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Understanding Hospital-Based Nurses' Experiences of Structurational Divergence

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Abstract

This study examined hospital-based nurses' experiences of structural divergence. I used a semi-structured narrative approach to interview 10 hospital-based nurses and data was analyzed using phenomenological methods. This resulted in the identification of the following three themes, which capture instances of structural divergence and resulting interpersonal, intrapersonal, and organizational conflicts: Managing Overload, Identifying and Negotiating Boundaries, and Substituting and Advocating. I also discovered an additional theme, Eating their Young.. Results have implications for future research in health and organizational communication and reflect the importance of research into the communication between and amongst nurses, patients, and physicians and the impact of that communication on patient health outcomes.

Keywords

Structural Divergence, Nurses, Health Communication, Health Care Organizations, Qualitative Methods.

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Understanding Hospital-Based Nurses' Experiences of Structural Divergence

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This study examined hospital-based nurses' experiences of structural divergence. I used a semi-structured narrative approach to interview 10 hospital-based nurses and data was analyzed using phenomenological methods. This resulted in the identification of the following three themes, which capture instances of structural divergence and resulting interpersonal, intrapersonal, and organizational conflicts: Managing Overload, Identifying and Negotiating Boundaries, and Substituting and Advocating. I also discovered an additional theme, Eating their Young.. Results have implications for future research in health and organizational communication and reflect the importance of research into the communication between and amongst nurses, patients, and physicians and the impact of that communication on patient health outcomes. Keywords: Structural Divergence, Nurses, Health Communication, Health Care Organizations, Qualitative Methods.

Nurses play multiple vital roles in the functioning of any healthcare facility. Nurses facilitate the physician-patient relationship; they are the conduit through which physician-patient communication occurs (Apker, Propp, & Ford, 2009). Nurses experience extreme demands on their time and are often overworked and stressed (Lu, 2008; Ramanujam, Abrahamson, & Anderson, 2008; Shattell, 2004; Vivar, 2006). Moreover, as Nicotera and Clinkscales (2010) explained, nurses are institutionally positioned in such a way that they are often thrust into negative communication cycles with a host of individuals including physicians, patients, and their own peers. These conflicted cycles lead to an inability to accomplish goals which contributes then to fuel the conflicts that initiated the cycle (Nicotera & Clinkscales; Nicotera, Mahon, & Zhao, 2010). This negative cycle, rooted in incompatible rules and/or meaning systems placing simultaneous competing demands on the individual, has been termed *structural divergence* (Nicotera & Clinkscales, 2003, 2010). This constant need to prioritize competing demands not only hinders goal achievement, it also complicates organizational relationships, pitting the nurse's loyalties to the patient, the attending physician, his/her fellow nurses, and nurse managers against one another. Conflicting expectations of nurses and the resulting inability to provide comprehensive care are the most important issues reported by nurses today (Forsyth & McKenzie, 2006). Further, in their study Davidson, Folacarelli, Crawford, Duprat, and Clifford (1997) found competing job duties and little time to perform required duties to be mitigating factors in nurses' decisions to leave their positions.

Given the important role that nurses play in caring for and providing interpersonal and physical support to patients, it is important to understand the factors that may lead to nursing turnover or dissatisfaction with duties. This study seeks a better understanding of nursing dilemmas created as a result of structural divergence. Specifically, this study sheds light on structural divergence and the resulting interpersonal, intrapersonal, and organizational conflicts that may impact patient care.

Literature Review

The overall ideology of teamwork amongst and between physicians and nurses is disrupted by an organizational focus on separation. A distinguishing feature of hospitals, notes Lammers, Barbour, and Duggan (2003), “is its dual hierarchy: physicians are organized in one hierarchical staff, and other hospital personnel – including nurses and other departments and staff – are organized in a second chain of command” (p. 327). The dynamics of role negotiation are therefore ongoing and complex.

According to a review of nursing organizations by Poole and Real (2003), leadership roles in hospitals are constantly negotiated. While it might be assumed that physicians maintain the primary leadership position, it is often the case that a nurse is asked to fill the role. Fountain (1993), however, explains that nurses are not adequately prepared to take on leadership positions because they are trained to *assist* physicians in a technical role. This inexperience coupled with the expectation of the physician to serve as group leader can lead to the nurse experiencing role ambiguity and uncertainty. This may in turn necessitate the physician reclaiming the leadership role (Fountain, 1993) despite the nurse having the most direct interaction with the patient (Forsyth & McKenzie, 2006). This shifting power balance is a key factor impeding collaborative efforts between physicians and nurses, and one that can ultimately impact the quality of patient health outcomes (Neale, 1999).

One form of structural divergence, the constant negotiation of power between physician and nurse, is one of many factors that can lead to organizational and/or interpersonal conflict. As might be expected in any high-stress organization, these types of conflict occur frequently in the healthcare setting, and between a number of dyads and small groups. Physician-nurse conflict, however, can have very serious implications for patient healthcare. Poor communication between physicians and nurses can lead not only to conflict but to general feelings of frustration and distrust, as well as greater risk of medical errors and negative patient outcomes (Burke, Boal, & Mitchell, 2004).

Physicians “do not always recognize nurses’ perspectives on conflict” (Back & Arnold, 2005, p. 1378). In fact, studies suggest that physicians perceive themselves as much more supportive and respectful of nurses than nurses actually report (Back & Arnold). This may result from the aforementioned differences in training or, as Keenan, Cooke, and Hillis (1998) suggest, these perceptions may arise from the fact that physicians and nurses are not socialized to collaborate, and feel that they should not have to interact. Regardless of the reasons for physician-nurse conflict, research suggests that nurses often feel powerless in their positions and unable to resolve their differences with managers and administrators, thus resulting in higher turnover and discontent in nursing positions (Forsyth & McKenzie, 2006). Only by gaining insight into how physicians and nurses negotiate conflict can researchers develop best-practices for facilitating communication and reducing the negative outcomes of conflict, improving not only the physician-nurse relationship, but patient health outcomes as well.

Contemporary models of healthcare suggest that the nurse-patient relationship is more of a partnership, with nurses moving from the role of expert care giver to healthcare partner (Gallant, Beaulieu, & Carnevale, 2002). To develop an effective nurse-patient partnership, the nurse must involve the patient in shared-decision making and actively seek to empower the patient (Gallant et al., 2002). Despite a nurse’s best attempts to empower the patient through shared decision-making, there are times when a nurse must negotiate the conflict created when, for example, a physician deliberately withholds information from a patient. In this instance, the nurse may be required to choose between his/her role as the physician’s assistant and his/her role as the patient’s partner, a role conflict indicative of structural divergence.

The truth is sometimes hidden from patients for their perceived benefit, or somehow distorted to assist the physician in delivering bad news (Gillotti, 2003). However, Goldman (1980) argues that it is the patient's right to be fully informed of his/her conditions and rights, and that the delivery of the truth is necessary for patients to make decisions about their own healthcare. He claims that two conditions exist for which a physician might choose to withhold information from a patient: when the knowledge might create the condition in which the patient loses the will to live or when the information may lead the patient to choose the wrong treatment, if treatment is even chosen. Goldman (1980) contends that even in those two situations, withholding the truth from the patient can lead to greater harm than denying a patient of his or her rights.

Recognizing the important role that nurses play in patient's receipt of bad news, Fry (1998) asserts that nurses have four primary responsibilities in end-of-life care: to serve as a patient advocate, to help relieve the patient's pain and suffering, to provide comfort to the patient, and to avoid instances of assisted suicide. These roles, however, cannot be fulfilled if a patient is not given the truth about his/her condition. Withholding information from a patient can lead to intrapersonal conflict for the nurse, as well as interpersonal conflict between the physician choosing to withhold the information and the nurse who seeks to fulfill those key roles of both patient advocate and physician's ally. Again, this is an example of structural divergence, as role conflict prevents nurses from fulfilling demands on their jobs. Unfortunately, social science literature focuses largely on the physician-patient dyad in issues related to disclosure, thus creating a gap in research that ignores the role of the nurse in negotiating the space between patient right-to-know and physician orders.

Research Questions

After a careful review of literature on physician-nurse relationships, conflict, and nurses' role in medical disclosure, the following research questions were posed:

- R1: How do hospital-based nurses describe instances of structural divergence?
- R2: How do hospital-based nurses describe instances of structural divergence or conflict that stems from structural divergence?

Bracketed Experience

This study was undertaken while I was a student in a doctoral level interpersonal communication course at a large mid-Atlantic university. My interest in this subject derived from my advisors' then-ongoing studies of structural divergence. I felt these studies illuminated an understudied area of communication in health care organizations and I was interested in completing a study on structural divergence using qualitative methods. I completed this research with the assistance of three additional students, who conducted either one or two interviews each. I completed six of the 10 interviews completed for this study and I did not know the participants prior to interviewing them. Before recruiting participants, I completed training in qualitative interviewing as well as a norming session with fellow interviewers. I completed the analysis and the resulting manuscript became my final course paper. The manuscript was presented at an international communication conference.

Methods

Participant Recruitment

Participants were 10 hospital-based nurses, most in the mid-Atlantic region, with some from other regions recommended through local participants and interviewed by phone. All participants were recruited through the research team's social and professional networks. Thus, this was primarily a network sample though multiple participants were identified by snowball method. Recruitment methods included email, phone calls, and listings on social networking websites, as well as face-to-face recruitment. Each student was responsible for recruiting and conducting interviews with interested participants. All participants were required to be employed by a hospital and work inside a department providing direct services to patients. Participants could be either full or part-time employees. Participants were White and included nine females and one male, ranging in age from 25-60, with an average age of 44. All nurses were hospital-based, however, participants represented a range of hospital departments. These departments ranged in size from three nurses to 50 nurses.

Interview Protocol

All participants were interviewed using a semi-structured narrative method in which the researcher asked the participant to describe their experiences with conflict or structural divergence in the workplace. Participants were asked to relate stories of experiences at work in which they felt immobilized by competing demands on their time, and the competing "rules" of such demands. Participants were asked probing questions in response to these stories in order to elicit the essence of the nurses' experiences with structural divergence. All participant interviews were audio-recorded. In compliance with the Institutional Review Board approval, all participants reviewed and signed informed consent forms and provided basic demographic information in addition to providing information about their nursing position(s). All interviews were transcribed into typed transcripts. Audio files were stored on my secured computer, in which files could only be accessed via password. This computer was located in a locked office at all times. Additionally, transcribers used headphones when completing their work and provided transcriptions over a secured server. These files were downloaded to my password protected computer which was stored in a locked office at all times. All participants were assigned code numbers to maintain confidentiality.

Methodological Approach

The specific type of qualitative methodology guiding this study is descriptive, or transcendental, phenomenology, which both Polkinghorne (1983) and Moustakas (1994) refer to as the method used to describe the basic structures, or essences, of one's lived experiences. This study relied on the methodological approach provided by Moustakas, (1994). Themes emerged through processes known as horizontalization and clustering, which means I read the interviews for significant statements relevant to the phenomenon and grouped these statements into meaning units, or themes. Once the meaning units were established, they were broken into textural and structural descriptions. Textural descriptions refer to *what* was experienced while structural descriptions refer to *how* the phenomenon was experienced (Creswell, 2007). This approach enabled the illumination of commonly occurring themes based on the experiences described in participant interviews. Themes were established once data were saturated. Saturation was achieved once I no longer saw new descriptions emerge

from the data. Saturation illustrates the importance of a particular descriptions to the experience of being a hospital-based nurse managing structural divergence. After themes were established, two nurses validated the accuracy of the themes through a process known as member validation, a strategy that enables the researcher to improve the credibility of a study by having other researchers or those involved with the phenomena actually review, provide input for, and correct the data analysis, when necessary (Creswell, 2007; Golafshani, 2003). One of the nurses involved in this stage was a study participant, while the other was a hospital-based nurse not otherwise involved in the study.

Findings and Discussion

Three themes emerged that directly relate findings to the research questions posed in this study: *Managing Overload*; *Identifying and Negotiating Boundaries*; *Substituting and Advocating*. Though this study did not explicitly seek to describe the conflict between nurses and their nurse managers, a theme regarding this relationship did emerge from the interviews. This fourth theme is labeled *Eating their Young*.

Managing Overload

Nurses are exceedingly frustrated by the administrative demands of their roles, such as increasing amounts of paperwork. Nurses are also concerned with the decreased importance placed on patient caretaking. Forsyth and McKenzie (2006) found that nurses' job satisfaction is correlated to their ability to provide comprehensive patient care. Their findings also suggest that nurses encounter more and more barriers to providing this level of personal care; as one of their respondents claim that nurses barely have time to give basic care, a problem that some nurses blame on the rise of managed care systems (Apker, 2001; Apker & Ray, 2003). This increased demand on nurses' time requires some nurses to take short cuts in their care of patients (Forsyth & McKenzie, 2006, p. 212), which can have direct impacts on patient satisfaction and nurse job satisfaction. Patients want nurses who make time for them and who are available and willing to talk with them. However, the ability to provide this level of care is often usurped by competing demands on the nurse's time (Shattell, 2002).

These concerns are shared by the nurses participating in this study. Nurses reported the need to constantly balance patient care with charting, patient intake, answering phones, and other regulatory obligations that impact patient care. The following excerpt from a participant interview explains the immobilizing effect that role conflict and divergence has caused:

[Immobilization often happens due to] the amount of paperwork that has to be done, in comparison to the amount of patient care that needs to be done... I sometimes feel that administration forgets that there's patient care involved in nursing.

Another participant explained how role conflict and divergence impacted her work:

All the sudden we wore 20 hats. And the one that we wanted to wear, that of being a bedside nurse, doesn't often get included in the mix as much as we'd like it to.

When asked how this conflict is managed, one participant stated that she will often say to her nurse manager, "I'll get [paperwork] done if I have time." However, her hospital

does not allow for overtime, meaning yet another conflict is created: Nurses must make the decision to either work extra time without pay or sacrifice patient care to complete their job during their shift. The majority of the nurses in this study reported feeling this way, and also reported that as a result of this role conflict, patient care is lacking. Forsyth and McKenzie (2006) found this lack of time for and attention to the patient to be a common issue amongst the nurses they interviewed as well, particularly for nurses working in aged care because funding is dependent upon detailed nurse reporting.

Nursing has undergone restructuring in the past two decades due to greater emphases on issues like case-load demand and time constraints, and also on cost-effectiveness or “bottom line” profits (Apker & Ray, 2003; Forsyth & McKenzie, 2006). Many of the respondents confirmed their dislike for the bureaucracy of the nursing profession during their interviews, with such statements as “[Nursing] is a business, not a profession anymore.” Another participant relates the following story about an instance where the need to “push” patients through the operating room created conflict or stress for both her and her nurse peers:

On Saturday or Sunday I can only run so many operating rooms. Like I only have staff for five. So they'll try to squeeze in six or seven cases and they play that game, “oh my patient is dying” or “oh my patient needs the OR now.” And of course we're going to admit them and help the patient.

This section illuminated the experiences of nurses who feel frustrated with new and increasing restrictions on their ability to provide what they feel is adequate patient care. The excerpts from participant interviews provide clear examples of structural divergence. Nurses must manage ever-increasing workloads and are often forced to choose between multiple conflicting demands on their time. This finding is important as nurses' high stress levels can impact patient outcomes, including satisfaction with their hospital stay, medical care, and services provided (Leiter, Harvie, & Frizell, 1998). Though important, this is certainly not the only job stressor or source of conflict reported by nurses in this study.

Identifying and Negotiating Boundaries

Nurses and physicians have long operated under a paradigm that places the physician in a dominant position over the nurse (Keenan et al., 1998). A common concern voiced by the participants is being treated as “just a nurse.” Many nurses in this study reported instances where they were ordered to fulfill an order they neither approved of doing nor felt comfortable carrying out. The majority of those reporting having been in this situation also reported refusing to write or perform the order. One nurse told of her experience refusing a direct order from a physician, and then seeking support from her nursing manager, who told her “you have to do everything that the doctor tells you to do honey, you know, he wrote the order, you ought to do it.” Others explained that they simply said their refusal to carry out the orders was a matter of licensing regulations, and therefore not in their scope of practice, or simply against their morals. According to Keenan et al. (1998), nurse-physician conflict often results from a disagreement over a specific order.

Another source of conflict the participants mentioned occurred when the nurse took action without the prior approval of the physician. In a clear example of how the physician-nurse relationship is impacted by competing role demands, one participant explained how she took charge of a situation where a patient was in imminent danger of “arrest,” and when unable to reach the physician on call, she chose to admit the patient to the emergency room for immediate attention. Despite the fact that the patient *did* need attention, the attending physician was displeased with her, and expressed his dismay with her nurse manager before

then coming to her to express his concern that she had “made him look bad.” In another instance of a nurse “overstepping” his boundaries, one participant explains that he was chastised and threatened by a physician after briefly moving a patient's chart to update vital signs. Unaware of the physician's method of placing charts in a specific order, he quickly pulled a chart to update it. In these situations, the nurses were engaged in an event that produced two contradictory responses: either act in order to save a life, or follow proper procedure. In cases such as these, nurses may feel both helpful because they have assisted a patient, yet fearful of being reprimanded for not following the “rules” of the organization.

Regardless of how these situations were handled, the nurses reported feeling “disrespected” by the physician with whom they were working. Keenan et al. (1998) explore the power imbalance between physicians and nurses, stating that this imbalance is the major barrier to nurse-physician collaboration. To overcome this problem, they suggest nurses and physicians seek to collaborate more, which can only occur once physicians become less dominant in their communication, and nurses become more assertive. These are not easy tasks, however, as both nurses and physicians will have to work in ways in which they are not accustomed. Adding to the difficulty of working collaboratively is Morse and Piland's (1981) assertion that the nurse-physician relationship is a closed system.

Geist and Hardesty (1992) point out the dual hierarchy as a distinguishing feature of the hospital system: physicians make up one staff while nurses and other hospital staff comprise another separate hierarchy. This, perhaps inadvertently, sets up a system of “multiple subordinate” (p. 37) positions in the traditional physician-dominated health care system. This may also set up a system where physicians are empowered and nurses, and other staff, are rendered powerless, as nurses are understood to have no power in certain situations. To help offset this power imbalance, Burke et al. (2004) suggest that nurses be more assertive when it comes to communicating with physicians about patient care. Specifically, they suggest that nurses begin to view themselves as equal to the physician when it comes to providing patient care. Certainly these suggestions provide nurses with an idea of how to better communicate with, and view their relationships with, physicians. These suggestions may also be helpful as nurses seek to sift through the conflict that arises when nurses find themselves filling in for an absent physician or advocating the patient perspective to a physician.

Substituting and Advocating

This theme highlights participants' experiences in fulfilling two common roles: that of a substitute physician and patient advocate. Apker and Ray (2003) define *role stress* as the expectations for nurses to fulfill the duties of two roles simultaneously. Role stress is divided into *role conflict* and *role ambiguity*. Role conflict is exhibited when these nurses are forced to engage in multiple incompatible roles, such as that of both the nurse and the substitute physician, while role ambiguity refers to the nurses' lack of understanding the expectations of a certain role. As previously mentioned, nurses experience work overload regularly, as they are expected to conduct administrative duties in addition to their roles as bedside nurses and caretakers. However, nurses interviewed in this study also expressed their concern for the additional job duties required of them by physicians who are less involved in patient care, forcing the nurses to perform their duties in an effort to maintain a standard of care. One participant lamented that nurses' extra job duties are partially due to inaction by physicians, stating “doctors continuously add more responsibility to what the nurses have to do, which has really been in *their* scope of practice to do.”

Multiple participants mentioned having to perform duties a physician would normally perform, due to the physician simply not wanting to be bothered. This ambiguity is created, in

part, because nurses often do not know which role they will be expected to fulfill at a specific time. For instance, some nurses mentioned that despite having a patient in the hospital, it is often the case that a physician will not check on a patient; rather, the physician waits until his/her next hospital visit and expects the nurse to provide up-to-date information on the patient rather than obtaining the information from the attending physician or reading charts. Also, by not attending to the patient over the weekend or while off-duty, physicians create the situation where nurses are expected to answer patient and family questions, regardless of whether the nurse has the knowledge to do so.

Informed consent and medical disclosure were also discussed at length by most study participants, who expressed that they must often explain to patients that they have the right to refuse a treatment or procedure and must also “dance around things a little bit” to avoid disclosing medical information the doctor has withheld from the patient. In the case that a nurse is asked by a physician not to release information to a patient but is asked by a patient to provide such information, the nurse is faced with making a decision between two contradictory responses.

According to Gillotti (2003), physician-patient information exchange and medical disclosure have received a great deal of scholarly attention. Studies have found that physicians withhold medical information for a variety of reasons including not wanting the patient to lose hope and discomfort or anxiety about delivering bad news (Gillotti, 2003; Thompson & Parrott, 2002). Informed consent, it seems, is more a matter of simply signing a document than truly providing a patient with information. A study by Bottrell, Alpert, Fischbach, and Emanuel (2000) found that of 540 informed consent forms, only 26 percent actually provided adequate information regarding the nature of the procedure, the risks and benefits associated with the procedure, and the alternatives to the procedure. In addition, there is a difference in what nurses and their patients feel comprise informed consent and what physicians view as informed consent (Thompson & Parrott, 2002). This disconnect can create conflict in the nurse-physician relationship as the nurse takes on the role of patient advocate. One nurse discussed an instance where conflict was created between her and a physician when she informed a patient that a test was not required:

A resident was pushing a patient for a specific test and it was honestly like the patient didn't realize it was, you know, someone who was inner-city, doesn't have a lot of education, doesn't, and, and they just kind of feel like they have to do whatever they're told to do. And you know and I did tell the patient, 'You do have the right not to have this invasive procedure if you don't want it'... and there was a conflict that came out of that...where, you know, the physician said to me 'why did you tell the patient that?' and I replied back, because the patient has the right to decline anything and that's part of my job. I think there is conflict when you're an advocate for your patient and you're not agreeing with, you know, what the physicians wants to do.

Nurses described feeling uncomfortable and frustrated by knowing that physicians are withholding information, which one nurse claims happens “very, very often.” They explain that when physicians withhold information from the patient, nurses are forced to weigh their obligation to their patient against the wishes of the physician. The same situation is created when physicians avoid patients and their families by conducting early morning rounds or refusing to speak with the patient's family. One nurse explains that private physicians “come to make rounds at 6:00 am just to avoid families” while another finds that she has to tell the family “I can page him for you, but I can't make him talk to you,” which she relates to being in “between a rock and a hard place” because nurses cannot legally provide some information

and simply do not have the knowledge required to provide other information.

It is interesting to note the tactics of those nurses who reported not disclosing to the patient. Some nurses reported ways of encouraging patients without directly disclosing withheld medical information. For instance:

The physician's role is to be ultimately responsible and is not something that I envy...[but I] support the patient in getting the information in a different way...encourage them to bring in another party, a family member, a child or husband, and say you know, you may need to consider talking to another physician or changing physicians or getting a second opinion. I try to empower them to get more information and act more assertively on their own.

Another nurse explains her way of managing patients and families as well as her reasons for disclosing withheld information:

Very early in your nursing career, you learn how to dance around things a bit so you learn how to buy some time and you learn to say 'Dr. So and So, after his rounds will be in to speak with you' but there have been times where I have disclosed things to family because I know that nobody else is going to do it and they deserve to know. It has happened. But you know it's worth it, because I've also been a caretaker and a loved one of somebody.

One nurse said that she sees nurses as displaying "passive acceptance...you learn to accept certain decisions that the physician makes and even if you don't agree with it, you accept that they're the physician and you're the nurse." As another nurse states, the "physician always wins" and she implies that nurses spend more time advocating for their patients than should be necessary. As was previously mentioned, this inaction on behalf of the physician can lead to job stress created by role conflict and role ambiguity and can lead to increased "emotional labor" for the nurse, who must manage his/her feelings in a way that is publicly acceptable (Apker & Ray, 2003). In addition, as these participants point out, it can lead to patient dissatisfaction with care.

Eating their Young

Consistent with Morse and Piland's (1981) claim that the most complex nursing relationships are the ones between nurses, the final theme that emerged from the data concerns the adage that nurses "eat their young." This phrase refers to what researchers have termed horizontal violence, bullying, or poor workplace relationships between nurses (Farrell, 2001; Hutchinson, Vickers, Jackson, & Wilkes, 2005, 2006a, 2006b; Hutchinson, Wilkes, Vickers, & Jackson, 2008). One participant observed that:

There is this theory that nurses eat their young. I don't think we mean to but I think that, you know, keeping yourself calm and cool with your patients, that I do think there are times where you're not as calm and cool with your colleagues as you could and should be. I literally saw two nurses come to physical blows... there is a lot of negativity and a lot of resentment that can definitely influence nursing units. There is a lot of dysfunction.

Some of this dysfunction, claims Farrell (2001) can be attributed to nurse's attempting to manage a difficult workload, which requires that they complete a number of tasks within a

certain timeframe. Nurses unable to complete their tasks within their shift may become disgruntled and unpleasant with colleagues. In addition, nurses may feel their limited time is better spent caring for patients as opposed to managing conflict (Vivar, 2006). Age may also play a role in horizontal violence. Various scholars have reported that younger nurses experience higher levels of conflict in their positions as nurses (Almost, 2006; Farrell, 2001; Vivar, 2006), an idea supported by the participants in this study who say that being a junior nurse is “kind of like sink or swim.” The difficulty of being a junior nurse is due in large part to the fact that nurses report that there is no possibility of receiving assistance from senior nursing staff; rather, junior nurses report on the impossibility of fully and successfully integrating into the work environment.

A number of scholars have written on the importance of the nurse-nurse manager relationship and the conflict, and impossibility, which commonly defines this dyad. In fact, Forsyth and McKenzie (2006) suggest that horizontal violence may occur due to the nurse’s inability to resolve job-related complaints with nurse administrators and managers. This seemed to be true for the nurses in this study. One nurse relates the following experience about a series of unresolved conflicts with her nurse manager and how it both emotionally and physically impacted her:

I learned that you couldn’t go to [the nurse manager] and that is fundamentally wrong, when your nurses can’t go to you...and I’ve also learned that why write it up because its not even worth your time because nobody gets back to you, nobody cares, its not even...I don’t waste my time...I’m sitting at my desk and I’m thinking I feel like I’m waiting to exhale. Nothing’s gonna happen to her, she’s not going, and she’s just gonna make your life more miserable as time goes by...To have nobody...to have people point blank tell you we don’t care, we don’t care you’re suffering, we don’t care...as time went by and I was coming into work I would start feeling sick.

Another nurse sums up her experience with her nurse manager in the following statement:

I have gone above my nurse manager’s head to administration and talked to them about the inconsistencies and the, and the pressure on our time and they listened and they agreed, but they don’t ever do anything about it. I think its unfortunately the nature of the best now...I don’t feel like she supports us as nurses...she’s more concerned with the bottom line than she is about nurse satisfaction.

Yet another nurse discusses her nurse supervisor’s role in resolving intergroup conflict between peer nurses.

There are cliques in the department I work in...these cliques have out and out argued with one another. The supervisor doesn’t sit down and talk to the people and they just had to, they work together or came out.

In these excerpts, it is clear that the participants felt a sense of impossibility in managing their relationships with their nurse managers, to the point that they left their positions. Farrell (2001), recognizing the importance of the nurse-nurse manager relationship, asks why managers are generally inactive about addressing the concerns of their subordinates. He claims that it is often the case that nurse managers are promoted without having gained the experience or skills necessary to be successful in their position. Valentine

(2001) found that nurse managers tend to avoid conflict, meaning they arrive at decisions not by confronting the problem, but rather by default. The emergence of this theme is particularly significant given conflict, which can have positive effects, typically leads to negative relational outcomes (Almost, 2006). In their study, Forsyth and McKenzie (2006) found a lack of understanding by managers and administrators of the demands on nurses to be one of the main reasons for dissatisfaction.

Limitations and Directions for Future Research

A significant strength of this research is that it paints a “real world” picture of what life is like for 10 hospital-based nurses. According to the literature, participants’ experiences are quite typical of nursing, regardless of specialty or location. Yet, despite gaining valuable knowledge about the structural divergence issues that occur between and among nurses, physicians, nurse managers, and patients, this study has limitations. First, the sample is not representative of the diverse nursing workforce as it represents only White nurses and only one male nurse. Secondly, this sample consisted of a variety of hospital departments, making it impossible to link any patterns in the findings to the demands of particular specialties (such as oncology or emergency medicine). However, generalizability is not the goal of phenomenological research and the results of this study do provide an understanding of the similar experiences of structural divergence that hospital-based nurses face. Other demographic factors that may influence findings include age, geographic location, and size of the nursing department. While these variables were captured for this study, they were not analyzed with this data set due to because the goal of this research was not to establish a causal link between participant demographics and response. Future comparative studies should explore the relationship between participant demographics and response. An additional limitation is that, while providing valuable insight into the experiences of hospital-based nurses, this study illuminates only the experiences of the nurse-subordinate. Additional studies should explore the experiences of physicians and nurse managers, particularly as related to interpersonal exchanges. Finally, despite their differences, what each caretaker has in common is his/her desire to provide patient care. Therefore, it is important to uncover the ways in which patients experience the conflict that results due to instances of structural divergence and its impact on care providers.

Conclusion

I found four themes to be common regarding hospital-based nurses’ experiences of structural divergence and their management of those experiences and resulting conflicts. These themes included Managing Overload, which addressed nurses’ increasingly burdensome workload; Identifying and Negotiating Boundaries, which provided insight into how nurses communicate with physicians about orders they feel are not within their scope to carry out or that are inconsistent with the nurse’s moral values; and Substituting and Advocating, which detailed nurses’ experiences advocating for patients in the absence of a physician or when physicians choose to withhold medical information. An additional theme emerged during data analysis, eating their Young, which pointed to the often immobilizing conflict that occurs between nurses and their managers.

This study found that structural divergence is a problem for hospital-based nurses across varying hospital departments. Participants explained that increased workload leads to less time for patient care. Participants also expressed a concern that they were treated with disrespect, and often asked to perform duties for which they had not received training or with which they were not comfortable. In addition, participants discussed the emotional labor

associated with playing the role of patient advocate. This study also found that hospital-based nurses often experience poor workplace relationships with their peer nurses. These negative relationships are often unmediated or unsatisfactorily mediated by nurse managers thereby fueling the downward spiral of communication typical in situations of structural divergence.

Despite its limitations, this paper represents a detailed phenomenological effort to explore and describe the experiences of nurses who, despite often feeling overworked, underappreciated, and disrespected, continually work long hours to provide care to ill patients throughout the world. Given the themes that emerged from this study, it is evident that additional research into the experiences of nurses is necessary in order to develop models and methods aimed at alleviating these concerns thus leading to a more positive, satisfactory environment for not only nurses, but their co-workers and patients as well.

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