SECOND EDITION

ENDING
NURSE-TO-NURSE
HOSTILITY

Why Nurses Eat Their Young and Each Other

Kathleen Bartholomew, RN, MN

Second Edition

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C o n t e n t s

Dedication

With great admiration and love to all the Orthopedic and Spine staff of the Swedish Orthopedic Institute in Seattle—the wind beneath my wings.

Acknowledgements

To the numerous researchers who have dedicated their energy and time to understanding our relationships with each other, most notably Sandra Thomas, RN, PhD, FAAN, Gerald Farrell, RN, PhD, Martha Griffin, PhD, RN, CNS, FAAN, and Cynthia Clark, PhD, RN, ANEF, FAAN; my teachers, Genevieve Bartol, RN, EdD, AHN-C(P), and Linda Westbrook, RN, PhD; colleagues, Brady G. Wilson (Juice, Inc.), Deb Cox and Dianne Jacobs (CoMass), John Nelson, PhD, MS, RN; AnnMarie Papa, RN, FAAN; and my ever-patient and supportive husband, John Nance.

About the Author

Kathleen Bartholomew, RN, MN

Before turning to healthcare as a career in 1994, Kathleen Bartholomew held positions in marketing, business, communications, and teaching. It was these experiences that allowed her to look at the culture of healthcare from a unique perspective and speak poignantly to the issues affecting providers and the challenges facing organizations today.

Bartholomew has been a national speaker since 2001. As the manager of a large surgical unit in Seattle, she quickly recognized that creating a culture where staff felt a sense of belonging was critical to retention. During her tenure as manager, staff, physician, and patient satisfaction reached the top 10% as she implemented her down-to-earth strategies. Despite the nursing shortage, she could always depend on a waiting list of nurses for both units.

Her bachelor's degree is in liberal arts with a strong emphasis on sociology. This background laid the foundation for her to correctly identify the norms particular to healthcare—specifically physician-nurse relationships and nurse-to-nurse hostility. For her master's thesis, she authored *Speak Your Truth: Proven Strategies for Effective Nurse-Physician Communication,* the only book to date which addresses physician-nurse issues.

In December of 2005, Bartholomew resigned her position as manager in order to write the first edition of *Ending Nurse-to-Nurse Hostility*, her second book on horizontal violence in nursing. The expression "nurses eat their young" has existed for many years in the nursing profession (and has troubled many in the profession). Her book offered the first comprehensive and compassionate look at the etiology, impact, and solutions to horizontal violence. She won the best media depiction of nursing for her op editorial in *The Seattle Post Intelligencer* and in 2010 she was nominated by HealthLeaders Media as one of the top 20 people changing healthcare in America.

Bartholomew's passion for creating healthy work environments is infectious. She is an expert on hospital culture and speaks internationally to hospital boards, the military, leadership, and staff about safety, communication, cultural change, and power. With her husband, John J. Nance, she co-authored *Charting the Course: Launching Patient-Centric Healthcare* in 2012, which is the sequel to *Why Hospitals Should Fly* (2008).

From the bedside to the boardroom, Kathleen Bartholomew applies research to practice with humor and an ethical call to excellence that ignites and inspires health caregivers and leaders to unprecedented levels of excellence.

Other books authored or coauthored by Kathleen Bartholomew, RN, MN

> *Speak Your Truth*
>
> *Stressed Out About Communication Skills*
>
> *Charting the Course*

Educational video and audio (Information at *www.kathleenbartholomew.com*)

> *Ending Nurse-to-Nurse Hostility: Raising Awareness*
>
> *Ending Nurse-to-Nurse Hostility: Powerful Conversations*
>
> *Creating Healthy Relationships (CEUs: 4)*

Learning objectives for *Ending Nurse-to-Nurse Hostility,* **Second Edition:**

1. Define horizontal hostility.
2. List two overt examples of horizontal hostility from your work setting.
3. List two covert examples of horizontal hostility from your work setting.
4. Discuss the impact that horizontal hostility has on 1) the individual and 2) the organization.
5. Explain the impact that horizontal hostility has on patient safety.
6. Explain one way in which the current system is designed to support the invisibility of nurses.
7. List two populations at risk for experiencing horizontal hostility.
8. State four of the most frequent forms of lateral violence.
9. Explain why horizontal hostility is so virulent.
10. Identify two intrinsic forces that play a role in horizontal hostility.
11. Explain how the organizational structure enables oppression.
12. Select two factors that contribute to nurses' stress from the context of our world.
13. List two impediments to a healthy student or resident nurse experience.
14. Describe six steps that can be taken to create a healthy environment for student nurses.
15. Name two signs that may indicate that horizontal hostility is taking place.
16. Explain what is meant by a "twofold approach" to eliminating horizontal hostility.
17. Select one way in which nurse managers can empower staff.
18. Identify two strategies to nurture a healthy culture within the organization.
19. Identify two strategies to decrease hostility within the organization.
20. Identify two practices or behaviors characteristic of an open system.

Prologue

Skye is a nursing assistant on our unit. Despite having a bachelor's degree in public health and a 3.9 GPA, she is still number 54 on a waiting list for nursing school. Her goal is to gain experience by working as a nursing assistant and eventually become a nursing instructor. However, the experience she is gaining at our hospital isn't just limited to clinical practice.

On this particular morning, she and I are watching the drama unfold as the charge nurses argue over staffing for the floor. There is no point in intervening. It is just a few minutes before 7 a.m., and I have counseled both nurses in the past. Emotions are high, and the nurses are arriving at good decisions for the floor despite their arguments.

Finally, everyone goes into report and Skye looks at me with a puzzled expression. "Why the drama?" she asks. I remember that yesterday Skye worked with two staff nurses who spent the entire shift venting about one another—to everyone on the floor but each other. "Is this what they mean by nurses eating their young and each other?" she asks hesitantly.

I take a deep breath. Horizontal hostility is a complex problem with many facets, and I don't want to gloss it over or turn her off to nursing. I want Skye to truly see and understand the forces that create and maintain this problem. It would be just as much of a disservice to Skye as it would be to nursing not to answer this question thoroughly and honestly. Drawing upon my own experience as a nurse manager, as well as research that has been conducted in the United States and other countries, I turn my answer into a book.

Section 1

Understanding the Forces

C h a p t e r 1

What Is Horizontal Hostility?

Define your terms, and I will speak with you.

—Voltaire

Defining Horizontal Hostility

When I began researching horizontal violence in 2005, there were approximately 200 articles in PubMed with the vast majority listed under "verbal abuse." Today, there are thousands of peer-reviewed papers, and a Google search will yield more than 600,000 hits. But after almost a decade of research, there are still numerous terms used to describe these negative interactions among humans:

◆ Interactive workplace trauma, anger, relational aggression, horizontal hostility, bullying, incivility, verbal abuse, and horizontal or lateral violence.

These terms are then further subdivided within relationships: nurse-to-doctor, patient-to-nurse, and nurse-to-nurse. Researchers agree that all of these terms fall into the category of **disruptive behavior,** which may be defined as:

> *… any behavior that interferes with effective communication among healthcare providers and negatively impacts performance and outcomes.*
>
> —*Center for American Nurses Position Statement*

Although the literature provides a better understanding of the presence and effect of negative emotions in healthcare settings, the lack of a single universal term makes it quite a challenge to integrate the research into one cohesive picture or to study the prevalence. The following are just some of the definitions used in literature on the subject:

- **Incivility:** "Rude or disruptive behaviors which often result in psychological or physiological distress for the people involved—and if left unaddressed, may progress to threatening situations" (Clark, 2013).

- **Verbal abuse:** "Communication perceived by a person to be a harsh, condemnatory attack, either professional or personal. Language intended to cause distress to a target" (Buback, 2004).

- **Bullying:** "The persistent, demeaning, and downgrading of humans through vicious words and cruel acts that gradually undermine confidence and self-esteem" (Adams, 1997).

Initial research on aggression in nursing came from Australia and Great Britain, where bullying is a much broader term which includes aggression from superiors, subordinates, and peers in the workplace. The definition of bullying shares three elements that come from racial and sexual harassment law. "First, bullying is defined in terms of its effect on the recipient—not the intention of the bully. Secondly, there must be a negative effect on the victim. Thirdly, the bullying behavior must be persistent" (Quine, 1999).

In America, however, the term "bullying" is most commonly used to refer to someone who holds power over you whether formally or informally. For example, a charge nurse has the power over the assignment and can use that power to punish a nurse by giving him or her a bad assignment—or a manager can bully by refusing a vacation

request for no apparent reason other than retaliation because the nurse called in sick a week earlier.

- **Horizontal violence:** "Sabotage directed at coworkers who are on the same level within an organization's hierarchy" (Dunn, 2003).

- **Horizontal hostility**: "A consistent pattern of behavior designed to control, diminish, or devalue a peer (or group) that creates a risk to health and/or safety" (Farrell, 2005).

The terms "horizontal hostility" and "lateral violence" are used to portray aggressive behavior between individuals on the same power level, such as nurse-to-nurse and manager-to-manager. Because "violence" infers physical acts of aggression for many people, I use the term "horizontal hostility," as defined by Gerald Farrell, RN, PhD, and congruent with the elements of harassment law listed above. Ironically, researchers have found that the more indirect, covert incivilities (like denigration) resulted in more extensive emotional trauma and stress than did outright physical abuse (Mayhew et al., 2004).

Overt and covert behavior—Call it what it is!

A Chinese magician's apprentice asked, "Master, how do you take the power away from something?" "That's easy," replied his master. "You just call it by its name."

Horizontal hostility can be either overt or covert. It can also take many forms: physical, verbal, nonverbal, or psychological. The psychological forms of hostility are often covert, which makes the behaviors a challenge for managers to address. A lack of cooperation, poor teamwork, refusing to help someone or pretending you are too busy, blaming, and withholding information are all forms of psychological hostility (Blair, 2013).

Since studies show that the majority of our communication is nonverbal, and stress is heightened in ambiguous situations, covert behaviors have the biggest impact.

- **Overt:** Name-calling, bickering, fault-finding, backstabbing, criticism, intimidation, gossip, shouting, blaming, using put-downs, raising eyebrows, eye-rolling (perceived), ignoring someone's greeting, nicknames, failing to give credit when due, etc.

◆ **Covert:** Unfair assignments, sarcasm, eye-rolling (behind someone's back), ignoring, making faces behind someone's back, refusing to help, sighing, whining, refusing to work with someone, sabotage, isolation, exclusion, fabrication, etc.

Examples of these covert and overt behaviors run as a continuous thread through the numerous stories I have heard throughout my career. I have incorporated these stories into this book. The following is an example of overt hostility experienced by a fellow nurse:

I am used to being in a charge nurse position and am now working with recovering patients from the cath lab. The hostility here is thinly veiled. I come into work and say something like, "Nice day today," and the charge replies, "What's that supposed to mean?"

We have really sick patients just fresh out of the cath lab. When the charge nurse told me she was going to take a break, I asked her a few questions so I would have the information I needed to cover. I asked, "Does 212 have a sheath in?" and the charge nurse said, "What do you want to know for?" I try to ignore her and just do my job.

When she came back from break I told her all that had happened in her absence— for example, that I taped down the IV in 214. Coldly, she responded, "That could've waited until I returned."

It's a constant, negative, put-you-down undercurrent that never ends.

Continuum of harm

Dr. Cindy Clark recognized that hostile and rude behaviors occur on a wide spectrum of harm that ranges from low to high risk and from disruptive to threatening. Her work gives perspective to negative acts and helps leaders to understand that if left unaddressed, hostile behaviors can escalate. For example, eye-rolling and sarcastic comments would be classified as low risk and intimidation and physical violence as high risk (Clark, 2013).

| Figure 1.1 | The wide spectrum of harm from hostile behaviors |

Continuum of Incivility

Distracting, annoying irritating behaviors

Aggressive, Potentially violent behaviors

Low Risk   High Risk

Disruptive Behaviors   Threatening Behaviors

Behaviors range from:

eye-rolling • sarcastic comments • bullying • taunting • racial/ethnic slurs • intimidation • physical violence • tragedy

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In June 2010, after the death of an operating room nurse, the government in Ontario passed "Bully Busting Bill 168" in order to raise awareness of the critical need to address low-risk, disruptive behaviors that, if left ignored, can result in tragedy. This bill is an amendment to the Occupational Health and Safety Act and requires organizations to develop a policy, educate employees, post the policy, and conduct a risk assessment. Bystanders who witness harassment now have a moral, ethical, and legal obligation to act. Examples of harassment include making remarks, jokes, or innuendos that demean, ridicule, intimidate, or offend. The OSHA definition is:

◆ **Workplace harassment**: "Engaging in a course of vexatious comment or conduct against a worker in a workplace that is known or ought reasonably to be known to be unwelcome." Any repeated words or actions, or a pattern of behaviors, against a worker or group of workers in the workplace that are unwelcome are considered harassment.

Is Horizontal Hostility Intentional?

For more than an hour, Bethany has been recounting examples of horizontal hostility over a 14-year career, which brought her to three different states and through major depression. At the end of the interview, I ask her, "Do you think the nurses knew what they were doing? Were their actions intentional?"

She bristles and responds almost indignantly, "Their actions were very intentional. They knew exactly what they were doing!"

I press further, "But were their actions conscious? Do you think those nurses were aware of the pain they were causing you?"

Bethany pauses and her face softens. "No, they were clueless to the effect of their actions. They never looked past [their actions] to see how another person would feel. What got me was how a person could hate someone they didn't even know."

The above scenario has occurred with hundreds of nurses whom I have counseled. The intent of backstabbing, intimidation, fault-finding, etc., is to alienate, attack, or punish a coworker. However, in the majority of cases, the perpetrators did not understand the consequences of their actions. Many believed that they were superior because they were upholding a particular standard of quality patient care.

Only through education, which began by raising awareness of the damage and confronting the behavior, did nurses begin to comprehend the full extent of their actions. And when a nurse did "get it," the behavior stopped immediately. This is the reason horizontal hostility is such a threat to our profession: because it is so insidious. Nurses do not perceive the harm that they are causing. And the harm is devastating.

Victims are as wounded as if the attack had been physical. They suffer for months, fear more abuse, function apprehensively, and believe that there is something wrong with them—that they are not good enough or "not cut out to be a nurse."

In a study of 227 nurses, over one-third of nurses admitted that they had engaged in negative behaviors. When nurses were asked to reflect on why, they said they were "sadly caught up in the moment" and expressed disappointment in themselves for participating in the negativity (Walrafen et al., 2012).

Opportunity: Understanding how humans behave in groups

The greatest need of the soul is for belonging.

—Thomas Moore

We have both an opportunity and an obligation to listen to nurses' stories and learn from these experiences in order to create a new reality: a healthy workplace for each other and our patients. We can start by learning more about human behavior in groups.

When humans become part of a new group, they adopt the behaviors of that group in order to be accepted because the threat of exclusion is so devastating. This process—where we unconsciously accept the behaviors of the group—is called assimilation. For example, if you join a unit and hear nurses constantly talking and gossiping about someone, then before long you will find yourself doing the same thing. While you may have been surprised at the gossiping at first, the behavior becomes normal because no one ever challenges it, and you see frequent examples every day (Ceravolo et al., 2012).

Not only do staff members match the behavior of each other, but they also normalize behaviors and tolerate a culture of hostility when the supervisor is the source of the abuse (Hutchinson et al., 2010). The collective belief established appeared to be, *"If the manager can behave that way, then everyone else can too."*

In short, the more people that watch a behavior, the less chance that someone will actually intervene. Responsibility diffuses in a crowd.

Opportunity: Understanding powerful emotions

The expression "nurses eat their young" has existed for as long as nurses can remember. We secretly acknowledge the culture to each other, yet never admit this out loud. This aphorism implies that there is a problem specifically within the nursing profession and is accompanied by a feeling of shame. This is the primary reason why it has taken us so long to address the issue. But the more I researched the phenomena of horizontal hostility, the more I realized that I was studying all human behavior—not just nursing behavior.

In her pivotal book, *Odd Girl Out,* Rachel Simmons zeroes in on the hidden culture of aggression in teenagers. She points out these very same overt and covert behaviors happening between middle school students. Or perhaps you remember your high school cliques? In that setting, gossip was used to spread information on how each person was supposed to behave (so that the person listening learned how not to behave). The person who spread the gossip gained power and status because they had the "goods"—or the information—that no one else had (Brooks, 2011).

> *We tell ourselves stories about those who violate the rules of our group both to reinforce our connections with one another and to remind ourselves of the standards that bind us together.*
>
> —*Haidt, The Righteous Mind*

It is difficult to admit that we could be hurting each other in a profession that has its fundamental roots in caring. Uncovering and discussing horizontal hostility is about as easy as a family acknowledging how damaging it is to live with alcoholism. It is embarrassing and is so remotely removed from our idea of the perfect nurse that we shudder to think that it may be true.

In addition, there is an unspoken fear, warranted or not, that acknowledging the problem will make it worse. However, if nursing is to survive, we need an immediate intervention. This intervention starts with listening to the voices in the room—the researchers who have uncovered this behavior, and the nurses who are experiencing the hostility.

Tales From the Front Line

> *Our communication is fraught with indirect aggression, bickering, and fault-finding. It is disheartening to experience the underhanded and devastating ways that nurses attack each other. These rifts divide us and lead us to injure one another.*
>
> —*Laura Gasparis Vonfrolio, RN, PhD*

There is nothing as powerful as a story. Stories put the truth out into the world—once a story is shared, you cannot call it back. Stories are a means of truth-telling. If we

have had a similar experience, a story resonates with us at the deepest level, and there is comfort and validation as we realize that others share our experience.

At the "Horizontal Violence in the Workplace" conference held by the Oregon chapter of the American Psychiatric Nurses Association, I asked participants whether they would be willing to share their stories about hostility in the workplace. I collected a list of names and phone numbers of interested nurses and arranged convenient times to speak to each one by phone. As I listened to the first story, I was shocked at the intensity of aggression the nurse had experienced and by the fact that the continual verbal abuse had resulted in a suicide attempt.

From hospitals and academia to outpatient clinic settings, nurses shared with me their poignant experiences with horizontal hostility. Research shows that these stories are not isolated events and that the effects of these negative emotions have a serious impact. "Horizontal hostility drains nurses of vitality and undermines institutional attempts to create a satisfied nursing workforce" (Thomas, 2003).

> *This is what the group of nurses would do to me: I never sat down for 12 hours. It was horrendous. All I know is that if a group works together for long enough, they keep the others outside.*

> *The smallest thing would trigger retaliation. [The charge nurse's] refusal to speak was the worst. Once she went 27 days without speaking.*

> *It was the looks [the preceptor] gave me, like I was stupid. In my whole three months of orientation, I can't think of a single time anyone ever complimented me.*

> *The orientation nurse was ultimately fired. She started drinking and felt attacked all the time. Everything was her fault, all the time.*

As nurses shared their experiences with me, two common themes emerged. First, every single participant was gravely concerned about maintaining anonymity for fear of being identified. Even if the violence had happened 10 years ago and had been resolved by the abuser leaving the workplace, all nurses feared retaliation. The workplace was still viewed as dangerous, and nurses continued to feel vulnerable.

Secondly, no matter what the situation, the stories clearly brought up a lot of emotional pain that was difficult to acknowledge. Like those suffering from post traumatic stress disorder, participants appeared to be reliving their hurt all over again.

The air was still thick with feelings of loss and betrayal after the conversations were finished. As stories were coaxed from each nurse, the courage required to tell their stories became obvious. Even to be a witness to another's story was upsetting:

> *Survivors have to look the other way ... or go along with the crowd to survive.*
> *You have to take the party line even if you don't believe it.*

When asked to reflect on horizontal hostility, people can frequently identify the bully but fail to realize the critical importance of the supporting roles. Witnesses reported feeling two types of anger: a generally angry mood and a personally targeted anger toward the offender (Porath, 2009).

The "silent witness" is a term used to identify people who watch the behavior but say or do nothing. By their apathy and silence, witnesses allow the practice of bullying to continue as an acceptable norm. Because responsibility diffuses in a crowd, witnesses frequently do not feel the need to act. Also, many witnesses report feeling relieved that the bullying or hostility is not directed at them. Many report that their biggest fear is that by speaking up and becoming visible, they will inadvertently redirect the hostility toward themselves.

The target or victim is another key player in the horizontal hostility drama. As we will discuss in later chapters, the most vulnerable target is always someone who is different from the group. Targets are not limited to the new nurse—now there are several reports of older nurses being targeted with hostile behaviors. The only criteria is being different. Therefore, the manager who reaches unprecedented levels of patient or employee satisfaction can also be a target.

The unspoken and unconscious motive of the hostility is homogeneity. Powerless groups travel like a school of fish in order to stay psychologically safe.

Horizontal hostility exists at all levels

> *I was standing next to the executive director for recruitment and retention for a West Coast state. I was thrilled because I had just been invited on to a radio program in San Francisco that would reach over a million listeners. But when I shared this information with her, she immediately responded, "That shouldn't be you—it should be a California nurse. Why do you get to go?"*

I was the outgoing president of a nursing organization representing over 20,000 nurses. During her acceptance speech the new president announced, "And I want you to know that THIS year we will be doing things right!" I sat in the audience mortified as several peers emailed their disbelief and sympathies at the words they were hearing.

A lead instructor of mine rolls her eyes and huffs when asked a question … she makes all of us feel as if we are wasting her time, and begins every class by saying, "We have a lot to cover today so don't ask any questions."

I was supposed to have two faculty mentors for my graduate project. But they refused to talk to each other, or meet me together … and so I felt like a Ping-Pong ball and wasted a tremendous amount of time redoing work.

From staff nurse to chief nursing officer, nurses have reported experiencing hostile behaviors. No one is exempt. To be dissed by the profession that you have dedicated your life to is simply devastating. Frequently, however, nurses minimize the impact because they internalize the pain. They believe these situations only happen to them because they don't know how frequently these behaviors occur elsewhere.

Prevalence in the U.S. and Beyond

How frequently do these behaviors actually occur? The larger body of literature reflects a huge spread of incidence of horizontal hostility, experienced by as few as 18% to a high of 76% of those surveyed (Vessey et al., 2011). One reason for this wide spread is because hostility was defined and measured differently across the various studies by different researchers. The most consistent information about prevalence came from two rigorous studies that used the same reliable and valid measures. These two studies found a prevalence rate of 27% and 31% respectively of nurses who experienced hostility (Purpora et al., 2012).

Horizontal hostility in nursing is not unique to the United States. On an international level, one in three nurses plans to leave his or her position because of horizontal hostility (McMillan, 1995). In 1996, a survey was conducted of more than 1,100 employees of a National Health Service Community Trust in England, which included 396 nurses. The bullied staff reported lower job satisfaction, higher job stress, greater depression and anxiety, and greater intent to leave their job. The bully was a superior in 54% of cases, a peer in 34%, and a subordinate 12% of the time. Thirty percent of

respondents in the study stated that they were subjected to aggression "on a daily or near daily basis" (Farrell, 1999).

A study in the United Kingdom of 4,500 nurses showed that one in six nurses reported that they had experienced workplace mistreatment in the past year and that 33% were intending to leave the workplace because of verbal abuse. Mistreatment by peers accounted for 41% of verbal abuse (Gilmour and Hamlin, 2003).

Studies in the United States indicate that 90%–97% of nurses experience verbal abuse from physicians (Manderino and Berkey, 1997). Some speculate that verbal abuse by physicians contributes significantly to horizontal hostility because nurses pass their anger and frustration with physicians onto vulnerable coworkers. This is called "submissive aggressive syndrome." When researchers studied primates, they discovered that when a primate lost a fight, he would walk away and swat another primate who was innocently minding his own business.

Nurses often cite verbal abuse from peers and supervisors as a reason for leaving their jobs. "Researchers report that verbal abuse contributes to 16%–24% of staff turnover and 25%–42% of nurse administrator turnover" (Braun et al., 1991; Cox, 1991; Hilton et al., 1994). In the U.S., "the turnover rate is 33%–37% for clinical practicing nurses and 55%–61% for newly registered nurses. Approximately 60% of newly registered nurses leave their first position within six months because of some form of lateral violence" (Griffin, 2004). In another study, 45% of new-to-practice nurses were humiliated (McKenna, 2003).

In addition, nurses who report the greatest degree of conflict with other nurses also report the highest rates of burnout (Hillhouse and Adler, 1997). In 2001, Dr. Linda Aiken of the University of Pennsylvania's Center for Health Outcomes and Policy Research released a study that examined reports from 43,329 nurses from the United States, Canada, England, Scotland, and Germany. The study found that nurse dissatisfaction was high in all of those countries except for Germany. Burnout and dissatisfaction were reported by 43% of U.S. nurses, and 27.7% planned to leave the profession within a year (Aiken, 2001).

In a nursing shortage, these statistics are especially foreboding and demand that every nurse, on every level, accept the challenge of ending nurse-to-nurse hostility and creating a new culture.

Food for Thought: Exercises

1. Answer this question: Could the potpourri of terms that we have created to describe negative behaviors be an example of the very infighting they describe?

2. Consider this: Nursing theorist Margaret Newman believed that transformation happened through pattern recognition and that shifts occur as the client recognizes their own patterning. If we are the client, what pattern do you recognize within yourself that has the ability to transform your work environment from hostile to healthy?

Summary

The wide variety of terms used to describe negative, disruptive behaviors has hampered our ability to study the problem. Understanding these behaviors along a continuum of harm is not only helpful, but demonstrates how these behaviors can escalate. In this book we will explore horizontal hostility within the context of peer-to-peer relationships between nurses.

The commonly held belief that horizontal hostility is a staff nurse problem is a myth, as these behaviors have been found at all levels of the profession. Stories from the front line are disturbing and along with recent research on prevalence confirm that we do indeed have a problem.

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Why Nurses Eat Their Young and Each Other

Kathleen Bartholomew, RN, MN

Expanded and meticulously revised to address the real needs of nurses in our rapidly changing post–Affordable Care Act healthcare world, the second edition of *Ending Nurse-to-Nurse Hostility* provides empirical research and tested techniques for creating a workplace that promotes team relationships and career development while preventing burnout.

Ending Nurse-to-Nurse Hostility offers nursing students, staff, managers, and nurse educators:

- Skills for identifying and responding to verbal abuse, bullying, and other detrimental behaviors that undermine individual nurses and the unit, and threaten the quality of patient care
- Revealing and all-too-familiar stories from nurses who have experienced all forms of horizontal hostility, presented in their own voices
- Tips and thoughtful exercises for nurses, managers, and educators who seek to create a positive work environment by challenging the old beliefs, and ending the blaming, scapegoating, and sense of helplessness that perpetuate hostile behaviors

Throughout the book, readers will find the validation and guidance they've come to expect from *Kathleen Bartholomew*, a trusted and supportive champion for nurses' professionalism, self-esteem, and authentic self- and patient-centered caring.

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