

**Leadership**

## Lateral violence: Why it's serious and what OR managers can do

A nurse hides a surgeon's favorite instrument when a substitute fills in as the scrub. A circulator does not tell a new nurse who is scrubbed that she knows the shunt the surgeon selected has fallen on the floor. A newly hired RN who was previously a scrub tech is shunned by both camps. Is this just life in the OR? Is it part of a nurse's rite of passage? Or is it something more insidious—bullying?

Research suggests these behaviors are prevalent and drive nurses away. The behaviors go by several names: lateral or horizontal violence, nurse-to-nurse bullying, sabotage, or the popular phrase, "nurses eating their young."

The nursing literature over the past 20 years has documented lateral violence and its effects. Some researchers see a connection between nurse-to-nurse bullying and the behavior of oppressed groups. The thinking is that health care organizations tend to be hierarchies headed by physicians and administrators. A hierarchy places power in the hands of a few people at the top and disempowers nurses, who take out their aggressions on one another.

Bullying is especially serious for newly licensed nurses, says researcher Martha Griffin, RN, PhD, because it keeps them from asking questions, validating their knowledge, and feeling like they fit in—all necessary for them to build their knowledge and become part of the organization.

She has cataloged 10 behaviors that characterize lateral violence (sidebar).

"No other area in the hospital has a higher probability of lateral violence than the operating room," says Griffin, who is director of nursing professional development at Brigham & Women's Hospital in Boston and was a certified perioperative nurse early in her career. "People from the operating room call me the most, and I understand it because I've lived it."

There's consensus that lateral violence needs to be stopped. It's not just inhumane—it has a corrosive effect on nurse recruitment and retention. It also affects patient safety. Experts agree communication breakdowns and lack of teamwork are a root cause of errors. If nurses are afraid to speak up because they fear being bullied by fellow nurses and physicians, patients can be harmed.

Nurse directors and managers play a pivotal role in defusing lateral violence.

"Directors carry the culture code of the organization. They are responsible by what they ignore or what they pay attention to—they set the standard," says Kathleen Bartholomew, RN, MN, author of *Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other* (HCPro, 2006).

### Is lateral violence increasing?

There are no studies documenting whether bullying is increasing, but "if you ask nurses about it compared with 10 or 15 years ago, they will say it is more common," says Bartholomew. She became interested in lateral violence after she entered nursing at age 38 and experienced it herself and later observed it as nurse manager of a 57-bed orthopedic unit in a large hospital.

She thinks the cost cutting that began in hospitals in the late 1990s is a factor. Shrinking resources, inefficient systems, and managers' broader span of control have fueled stress, she believes.

"Nurses are the last line of defense between patients and the system, and they take more on themselves because we're never going to say no," she says.

Plus, with more nurses working 12-hour shifts, they no longer have time to go out after work. They have less chance to socialize and bond.

Coupled with social changes like more single parents, more people working longer hours each a week, and longer commutes, people are carrying a heavier load of stress.

### **A role for nurse leaders**

Though nurse managers and directors are stretched themselves, Bartholomew urges them to realize "this is not small stuff—the camaraderie and ability to communicate on your unit are mandatory for teamwork."

To address lateral violence, managers need training to make sure they have the needed skills, according to Karen M. Stanley, MS, APRN, BC, and Mary M. Martin, DNS, ARNP, of the Medical University of South Carolina (MUSC) in Charleston, who are also studying lateral violence.

"Participants reported over and over that they believed their nurse manager was aware of the behavior but did not take action to stop it," they say. They have developed a survey to measure lateral violence, which is slated for publication in *Issues in Mental Health Nursing*.

### **What we know works**

Griffin published a well-known study on lateral violence in 2004 in which 26 newly licensed nurses were taught about lateral violence. They learned about ways to respond to common forms of lateral violence, with laminated cue cards as reminders.

A year later, in focus groups, they were asked about their experience with lateral violence, use of the cue cards, and their socialization. Almost all (96%) had seen lateral violence during the year, and 46% said it was directed at them. All had responded to the incidents, though they said it was difficult. But the outcome was that the lateral violence stopped. Retention for the whole group of 62 newly licensed nurses in that year was 91%, compared to a national rate of 40% to 60% in other studies.

For the past 3 or 4 years, education on lateral violence has been included in the orientation of all nurses new to Brigham & Women's. Nursing staff also receive 1 hour of education during annual "competency days" given by nursing units. The education includes a short video illustrating incidents that have actually happened at the hospital followed by a 10- to 15-minute discussion.

Griffin is conducting a 2-year study designed to measure the perception of nurses' workplace behavior and the perceived impact of education on lateral violence.

### **What can managers do?**

This is advice from experts on lateral violence and on ways managers can intervene to help their staffs.

#### **Educate yourself**

"Educate yourself about lateral violence and why it exists," Bartholomew advises.

"As a manager or director, you are charged to see that your key people, your managers or your charge nurses, are educated, can handle conflict, and can set a standard of professional behavior."

One thing every nurse can do: Never be a silent witness.

"If you can do only one thing to lower the hostility, you should stop listening to nurses bad-mouth other nurses," she says. "Gossiping can't exist without an audience."

#### **Examine your own leadership style**

Adopt a style of leadership that moves away from top-down authority toward consensus building, Griffin advises. Give nurses more autonomy over their practice through structures such as shared governance. "The more you empower them, the less victimization there will be," she says.

#### **Set behavior standards**

Griffin outlines expected professional behaviors in her 2004 article.

The Medical University of South Carolina has standards of behavior for all employees based on core values. These include accountability, respect, excellence, and adaptability. Each value has expected behaviors, and all are reviewed with each employee. Employees are asked to sign a commitment to uphold the standards, which is includ-

ed in their personnel record, says Stanley. They are evaluated on adherence to the standards and rewarded by merit pay. Employees can choose not to sign, but the manager explains they will still be held to the standards.

#### **Educate managers**

Stanley recommends including education about lateral violence in regular educational offerings for charge nurses and preceptors.

"I've found that sessions that allow coworkers to learn about lateral violence and practice dealing with it together to be the most effective," she says.

A community hospital in Rhode Island holds workshops for nurse managers where they discuss clinical narratives about lateral violence incidents that have actually happened to nurses at the hospital (sidebar).

#### **Provide nurses with skills**

Nurses need skills to be able to address conflict with peers, such as conflict management and assertiveness. Bartholomew said it took about 2½ years of coaching before she saw a true cultural change on her unit. But the changes are long lasting once the staff can recognize lateral violence, see the damage it is causing, and have the skills to handle it.

"Nurses need to learn how to go to a peer and say, 'I heard you said something about me,' or, 'I was worried when you rolled your eyes after something I did,'" she says. "The reality is that we are not having these crucial conversations and lack the assertiveness skills to deal with these conflicts effectively. Learning these skills is critical to professional relations, quality of care, and patient safety."

#### **Give new nurses a shield**

Teach newly hired nurses how to shield themselves from lateral violence. As Griffin illustrated in her study, coaching nurses on methods for deflecting lateral violence, along with cues, can be effective.

#### **Give new nurses a chance to bond**

Provide support for orientees to help keep them from feeling isolated.

"Never hire just one nurse—always hire a minimum of 2," suggests Bartholomew. "With every nurse you add, you decrease stress for the group and increase the chances of them staying."

Give the group time to share stories and bond. And keep an eye on what is happening during the first week and first month. Keep in touch with new hires yourself. Have them come by once a week for a 15-minute chat. Say: "Come into my office. I want to hear about your week."

#### **Offer two-way feedback**

Preceptors give feedback to new nurses every day. Do you also encourage new nurses to give feedback to preceptors?

Bartholomew says one preceptor was shocked when she heard her orientee say, "I need to know I'm not in your way, that I am not a bother." The preceptor didn't understand why the nurse felt that way.

"The preceptor's body language conveyed what she was thinking, but she had no idea she was communicating that," she notes.

#### **Practice self-evaluation**

"To truly embrace change involves self-evaluation," Griffin says. "You need to think about, 'How does this organization function?' We all need to be looking at that."

You really can't change the people on the front lines if the leadership does not support them." ♦

—Pat Patterson

---

## References

- Bartholomew K. *Ending Nurse-to-Nurse Hostility: Why Nurses Eat Their Young and Each Other*. Marblehead, Mass: HCPPro, 2006. www.hcpro.com.
- Farrell G A. Aggression in clinical settings: Nurses' views. *J Adv Nurs*. 1997;25:501-508.
- Griffin M. Teaching cognitive rehearsal as a shield for lateral violence: An intervention for newly licensed nurses. *J Contin Educ Nurs*. 2004;35(6):257-163.
- Stanley K M, Dulaney P, Martin M M. Nurses 'eating our young'—It has a name: Lateral violence. *S Carolina Nurs*. 2007;14(1): 17-18.
- Stanley K M, Martin M M, Nemeth L S, et al. Examining lateral violence in the nursing workforce. *Issues Ment Health Nurs*. 2007. In press.

---

## The 10 most frequent forms of lateral violence in nursing

Listed by frequency.

1. Nonverbal innuendo (raising of eyebrows, making faces)
2. Verbal affront (covert or overt snide remarks, lack of openness, abrupt responses)
3. Undermining activities (turning away, not available)
4. Withholding information (practice or patient)
5. Sabotage (deliberately setting up a negative situation)
6. Infighting (bickering with peers)
7. Scapegoating (attributing all that goes wrong to one individual)
8. Backbiting (complaining to others about an individual and not speaking directly to that individual)
9. Failure to respect privacy
10. Broken confidences

Source: Reprinted with permission from Griffin M. *J Contin Educ Nurs*. 2004;35(6):257-163. Adapted from Duffy E. Collegian: J Royal Coll of Nurs Australia. 1995;2(2):5-17; Farrell G A, *J Adv Nurs*. 1997; 25:501-508; McCall E. *Lamp*. 1996;53(3):28-29; McKenna B G, et al, *J Adv Nurs*. 2003;42:90-96.

---

## Lateral violence in the OR

Examples from OR Manager readers:

I worked with a nurse who actually once risked the patient to make herself look good and me look bad. We were doing a carotid, and I was scrubbed. I had a set of Javid shunts on my field, and before the incision, the surgeon looked at all of them and tied a suture around the one he wanted. He told us he didn't think he would need it, but if he did, he would need it fast and didn't want to have to wait for me to find it.

The case started, then, yes, he needed the shunt. I reached on my back table, but it wasn't there. As I was frantically searching, with the surgeon pretty angry with me, my circulator buddy reached into her pocket, pulled out the shunt with the string around it, dangled it in front of all of us and said, "Oh, doctor, look what I found on the floor after you draped!"

All that time she knew the shunt had fallen off my table; she was present and listening when the surgeon explained why he would need it fast. Yet she didn't bother to let us know she found it on the floor.

My manager was in the room. While this nurse was dangling the shunt in front of all of

us, my manager went to the vascular cart, grabbed another shunt and got it on the field pronto, so thankfully, the patient was okay.

The surgeon didn't stop fussing at me for the rest of the case because I had dropped the shunt and didn't realize it. As the circulator knew would happen, the surgeon did not hold her responsible at all.

—Director of surgical services

I was working for a supplemental staffing agency. My first assignment allowed me to experience lateral violence first-hand while in the scrubbing role. The surgeon had 2 favorite instruments that were essential for him to complete his planned surgery—diamond jaw Metzenbaum scissors and a diamond jaw needle holder. His favorite circulating nurse was gone for the day. I made a request for the instruments, but they were nowhere to be found. The case was completed with an unhappy surgeon who voiced my incompetence to the rest of the team and the supervisors. Two weeks later, I was in the same scenario, except this time his favorite circulator was there. I again requested the diamond jaw instruments. The circulator retrieved both, the surgeon was happy, and the procedure was completed. Then the surgeon explained to the circulator that during his last case, the instruments were nowhere to be found. The circulator stated she didn't understand the problem because the instruments were right where they belonged. Where they had really been was in her locker.

—Former perioperative director

Shortly after graduating in 1999, I took a job as a circulator in the OR. This seemed to be a natural extension of my previous 9 years of experience as a scrub tech. What I didn't understand going into the job is that the hospital had an unwritten hierarchy.

The OR had a locker/lounge area that was used by all female personnel at the beginning of the shift, but only scrub techs used it during the day as a lounge area. The main lounge/break room was used by the OR nurses. No one explained the idiosyncrasies of the OR setup to me during my orientation.

My preceptor introduced me to everyone as a scrub tech turned circulator. After those introductions, I was even more displaced. I was never made to feel welcome in the "nurses" lounge. When I would enter, all conversation would quickly become a low simmer rather than the previous boisterous engagements. I was constantly whispered about in that lounge, pointed to, and my name was often brought up loudly during those whispering conversations.

I tried to use the "scrub" lounge a few times and found that when I entered the room, most of the scrubs either ignored me or fled to other areas of the OR.

My preceptor never took the opportunity to show me how things should be done or how to prep correctly. Instead, she took every opportunity to throw me into a situation where I was not totally comfortable, and then scold me when I didn't do things the "right way." She would often tell me that since our room or case was delayed, I should take a break. As soon as I would take a 5- to 10-minute break, she would stand in the hall upon my return and scold me by saying loudly, "Where have you been?"

When I approached my director, she said that she preferred for the staff to handle their own difficulties.

—Nurse manager, outpatient endoscopy center