bullying and lateral violence, as some scholars have chosen not to differentiate. The victims see it as bullying, offensive behavior. Although all participants are registered nurses, there is a perceived power gradient on the part of the new nurses because they are "the new kid on the block" and their every move is scrutinized. In the new nurses' mind, they do not want to appear "*stupid*" or ask "*dumb*" questions for fear of *judgment in the early days* of their employment. For them, this could lead to unemployment or a lack of professional respect among their peers.

These lateral violence behaviors affect their job performance, stunts their professional growth and skill development, and has a trickle-down effect to patients. On too many nursing units we are creating a culture of incivility that leads to a lack of clinical competence that is not acceptable nursing practice and cannot be overlooked. Nursing professionals, organizations, and academics must be willing to acknowledge that lateral violence exist and is problematic and search for practical ways to rid nursing of this negative behavior. Accountability for acts of incivility, or the lack thereof, as described by the participants in this study, is a burden that new nurses, seasoned nurses, nurse managers, health care organizations, nursing academia, and the nursing profession all share. What is the role of each of these entities in addressing LV in the workplace?

The *lack of experienced preceptors* that are training new nurses in the *orientation phase* of employment, or the multiple preceptors used to train a new nurse, is staggering. Though this is a small sample size and may not reflect a true picture of what is occurring in nationwide, it does reveal some disturbing trends in some facilities in the southeastern United States. The nurses interviewed represent a total of four different facilities, thus far. Their stories of *preceptee-shaming* and humiliation are startlingly parallel. Most feel that their orientation periods were *too short* and were disjointed because they had *multiple preceptors*.

Preceptors themselves lack the experience and training needed to facilitate the professional growth and development of new nurse graduates. Preceptors with less than one year of experiential nursing should not be teaching new graduates when they are still new and probably lack the self-confidence and skilled-know-how to coach and mentor new graduate nurses into their roles. Organizational accountability and nurse managers should mandate a minimal amount of time in experiential nursing before being allowed to serve in the role as preceptor. Though I realize the push-back to this notion is that nurses aren't staying long enough, my counterargument is that if they are *trained, mentored*, and developed appropriately and treated with *dignity* and *respect* in their work environment, then the *attrition* trend may begin to shift, as well.

MEMO

November 2016

### How Do the Nurse Participants Experience Lateral Violence in Their Work Environments?

Five of the nurse participants in this study use the term bullying in their definition of lateral violence. Although given clarification that lateral violence and bullying are differentiated in the literature among some scholars by the attributes of power and time, some nurse participants still spoke of experiences with physicians, licensed practical nurses, patient care assistants, or patients when discussing instances when they felt as if they were *disrespected or treated in an unfavorable manner*. Definitions offered by the participants include, “workplace *bullying*,” “*belittling or bullying* by fellow employees at a job that causes emotional or physical stress,” “*bullying or harassment* between colleagues in the workplace,” “*abuse* among coworkers or people who are in equal roles,” “*negative interactions* between coworkers that can directly affect outcomes for the patient,” and “*violence* directed at your peers versus the source of your anger” to name a few.

The nurse participants had all witnessed LV, been a direct victim of LV, or both. Lateral violence ranged from encounters with experienced nurses not helping a nurse participant whose patient’s condition was declining to an experienced nurse telling a nurse participant not to ask her any more questions. All of the nurse participants see *gossip, cliques, and a devaluation of the nursing profession* as a systemic problem in the culture of their organizations that need to be addressed. Most nurse participants do not find fault with seasoned nurses for the culture of lateral violence that exist on their work units, but instead view it as an organizational problem that has caused nurses to *lack a sense of pride* in and commitment to the nursing profession. It is an accepted culture as one nurse participant blatantly suggested, “you know that nurses, sometimes we get treated bad anyway.” She went on to assert that “big people (organizations) don’t care about little people (nurses) problems.”

The nurse participants experienced a *lack of support* from their preceptors and other nurses on the unit. When asking questions, nurses would roll their eyes at them or make them feel “*dumb*” or “*stupid*.” “They expect you to already know everything.” New nurse *orientations were abbreviated* because according to a nurse participant, “they were understaffed and they needed us to hurry up and get off of orientation so that they could have adequate staff.” Many of the participants spoke of feeling *overwhelmed* with the new responsibilities of being a nurse with minimal hands-on training and skills and the angst that this caused. Some spoke of colleagues who had come in to orientation with them who had *quit the job* after a few weeks or months due to what they perceived as *inadequate training and preparation*.

## MEMO

December 2016

### Nurse Participants Descriptions of a Good Preceptor

In their own words, nurse participants describe what a good preceptor looks like and what quantifies an adequate orientation experience. Within these descriptors are also qualities of experienced nurses who serve as mentors to some of the nurse participants and the qualities they view as necessary for helping new nurses transition into their professional roles and the creation and maintenance of healthy work environments.

“When I come to them with a question, they usually are really nice to *listen* and they’ll *answer* it. And even go in with me to see my patient if they think that’s necessary. And sometimes they will even call the doctor for me just to *show me* how they would handle it.” –Tina

“Some of them *want to help me*. Some of them *want me to become a better nurse*. Some *take the time to help me* and *answer questions* when they can.” –Donna

“*Guidance* and I...I don’t know what word to use...I would say understanding. Because I feel like three months ago, my preceptor knew she had just come out of school and *she was going through the same thing that I am going through*, at that moment. So, I wish she could have been a little more *understanding*. And maybe *patient*.” –Faye

“She has been so *helpful*. She *stands by the bedside* with me or she is right outside the door if I need her. And she *helps me* with other stuff. Like she will say, this is how I communicate with pharmacy. Whereas my other preceptor would be like, here’s the phone...She *explains* and *teaches*. She will be like *watch me* do it or *listen to me* do it and then you do it. I *felt comfortable asking her questions*. Whereas, the first preceptor made me feel like if I ask questions, then you’re dumb...She is very *supportive*. She’s *encouraging*.” --Anne

“I think the nurses are *welcoming* where I work now. The ones that know that you are new *don’t expect you to know everything*. And they *help you* when you need it and they *answer all of your questions*. And they *don’t show their frustrations* if they are frustrated that you don’t know it all. Even having different preceptors during orientation, I can say that all of them *helped me*, *supported me*, and treated me, even though I was new, *treated me like a friend and a peer and a fellow nurse* and not someone that was beneath them or unknowledgeable just because I don’t know it all and I’m new.” –June

“I only had one. I will say, out of the group that was the experienced nurses, I had one person that made me believe that things could be different. Because *she took the time* and if it wasn’t for her, I feel like I would be in a mess a lot of times at work. But, she took the time to *teach me*, to *show me* stuff. You know at one point; you don’t even know how to call the doctor. You don’t know how to find numbers. You don’t know how to get anything because you are just there. You know, I’m like here I am and I’ve graduated, but I *don’t know what to do now*. That’s kinda how I felt. She took the time; you know? To *walk me through*...” --Sherry

MEMO

January 2017

*The Good Preceptor*

Hanks' Preceptor Guidelines

The following guidelines can be used in nursing clinical settings in higher education or in health care organizations to facilitate new nurse orientation or student preceptorships, residencies, or internships.

1. **Recruit a Preceptor.** Recruit preceptors who meet certain criteria. The preceptor must be willing to teach, mentor, and coach while accepting the added responsibility of having a new nurse or student working alongside and shadowing every professional move. Each preceptor should be encouraged to recruit a nurse to serve as preceptor to a new generation of nurses, remembering that the future of our profession is the new nurse.
2. **Commit to Maintaining and Supporting a Healthy Work Environment for All Nurses.** The preceptor should be committed to creating a nurturing and supportive relationship with the new nurse or student nurse.
3. **State Clear Expectations for All Participants in the Preceptor/Orientation Process.** It is acceptable to have clear organizational, management, preceptor, new employee, and/or student nurse expectations spelled out. The preceptor should carefully review these expectations with the new nurse or student on day one of orientation. This will negate any gray areas and everyone will know their responsibilities in the training process. These expectations should include cognitive, psychomotor, and affective responsibilities. If a conflict exists between the preceptor and the new nurse and/or student, there should be guidelines as to how to handle the conflict. If the unit is committed to creating a healthy work space for all employees, these instances should be worked out between the two participants involved without further incident. Having rules so that everyone understands their value and understand that their voices will be heard needs to be clearly stated.
4. **Be Willing and Prepared to Answer Questions.** After each patient round, ask the new nurse or student if there are questions about the patient's condition, medications, new prescriptions, etc. If not, ask some questions that you think should have been asked.
5. **Introduce.** Introduce the new nurse or student to important players on the unit (other nurses, physicians, pharmacists, physical therapists, etc.). This initiates the team building process and begins to shed the "outsider" mentality of the new nurse or student.
6. **Show and Tell.** In clinical situations that are complex or that the new nurse or student has not had hands on experience with, explain to the patient that you are going to perform the procedure together this time. Teach the new person by talking and coaching them through the procedure. Next time, let the new nurse or student perform the procedure while you watch.
7. **Scavenger Hunt.** Give the new nurse or student a list of commonly used items. Allow them a designated amount of time to find the items without your assistance. Tell them it is acceptable to ask others on the unit for help if they get stuck. This will allow them to meet new colleagues and learn their new unit.

8. **Calling the Physician.** Calling the physician, or anyone for the first time can be a nerve-wrecking, earth-shattering experience for the new nurse. If it is not an emergency situation (in which case the preceptor should be making the call anyway), role-play with the new nurse prior to calling by pretending to be the physician. Ask questions and make sure that all of the necessary information is in the nurse's hand before the call is made. This can help ease the anxiety level. Each phone call will get better. The more opportunities the new nurse has to practice phone calls in orientation with you listening, guiding, and coaching, the better.
9. **Practice Makes Perfect Practices.** Without overwhelming the new nurse or student, allow them to take on the role of a nurse in practice. By week two or three in the orientation experience, depending on your organization's and specialty area's policies, the new nurse should be ready to perform the duties that you perform as a nurse, but under your constant guidance and supervision. This is when the preceptor earns the title of mentor and coach. In accordance with your facility's policies, allow the new nurse to take the patient assignment. However, you **MUST** remain visible and present to answer questions and troubleshoot should a problem arise. Here is also when you start to teach the new nurse time management and management of care skills.
10. **Don't Be a Polar Bear.** It is believed that polar bears are now among the animals that eat their young. If the new nurse or student has a question of is having time management or other rookie issues, simply whisper "that was me once" and rescue them. It is our ethical responsibility as nurses to care for those who cannot care for themselves. Our patient's lives are dependent on how well you, as the preceptor, train the new nurse.

Let's build competent nurses, healthy work environments, and do what nurses do best, SAVE LIVES.

APPENDIX G  
SEMI-STRUCTURED INTERVIEW QUESTIONS

Tell me why you left (or are planning to leave) your first job as a registered nurse?

What supports do you feel that you needed that were not in place at your job?

When did you hear the term “lateral violence” for the first time?

What does the word “lateral violence” mean to you?

How have you personally experienced lateral violence in your work (victim, witness to, perpetrator)?

How did it make you feel to be a participant in lateral violence then?

Knowing the effects of lateral violence on young nurses now, how has this changed your mind?

How did your college or university prepare you to handle instances of lateral violence?

How do you think your professors could have helped to prepare you?

What do you think your employers could have done to prevent lateral violence where you work(ed)?

Tell me how the instances of lateral violence that you witnessed or were a part of have shaped you as a professional nurse?

Tell me what you know about the American Nurses Association Code of Ethics.

How were you taught to apply ethical principles to your practice as a professional nurse (as it relates to your colleagues)?

Which ethical principles directly relate to Interprofessional relationships?

What role does caring play in Interprofessional relationships?

In your own words, what makes a nurse a professional?

Prior to entering nursing school, what were your career goals as a nurse? Where did you ultimately see yourself?

How then, can professional nurses help to socialize new nurses into the role of new nurse in your opinion, that would encourage nurses to stay at the bedside?

APPENDIX H

EXCERPTS FROM INTERVIEWS OF FIVE NURSE PARTICIPANTS

## Sherry's Interview:

**Interviewer: Tell me why you are wanting to leave your first job as a registered nurse?**

Sherry: Ok. Well, to start with, a lot of us started at one time together. There were like five of us that started on my unit together. And I would say for a long time, at least the first three or four months, I was by myself. I was getting like 3-team patients (*assignments*), in like a critical care unit, and sometimes I would have 3 ventilator patients. Sometimes, I would have two ventilators and, like a psych patient in 4-point restraints. Just stuff that was not, in my opinion, safe. And especially not well thought out for a new graduate because you're still learning like: how to operate the ventilator, how to work on certain things. And then when they put all of that together on you, I felt overwhelmed. Honestly.

**Interviewer: So, how long were you allowed orientation in your unit or how long were you with a preceptor?**

Sherry: Probably, a month and a half.

**Interviewer: Is that the standard orientation time in the critical care unit in the facility where you work?**

Sherry: No. We were supposed to have a minimum of three and a half months of orientation.

**Interviewer: So what happened to change that for you?**

Sherry: They were understaffed and they needed us to hurry up and get off of orientation so that they could have adequate staff.

**Interviewer: So, when you would have three vent patients, would there be experienced staff there with you?**

Sherry: Sometimes. Now, the shift I worked was 3pm to 3am. So from 3-7p, there would be some people to help me. But, you know night shift...a lot of us are unexperienced. So from 7p-3a, I wouldn't have a whole lot of help. There may be one or two people that I could go to out of eight.

**Interviewer: So, out of the eight nurses on shift, six of you were new?**

Sherry: On a general night, five of us would be new.

## Donna's Interview:

**Interviewer:** Tell me why you are planning to leave your first job as a registered nurse?

Donna: Because, I don't get any help. They give me all the hard patients. They give me admissions when I am already having a hard time. I just don't like it.

**Interviewer:** And how long have you been on your nursing unit?

Donna: Like, two months...I went on my own kinda early. I wasn't ready to be on my own.

**Interviewer:** Explain that. Did you ask to go on your own, early?

Donna: No, I told her I wasn't ready.

**Interviewer:** You told who, you weren't ready?

Donna: My nurse manager.

**Interviewer:** And how long were you there before you were on your own? How long were you in orientation?

Donna: I started on the 20<sup>th</sup> of June. I was on my own, probably, mid-July.

**Interviewer:** What type of unit do you work on?

Donna: Orthopedic...urology...

**Interviewer:** So, a medical-surgical unit?

Donna: Yes.

**Interviewer:** So when you told her, it's a woman? Your manager?

Donna: Yes.

**Interviewer:** When you told her that you were not ready to be on your own, what did she say?

Donna: It's normal. It's normal to stay over. It's normal to have problems. It gets better with time. And she would expect me to stay over some mornings to finish charting and finishing up what I needed to finish up.

**Interviewer:** You're on night shift?

Donna: I'm on night shift. I went to nights because I thought it was going to be a little bit slower. And I was going to get a little hang of things and I have people who would have time to help me. But, I was wrong. It was horrible.

**Interviewer: So let me go back to your orientation for just a second. The nurse who was orienting you, do you know how long she's been working there?**

Donna: I think she has been there for eight or seven years. But I had a lot of...I had different, because I trained on different shifts. I was with one nurse first and then I went to nights and had a different person.

**Interviewer: So, you started with one nurse, first on dayshift and then you changed shifts?**

Donna: I started on dayshift first and then I went to night shift for training. Because I requested that, by the way.

**Interviewer: You requested to go to night shift to train?**

Donna: I suggested to go to dayshift first because I wanted to be familiar with the discharging and how dayshift works.

**Interviewer: So, you requested that? It wasn't planned that way for you?**

Donna: Um, no. It was not. I asked her, my nurse manager. Because I mean, it's like night and day. I wanted to be familiar with both ways.

**Interviewer: So, the person who oriented you on the dayshift, let's start with that person because you were with them first. How did she treat you, in your opinion?**

Donna: I enjoyed her actually. I didn't really learn a lot, but I enjoyed her. And when I say I didn't learn a lot, it's because I thought I was right. I thought I knew what I was doing as far as charting, patient care. But when I went to nights with a different nurse, I didn't know half of the stuff that I thought I knew. I didn't know I wasn't charting everything. *(sigh)* I was not really assessing patients. I didn't understand what some of the requirements for documentation was. Not once did I assess a patient on dayshift *(a system's assessment)* with my first nurse, on dayshift. When I got to the next nurse, I was doing assessments every night when I first got in. So I just, yeah, time management definitely. I didn't learn time management doing the dayshift because I really didn't do anything on dayshift. I just gave out medications and hung fluids and I just charted my rounds. I didn't really do anything.

## Jackie's Interview:

**Interviewer: Why are you looking for another place to work?**

Jackie: I feel like I am not valued or respected where I am at all. Like, it's gotten a lot better but when I first started out, our nurse to patient ratio was one nurse to four patients and you still had the potential to get two other patients in the hallway. So, it was potentially like a 6:1 ratio which wasn't safe. It was really stressful on me and I was actually at work a couple of months ago and my heartrate went up to 235 and I had to have an ablation done because they found out I had a birth defect. And the stress of the job made me have to have a cardiac procedure done.

**Interviewer: How long were you in orientation?**

Jackie: It was ten weeks.

**Interviewer: Do you know the normal length of orientation for new nurses in the emergency department?**

Jackie: Ten weeks in the normal length.

**Interviewer: Did you feel like you were ready to come out of orientation?**

Jackie: I did. I felt like the nursing aspect of it, I was comfortable with. But like, the computer system and some of the policies and procedures, I wasn't that oriented to just because the bulk of us going through orientation, they made us do these modules. Like you went to the computer and you had to view this big awful lesson that you didn't even have time to learn because you have an hour to get this done. It's not even possible for me to read all of this, absorb it, and then take the test at the end. And all of the other people in my rotation group were just skipping over the entire lesson and taking the test 15 times until they got that 80% average to pass.

**Interviewer: Did you do you student nurse preceptorship on that unit prior to working there?**

Jackie: No. I had requested to be in the emergency department but actually was placed in a medical intensive care unit.

**Interviewer: So when you were hired on as a new nurse in the ED, do you feel as though your preceptor was supportive?**

Jackie: I do...because I had a couple of different preceptors. I believe they were supportive, but it's just so stressful in the ED sometimes that you feel like you're getting on their nerves sometimes because you keep asking them enough questions.

**Interviewer: What support do you feel like you may have needed in orientation that was not there or how do you think it could have been better for you?**

Jackie: My orientation period was kind of hectic because it was in the middle of the nurse educator, she went on a mission trip. So she left for a little while, so while she was gone someone else stepped in and

taught us some of this stuff. But it was like, as soon as you became comfortable with one person, someone else jumped in. It was really chaotic because not even all of the stuff that we were supposed to cover got covered. Like the change in people, one day we would be learning ventricles and we are going to go over this now and learn this now, and you had one day to learn it. And right now, I don't even feel comfortable setting up a ventricular, like system.

**Interviewer: When did you first hear the term "lateral violence"?**

Jackie: At work, when I first got the name of it. That's not when I first experienced it though.

**Interviewer: What does that term mean to you, when you hear it?**

Jackie: It means violence, harassment, just kind of bullying among colleagues in the workplace.

**Interviewer: And you feel like you have personally experienced lateral violence?**

Jackie: Yes. Definitely.

**Interviewer: Can you describe some situations for me?**

Jackie: When I was still in orientation, I was just about to come out, a couple of days after that, I was on the trauma hall and there was a patient who came in and she was in DKA. And I had to co-sign with someone who was going to hang the insulin drip who was also a new nurse. So, I went to the room and I look at the IV site and I knew it wasn't good anymore. And so I got a flush and I'm trying to flush it. The site was cold. The patient was saying it was hurting. It was bubbled up and it just wasn't a good line anymore. And so, a different nurse, who this wasn't even her patient, came in and said, "That line is fine. I just flushed it with like 20 mLs. It's fine. Just use it." And I told her, I was like, "Well I'm not comfortable with that." And she left the room and we went ahead and we stuck her again and got a new line because I am not about to hang an insulin drip into someone's arm if I don't think the IV is in place. And so we got her a good line and she's going to have to go over to ICU anyway where she should have at least two lines, but I discontinued to the other one. So after I hung the insulin, I come out of the room and the nurse who told me the line was fine before pulls me into a side room and starts yelling at me about how I made her look stupid, I wasn't being a team player, how I wasn't advocating for the patient because I made her a pin cushion and she was just very angry and cornered me, literally into the corner of a room and started yelling at me.

## Carrie's Interview:

**Interviewer: What do you recall about the code of ethics and how it relates to your nursing practice?**

Carrie: The main ethical principles I adhere to are beneficence, to do good to all people and veracity, to tell the truth and be honest about what's going on during the hospitalization. With beneficence, not only doing good to my patients but also to my coworkers. Just trying to adhere to it if it was someone that I loved in that bed, I would want to see the nurses working well together. I wouldn't want to see conflict and I would want the nurse taking care of my loved one to just be honest and be like an open book and be able to ask questions and just not feel uncomfortable. I kind of adhere to that and try to incorporate that into every single patient that I see every single day that I go to work. Making sure that if there is someone way I can help my other nurses if they need help. And try to do good to that person that's there because they don't want to be there. Everybody wants to go home. Nobody wants to stay there. So just trying to do the best that I can and do good to other people at all times.

**Interviewer: Do you feel as though your nursing school helped to instill those principles in you or did you just come to nursing school knowing that?**

Carrie: I think that nursing school actually enforced it. But I've always had this veracity and beneficence principle in my whole life. I was raised that way. I think that my nursing school did a great job of laying out those principles and really hammering down how to apply them and how it works in every single day when you go on your unit. So, I think that I brought some principle to the table and then nursing school just built on top of them.

**Interviewer: Should nursing schools be responsible for teaching those principles to all nursing students?**

Carrie: Definitely.

**Interviewer: Where you work, do you feel as though your coworkers apply those principles in their interactions with you?**

Carrie: Yes. I do. Everybody has their good and bad days. There are some days when some of my coworkers are more stressed and they can't help me or they are so focused on a patient that things get taken by the wayside or I can't get the help that I need at the moment but, my teamwork is great. I know that there are always nurses on my unit that have my back. As a whole, I think that every day that I go into work I have a good team with me.

**Interviewer: Though you didn't use these specific words, I am going to ask you how do you use these, if you do, in your practice. Respect and care. What role do you think those two principles play in interprofessional relationships?**

Carrie: I think that you have to have respect for other people in your profession. You're working with so many different people, so many different aspects of hospitalization. You have your nutritionist, your pharmacist. People that you work with every single day. So you have to have respect for them. You can't just be totally focused on what you're doing all the time and not integrate those other principles

and other practices into what you're doing. It's a huge team that you're working with so you have to have respect for everybody in that team taking care of that patient. The whole point is to care for the patient and the patient is the main priority at all times. I hope that the patients that I have had feel like I am giving them the best care possible. I always try to think about, even if it's not the ideal patient, you know...they have a drug problem or they've been arrested and they come to our unit, I always try to treat people exactly the same. I try to not judge them before hand and I've found that treating everyone the same and being on the same playing field as anyone else has helped me tremendously in my interactions with patients. They feel like I'm not judging them beforehand. And I feel like their care has only been benefited by that aspect.

**Interviewer: Does that apply to your colleagues as well?**

Carrie: Yes. I mean, I'm always trying to help other people. Things get really hectic on my unit so if I have downtime when I don't need to document or I don't need to do anything for either of my patients then I always try to seek other people out that I know have been kind of tied of during the shift and I know can't really get away. It revolves around lunch breaks. A lot of people don't have time to do lunch. They've got to take a patient to CT or start a Foley or something. So, I always try to seek those coworkers out, offer my help to them. In the same way as I care for my patients, I care for them too. I think that builds a good team, offering up your assistance. Even when, you know there are probably still things that I need to be doing, but I don't want anyone to feel like they are abandoned so I try to offer my assistance. And have a positive outcome by offering up my assistance. Coworkers feel like they can trust me.

## Anne's Interview:

**Interviewer: Have you seen other nurses on your unit experience lateral violence?**

Anne: Yes. Let me just say that everybody talks about everybody behind their back. I mean, if you do one thing and you're not there the next day working that shift, then they are probably going to blast you for not doing their way.

**Interviewer: So there's a lot of gossip on this unit?**

Anne: Yes. They gossip about everybody. Everyone has their own little group and if you are not in that group then you will be talked about. It is very clicky.

**Interviewer: So how did being a recipient of this behavior make you feel?**

Anne: Dumb, stupid. Like I could never be a good nurse. Like I needed to go back to school and choose something else to do. It made me want to leave that unit, that facility. It has made me think about finding a completely different career.

**Interviewer: Since your preceptor has changed?**

Anne: It has been great. I have nothing bad to say at this point.

**Interviewer: What's different about your new preceptor and the first one?**

Anne: I think, that maybe since she does have more experience, I figured that maybe she would be even worse. I thought it was going to be worse because she is stuck in her ways and she is ready to retire. She's older, you know? She doesn't want to have to deal with all of this new stuff coming in. She has been so helpful. She stands by the bedside with me or she is right outside the door if I need her. And she even helps me with other stuff. Like she will say, this is how I communicate with the doctor or this is what I say when I call pharmacy. Whereas my other preceptor would be like, here's the phone. Well, I don't want to sound stupid when I talk to the doctor for the first time. I don't know what to say. The most important people I've talked to is the faculty at my nursing school. But stuff, like that. She explains and teaches. She will be like watch me do it or listen to me as I do it and then you do it. I felt comfortable asking her questions. Whereas, the first preceptor made me feel like if I ask questions then you're dumb.

**Interviewer: Would you say that your second preceptor serves as a coach and mentor?**

Anne: Yes. Exactly. And she is very supportive. If I do something good, she is like, "Well, that was great" or "Keep going." She's encouraging.

**Interviewer: So, knowing the effects of lateral violence on young nurses, how has it changed your mind about nurses or about the profession of nursing?**

Anne: Because this is something that's supposed to be so caring, so compassionate. I mean, you're supposed to be helping the public. If you can't even help your co-worker standing beside you, what makes you think that you can help the public or help your patient? I mean if you are going to bad talk

me behind my back, when I work with you, you're probably going to bad talk that parent that has that baby in the NICU.

**Interviewer:** Have you heard any of that?

Anne: Yes.

## APPENDIX I

### SAMPLE CODES AND THEMES DURING DATA ANALYSIS

## Lateral Violence Dissertation Themes & Codes

### Interview Question #1: How do Novice Nurses Experience Lateral Violence in the Workplace:

Holistic Codes	In Vivo Codes	Themes/Categories
Unhappiness (1.1, 5.1)	"Put in over your head" (1.2)	Sabotage (1.6 example, 3.3, 3.24)
Not fitting in (1.1, 3.3, 5.13)	"Pushed around" (1.2)	
Cliques (1.1, 1.13, 5.6, 5.15, 9.9)	"Sink or swim" (1.2, 4.1, 5.5, 6.3, 6.6)	Helplessness (2.10, 3.18)
Alienation (1.1, 3.1, 3.10, 3.18, 4.7)	"Behind my back" (1.5, 1.6, 5.1, 8.2, 9.2)	Engineered Failure (1.5, 1.6, 3.2, 3.3, 3.7)
Unfavorable Politics (1.1, 3.6, 4.6, 4.7, 5.2, 9.3)	"Talking bad about me" (1.5, 1.6)	Female Issue
Lack of Support (1.1, 1.7, 1.9, 1.10, 2.2, 2.3, 2.8, 3.2, 3.3, 3.17, 4.1, 4.3, 4.14, 5.4, 6.3, 8.3)	"People turning on me" (1.7)	Alienation
Inadequate Training/Orientation (1.3, 1.20, 3.1, 3.2, 3.5, 4.1, 4.3, 5.4, 5.5, 6.3, 8.5, 9.2)	"Made fun of her" (1.9)	Unskilled Preceptors
Workplace Bullying (1.4, 1.9, 2.1)	"They sink or swim"	Overwhelmed
Female Issue (1.4, 1.15)	"They let her sink" (1.10)	Belittling behavior/Embarrassment
Jealousy (1.5, 1.7)	"To make me look like I'm not qualified" (1.6)	Insufficient Leadership
Cattiness (1.4)	"They felt like they were being excluded" (1.14)	An overabundance of lack
Enclosed spaces (1.4, 1.15)	"They felt like they weren't apart of the group" (1.14)	
From alternate sources (PCAs, LPNs) (2.1)	"Back talk" (2.1)	
Questioning authority to delegate tasks (2.1, 9.2)	"Hammering you during report" (2.3,	
Embarrassment (2.5,	"Working a lot" (2.4,	
Attitudes/Rudeness (2.3, 3.3, 3.4, 7.8, 9.1)	"A lot to take in as a nurse" (2.7, 2.16, 2.17	
Unfair scheduling (2.4,	"You have to learn on your own" (2.10	
Treated differently from experienced nurses (2.5, 2.9)	"overwhelming if people do not show you the right way to be a nurse and patient's lives are on the line" (2.21	
Wrath of burnt out nurses (2.6, 3.21)	"I was by myself" (3.1)	
Overwhelmed (2.7, 2.16, 2.17, 2.21, 3.1, 3.3, 3.6, 3.7, 7.1, 8.4 Time of high stress 8.8)	"Ugh, she needs help again" (3.3,	
Concern for patient safety (2.7, 2.15, 3.1, 3.5, 4.15, 5.4, 6.4, 6.15, 8.3, 9.5)	"nurses eat their young" (3.4, 7.1	
Weight of the world on their shoulders (2.7)	"happens to a lot of people I work with" (3.7	
Silenced voices (2.9, 4.1,	"didn't know how to express myself" (3.7	
Unsafe patient assignments for novice nurse (3.5)	"Didn't like feeling that way" (3.7	

Witness to LV (1.9, 3.5, 5.6, 7.2)	"made me feel unsafe" (3.7)	
Victim of LV (1.6, 2.3, 3.1, 3.4, 4.1, 4.7, 5.1, 5.3, 6.3, 7.7, 8.2, 9.6)	"They just screwed me and they know it" (3.7)	
Intentional acts (3.7, 6.14)	"Just give 'it' (sickest patient) to the new girl" (3.7)	
Hurt feelings (3.8, 4.7)	"They would make jokes about it" (3.7)	
Accepted/anticipated culture of LV (3.9)	"I knew at some point it was going to happen" (3.9)	
Disrespected (3.13)	"Put us over in a little cage, like: YOU PEOPLE" (3.10)	
Infighting (3.19)	"others make fun of me" (3.11)	
Withholding information (3.17)	"I don't know why you are talking to them (new nurses)" (3.11)	
Multiple preceptors (4.3, 6.2, 7.2, 9.4)	"you feel like you don't matter" (3.13)	
Insufficient training time (4.5, 8.10)	"You're stupid" (3.13, 5.6)	
Resentment and harboring grudges (4.15, 6.5)	"They are talking about you" (3.14)	
Unintentional victimization (4.18)	"Nurses get treated bad anyway" (3.15)	
Nasty Tones and facial expressions (4.17)	"they don't care" (3.19, 3.23)	
Conforming to or shunning unit culture (4.15)	"big people don't care about little people" (3.23)	
New nurses are targets of misplaced frustration (4.24, 9.6)	"Some of them do it for pure fun" (3.24)	
Ignored 5.1, 9.2	"They want you to feel bad" (3.24)	
Uncomfortable asking potential life changing questions 9.5	"I don't exist" (3.18)	
Frustrated (5.1)	"It was horrible" (4.2)	
Just mean 5.17	"I really didn't know things" (4.5)	
Disorganized orientation period 6.3, 8.10	"I just needed more time" 4.5	
Improperly trained preceptor 4.4, 6.3, 6.11	"I was really struggling" 4.7	
Left alone to fail 6.4	"When I ask questions at work, sometimes I get looked at like I'm stupid" 4.9	
Finding information on her own 6.5	"So, I didn't get any help from him because...I just wanted a second opinion because you go in and I'm not getting a pulse." (4.14)	
Overheard preceptor talking about her in negative conversation 6.5	"If I have a problem, I just don't ask" (4.15)	
Lack of guided practice 6.6, 6.7	"Some nurses hate to...you can tell from the expressions on their face, they hate to see me come." (4.17)	

## Question 1 Themes and Categories

Sabotage	Engineered Failure	Alienation	Helplessness	Female Issue	Overwhelmed
"Behind my back"	Allowing new nurse to make mistakes	Unhappiness	Lack of support	Enclosed spaces	"working a lot"
"Talking bad about me"	Proactively not helping in patient situations	Not fitting in	Lack of sufficient training	Cattiness	"you have to learn on your own"
"People turning on me"	"Put in over your head"	Clicks	"They sink or swim"		"overwhelming if people do not show you the right way to be a nurse and patient's lives are on the line"
"They sink or swim"	"They let her sink"	Unfavorable Politics	Concern for patient safety		Wrath of burnt out nurses
"To make me look like I'm not qualified"	Unsafe assignment for novice	Jealousy	Weight of the world on their shoulders		"a lot to take in as a new nurse"
"You have to learn on your own"	Inadequate training	"They felt like they were being excluded"	Silenced voices		Not prepared yet to handle patient load
Lack of role transition period	orientation cut-in half	"They felt like they weren't apart of the group"	"hammering you during report"		"overwhelmed"
Unfavorable politics	Set up to fail	"Pushed around"	Lack of support		"understaffed and needed us to get off orientation"
Target new nurses	Inexperienced nurses outnumbered experienced nurses on the shift (3, 7)	"Made fun of her"	"ugh, she needs help again"		"It has been really tough"
"They want you to get upset"	Assigned "sickest people on the unit"	From alternate sources (PCAs, LPNs, patients, and family, doctors)	"nurses eat their young"		"This whole orientation process has been an absolute nightmare"
"some of them do it just for pure fun"	New nurses training new nurses	"I was by myself"	"didn't know how to express myself"		"It was just terrible"
"They want you to feel bad, slighted"	Leadership engaged in LV	New grads viewed as too needy	"made me feel unsafe"		"Incompetent"
Multiple preceptors	New nurses are targets of misplaced frustration	"They would make jokes about it"	LV hurts		"Help us"

APPENDIX J

CASE SCENARIO FINDINGS ON LATERAL VIOLENCE

**Case Scenario 1.** The first case scenario that was presented to the nurse participants was: A new nurse graduate has been out of orientation for 2 weeks and the charge nurse has assigned four patients, two of which are very demanding and time-consuming. The other nurses on the unit each have six patients and their beds are at capacity, but the acuity of their patients is much more stable than the new nurse's. You already know that two patients are scheduled to come to the new nurse's two empty beds, which will give her two new admissions requiring even more of her time. The new nurse comes to you to express her discomfort with the acuity level of the four patients and the fear that she may get two more patients. How do you respond to this situation? Select all that apply.

Table 4 represents the participants' responses to this scenario. Only one participant felt that this was part of the "*status quo*" that all nurses must learn to manage. This participant actually left her first job after 9 months due to LV encounters and other reasons, as discussed in chapter 4. However, her response matched the answers that she gave to similar interview questions on LV. The other nurse participants also answered this question in a manner similar to the responses in their interviews. Most of the nurse participants said they would "*value new nurses,*" "*integrate new nurses into the family,*" and "*develop relationships*" with the new nurses in their interviews. This was congruent with their responses to (a) 75%--help the nurse, (b) 100%--seek the charge nurse for assistance, and (c) 75%--listen and offer emotional support for a nurse who is overwhelmed with her workload.

Table 4

*Case Scenario 1 Responses*

Answer Choices	Responses	Percentages
Tell the new nurse that we all had to go through this at some point and that she will just have to manage the best she can.	1	8.33%
Offer to help the new nurse when the new admissions come if time will allow.	9	75%
Go to the charge nurse and see if something can be done to assist the new nurse with her current patients and redirect the new admissions.	12	100%
Listen to the new nurse's concerns and offer emotional support.	9	75%
Tell the nurse that this is the way the organization is run and that complaining will only make matters worse.	0	0%
None of these.	0	0%

*Note.* 12 Nurse Participants

**Case Scenario 2.** In Case Scenario 2, Dr. Brown is in a foul mood because the night shift nurse forgot to call him to report the morning lab results on a patient's prothrombin time and now the patient's surgery must be delayed. Joanne has just clocked in for the dayshift and is assigned to the patient. Dr. Brown turns to you and demands to see the "incompetent nurse that didn't call me." You are aware that the night shift nurse has already left and you know that Joanne tries to avoid conflict. Joanne is a good nurse who manages her patient's care well. How would you handle this situation? Select all that apply.

The responses to Case Scenario 2 are presented in Table 5. Two participants felt as though the nurse coming on duty should be able to discuss the lab results with the physician. Again, these two responses were congruent with the participants' responses to interview questions. Also, consistent was the one participant who chose to confront the physician about

his behavior. During the interviews, there was one participant who stated that her nursing faculty taught her to confront lateral and vertical violence situations, so this corresponds with that response. However, there was incongruence in the 83.3% of nurse participants who responded that they would “explain that mistakes happen and that the night shift nurse has left.” In the interviews, nurse participants were more likely to “avoid” uncomfortable situations than willingly enter into them. This finding suggests that fictional instances of LV may be more easily mitigated than nonfictional situations. The 58.3% of participants who chose to find the charge nurse was more consistent with interview findings, although this percentage is relatively high considering most instances of LV were simply not reported by participants and deemed a part of the process of becoming a nurse. One participant wrote in the response to “tell him that I don’t know who didn’t call him but I will get the patient’s nurse if he needs to discuss the patient.”

Table 5

*Case Scenario 2 Responses*

Answer Choices	Responses	Percentages
Go and tell Joanne that Dr. Brown would like to discuss a patient’s lab results.	2	16.67%
Explain to Dr. Brown that mistakes happen and that the night shift nurse has left.	10	83.33%
Confront Dr. Brown about his behavior at the nurse’s station and tell him that it is unacceptable.	1	8.33%
Find the charge nurse and have her intervene.	7	58.33%
None of these.	1	8.33%

*Note.* 12 Nurse Participants

**Case Scenario 3.** Two nurses are gossiping on the unit about one of your coworkers and how they hate to follow him after a shift because he is lazy and always leaves work for them to do. You have received change-of-shift report from the same nurse and find the opposite to be true. The nurses say that they are going to report him to Kim, the nurse manager on the unit, and make sure that she “gets rid of him.” The two nurse always takes smoke breaks together, are slow to respond to patient call lights, and never help other nurses on the unit. They graduated from nursing school with the nurse manager and she always praises them in front of patients, families, and colleagues. What action would you take in this situation? Select all that apply.

This case presented the most disparity between how the participants responded in a theoretical situation versus their responses to their own real-life instances of LV. Table 6 shows that 50% of the nurse participants would confront the nurses on their units who are gossiping about their co-workers. Although nurse participants acknowledged that the “rumor mill” is rampant on their nursing units, none of them admitted to confronting nurses when they heard negative conversations about themselves or their colleagues. One nurse would choose to do nothing about the situation, while another would report the incident to the colleague who is the victim of the two nurses’ gossip. The majority of the nurse participants, 58.3%, would report the nurses to the nurse manager even though the nurses are friends with the nurse manager. This was inconsistent with some of those interviewed who did not want to “cause any trouble” or “bring any undue attention” to themselves. Two of the participants who chose “none of these” and typed in responses answered in the manner that most of the nurse participants did during the interview process. One participant wrote, “I try to stay out of other people’s business,” which was consistent with her “do my job and stay to myself” attitude during our interview session. The other wrote, “If I was asked by the nurse manager of my thoughts of the coworker’s job

ethic, I would then answer honestly,” which basically indicated the same position as the previous participant.

Table 6

*Case Scenario 3 Responses*

Answer Choices	Responses	Percentages
Confront the two nurses and tell them that you disagree with their assessment of your co-worker.	6	50%
Go to the nurse manager and defend the co-worker that the nurses are gossiping about.	7	58.33%
Do nothing because it really doesn't concern you.	1	8.33%
Tell the co-worker what the two nurses are saying about him.	1	8.33%
None of these.	2	16.67%

*Note.* 12 Nurse Participants

**Case Scenario 4.** A student nurse is assigned a preceptor on your unit. The preceptor is great with her patients and allows the student to perform tasks, but does not engage the student outside of patients' rooms. You notice the student sits off by herself when the preceptor is interacting with doctors, pharmacists, physical therapists, and family members. The student often is sent to eat lunch alone. The preceptor does not allow the student to participate in change-of-shift report and does not notify the student when she takes low census days. Would you intervene in this situation? Select all that apply.

Table 7 represents the nurse participants' responses to the final case scenario. It was the opinion of 75% of nurse participants that one of the roles of the preceptor is to help socialize the student nurse to the nursing unit and disciplines that work on the nursing unit. During the interview process, this sentiment was expressed by all but one nurse participant. That participant also chose the response that it is the preceptor's responsibility to teach the student how she sees

fit. Two participants, or 16.67%, chose to write-in their own responses. In part, one participant wrote, “I would take the time to socialize with the nursing student so her experience on the unit can be better and allow her to feel comfortable because she may get offered a job on the unit...” The second participant wrote, “I would try to include the student in unit socialization and I would tell the student to go with her preceptor and ask to participate in all care of the patient.” Both responses were congruent with these participants’ interviews and the sense of ownership that they feel in helping new nurses to feel like part of a unit culture of belongingness.

Table 7

*Case Scenario 4*

Answer Choices	Responses	Percentages
Yes. The preceptor should do more to help socialize the student nurse to the culture of the nursing unit and other disciplines on the unit.	9	75%
No. It is the student’s responsibility to become more involved if she wants to be.	0	0
No. It is the preceptor’s responsibility to teach the student how she sees fit.	1	8.33%
None of these.	2	16.67%

*Note.* 12 Nurse Participants