POURQUOI, ÉTANT DONNÉ QUE NOUS SOMMES DES SOIGNANTS PROFESSIONNELS, SOMMES-NOUS SI MÉCHANTS ENVERS NOS COLLÈGUES?

Violence horizontale et verticale en milieu de travail

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RÉSUMÉ

L'auteure traite de la violence horizontale et verticale telle qu'elle existe en soins infirmiers depuis bien des années mais qui ne fait que débuter comme sujet de discussion.

Violence horizontale – entre pairs au même niveau hiérarchique
Violence verticale – entre collègues de différents niveaux hiérarchiques (normalement du haut vers le bas, mais peut aussi être l'inverse)

Le présent article examinera ces questions en illustrant avec des exemples tirés de partout au monde l'impact de ce type de violence sur le personnel périopératoire.

WHY, WHEN WE ARE DEEMED TO BE CARERS, ARE WE SO MEAN TO OUR COLLEAGUES?

Horizontal and vertical violence in the workplace

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ABSTRACT

The author discusses horizontal and vertical violence as they have existed in nursing for many years but are only recently beginning to be discussed and dealt with.

Horizontal violence *– across peer groups and similar levels of staff*
Vertical violence *– from senior to junior colleagues usually downwards but possible upwards*

Why are we so mean to our colleagues? (cont.)

The article will consider some of the issues from examples around the world and how they impact on perioperative nurses.

Introduction:

Horizontal violence in the workplace was a relatively unknown phrase around five years ago when Dr Lois Hamlin, a Senior Lecturer at Northern Sydney Health and University of Technology in Sydney Australia, presented a paper on the topic[1]. As she spoke, attendees were able to reflect on the many times the behaviours she described had been experienced, witnessed, or even conducted.

The evidence:

Lack of morale or positive attitudes to the working environment may have a negative impact on patient care because it leads to a loss of trust and a decrease in communication. It may also increase staff sickness rates[2].

Hamlin described nurses as often functioning within a hierarchy where they are deemed to be second-class health care workers, or the "Cinderellas" of health care, and that, despite the changing role of women in society, nurses continue to be oppressed[3]. Certainly some things have changed as we now have Nurse Consultants in the United Kingdom with (in the OR) their own surgical caseload, taking referrals directly from family doctors in the community, and working under the indirect supervision of a Consultant Surgeon. Nurse Consultants also teach junior doctors so perhaps, at some levels, nurses are less subordinate than in the past. This change has empowered these nurses, placed them on a similar level with their doctor colleagues and removed the 'hand-maiden' perception of the past.

However, further change is required as staff are still experiencing horizontal and vertical violence. New staff and students entering the OR are less likely to remain in this specialty if their initial experience includes working with inappropriate team members. With the world wide nursing shortage and an aging workforce, it is important that new recruits be treated well from day one. It is also crucial that we retain experienced team members by ensuring they are being treated well. During the author's research a colleague shared the story of a young, new, enthusiastic staff nurse being brought to tears by an Health Care Assistant who had been in the department for years and wanted to make sure that the staff nurse understood who knew more about the job!

In order to understand violence toward staff it is necessary to understand the types of violence, how to recognise it, what causes it, and how it can be effectively addressed and eliminated.

Types of Violence:

Horizontal and **vertical violence** can be overt or covert, physical or psychological. They can take place from a senior to junior staff member or within peer groups. Hamlin and Gilmour[3] (2003) describe the work of Rene Michael[4,5], who wrote two papers in 2001 entitled "Survive or Thrive? The Impact of workplace trauma on peri-operative nurses" and "When speciality becomes a nightmare." Michael showed that perioperative workplace traumas included verbal abuse, sexual harassment, sexual intimidation and physical assault from peers and those in authority.

Overt violence is "in your face" and obvious for everyone else to see. It can be either physical or psychological.

Covert, or hidden, violence is mainly psychological and would range from unkind behaviour to extreme cruelty.

How to Recognise It:

Overt violence can take many forms. Examples include a team member being constantly criticised in front of others. The critic may be doing so either through lack of consideration or in order to deliberately humiliate. Either way, this behaviour needs to be considered to be entirely unacceptable. If not handled properly, overt violence might be driven underground and result in covert violence.

Covert violence can include abuse of power such as ensuring certain staff members always work with the unpleasant surgeon or receive the difficult, long operating list. Denial of requests for time off or providing preferential scheduling to other nurses can allow an abuser to take advantage of the 'power of the rota'.

Michael's studies[4,5] demonstrated that the majority of physical violence in the workplace involved doctors and these perpetrators are mainly, according to the author, surgeons and anaesthetists. Among the more worrying stories was one nurse relating her story that a surgeon stapled her shoulder with a used skin staple gun. The violence can also often be of a sexual nature.

During the author's first week as a junior Sister in cardio-thoracic surgery she experienced two events that have remained strong in her memory.

During a cavity closure swab check it was discovered that a swab was missing and this fact was reported to the surgeon. Swabs were recounted and the circulator searched the theatre, bags, boots, under the table etc. It was reported back to the surgeon that the swab could not be located. The surgeon then opened his hand and said, "Is it this that you are looking for?"

The second formative event in the author's memory was more of a physical nature. While leaning through a hatch in the OR, another member of the team soundly slapped the author across the backside. The reaction, while wrong, was instinctive and involved slapping the face of the perpetrator… who then had to spend the day explaining the handprint on his face. To this day the author wonders how the perpetrator might have behaved if they hadn't been in a public place in front of colleagues.

Reporting bullying can have a positive impact for everyone in the workplace. While working in Africa the author witnessed a surgeon behaving badly towards a nurse and reported the abuse. The nurse, who was very junior, was not being allowed to place her instrument trolley in the most sensible position for either a view of the operation or to hand and receive instruments easily. The surgeon threw bloodied swabs in the nurse's direction and was abusive to both her and to the anaesthetist. After the report of abuse his contract was not renewed.

What Causes It?

What causes this behaviour? It is not unusual for human beings to be threatened by new and keen to learn staff. Add in to it pressure from above and personal tension at work, or home, which can often create these types of hostile, and unsupportive behaviour. But a quote from IFPN research undertaken across New Zealand, Australia, the UK and the US shows how certain negative behaviours are pervasive and sometimes accepted "Nurses eat their young, they do it all the time"[6].

Brewer's[7] research survey of nurses working in the UK showed that nurses from ethnic minorities are more likely to report being bullied by a member of staff than are Caucasian nurses. There was no information as to the reasons for why this was so. Perhaps, it was because these nurses felt that they were subject to racial abuse or perhaps it was because the Caucasian nurses perceived the behaviours as part of normal working situations.

Addressing and Eliminating Bullying:

So what are the mechanisms for dealing with bullying behaviours?

Direct confrontation is not without risk, but should always be tackled with a witness present to ensure the safety of all individuals and to provide a third person record of what has taken place.

Healthcare employers in the UK generally recommend dealing with issues through formal

channels. This ensures all issues are dealt with in a way that is in-line with policy and that follows structured and safe methodologies. While this route raises the profile of the issues and makes them more public, which can make some uncomfortable, it is also more likely to result in effective resolution. Documentation of incidents should be kept by anyone involved. If the situation becomes formalised they will need all documentation as evidence. These might include copies of off-duty or daily rosters, spiteful notes or similar communications. All should be kept and copied.

Informal methods of dealing with bullying are also often discussed and OR nurses often find their own ways of handling bullies. Nurses in the US have been calling a "Code Pink" when there is an event that needs handling in the OR. For example, if a doctor is shouting or being verbally abusive or throwing his (or her) instruments "Code Pink" is called and all colleagues who can be released from patient care, come into the room and stand, silently, staring at the abuser. This has been shown to be very effective[8]. Appropriate humour can also help diffuse situations, such as with the nurses seen to pretend to be plucking the air around them and when asked what they were doing responded with "Just un-ruffling your feathers". Another story was of a US nurse down on the floor looking for a tiny lost atraumatic needle and when an irritable co-worker asked what she was doing her response was "just looking for the glamour in my job."

While stress and difficulty can sometimes be turned in to fun, in the right situation, not all bullying can be diffused this way. Observers and victims need to make sure fear and self-pity do not stop them from acting against bullying. If no one acts it will never stop happening. Zero tolerance is the only policy that allows for change. Education will also help develop a collaborative environment equipped with knowledge of how to positively use change processes, conflict management, decision making skills, stress management and leadership with a focus on an outcome that suits the whole team, not just an individual.

CONCLUSION:

While in Africa with Kate Woodhead, President of the IFPN, the author witnessed much to demonstrate the strength of a good team. Nurses, with nearly no physical resources or staff and working under enormous pressure, were laughing, having fun, and caring for each other as they worked to achieve the best that could be achieved together. By creating a strong, supportive environment we make sure bullies do not have an opportunity to thrive and will eventually be able to stop these destructive behaviours.

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