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I have been to Scutari, to that immense and formidable hospital where Florence Nightingale cared for thousands of British soldiers wounded in the Crimea. Prior to my visit, I had read all about what happened there, but the written accounts of Nightingale’s wartime experiences did not adequately prepare me for the emotional impact of being in this place. As I walked through the long dark corridors, the anguished cries of the sick and dying men still rose, reverberating against unfeeling stone. I could see them piled like so many bloody discarded rags, thrashing and moaning. What consternation Nightingale must have felt upon finding 3,000 men crammed into the Selimiye Army Barracks which served as the hospital. Four miles of beds, tightly crushed together, held the mutilated bodies awaiting Miss Nightingale’s ministrations. The “hospital” had no kitchens, no laboratory, no operating table, no bed linens. It is hard to imagine the conditions at Scutari.

There were no basins, no towels, no soap, no brooms, no mops, no trays, no plates… no knives or forks or spoons. The supply of fuel was constantly deficient. The cooking arrangements were preposterously inadequate, and the laundry was a farce. As for purely medical materials, the tale was no better. Stretchers, splints, bandages—all were lacking; and so were the most ordinary drugs…. The very building itself was radically defective. Huge sewers underlay it, and cesspools loaded with filth wafted their poison into the upper rooms… the walls were thick with dirt; incredible multitudes of vermin swarmed everywhere. (Strachey, 1918/1996, pp. 16–17)

Have any of us in modern nursing ever faced such appalling conditions? So daunting a task? Probably not, unless we have nursed during primitive wartime or disaster conditions. Yet all of us can readily empathize with the enormity of Nightingale’s workload. So many patients, so many urgent needs. Compounding the difficulties presented by the sheer volume of work at Scutari was the scathing hostility of the men in authority. The intrusion of Nightingale and her small band of nurses into the all-male military environment was greeted with derision. Obstacle after obstacle was placed before her by the unyielding army bureaucracy. Even today, we can identify with such obstacles. We decry “the system” that prevents us from giving the kind of care we long to give. Nightingale also had to deal with conflict and dissension within her own staff—a destructive phenomenon still common in among nurses. At one point, Florence began to believe that none of her colleagues had the proper dedication to the work. From this place of filth, horror, and death, a discouraged Nightingale wrote in an early

But you know the rest of the story. She did not abandon hope. Enshrined in the lore of nursing history are the incredible achievements of Nightingale at Scutari. With energy, vision, and astute management of people and resources, the mortality rate of the soldiers was reduced from 42% to 2% in 6 months. Scutari was transformed to a place of caring, order, and cleanliness. For these remarkable achievements Nightingale was accorded the attributes of near-sainthood. An ideal image of nurse entered the psyche of the British people: the gentle "lady with the lamp."

Less well known is the force of Nightingale’s anger. Late at night in her little room in the Northwest Tower of Selimiye Barracks, she vented that anger in a torrent of letters that document its extent and force. She minced no words as she described the privations of Scutari to the people back home in England: "No sufficient preparations have been made for proper care of the wounded. Not only are there not sufficient surgeons . . . not only are there no dressers and nurses . . . there is not even linen to make bandages . . . the commonest appliances of a workhouse sick-ward are wanting" (Woodham-Smith, 1951, p. 85). Nightingale passionately advocated for better sanitation, nutrition, and medical care for the British soldiers. Her missives were successful in capturing the attention of the public and kindling their rage as well. For Nightingale, anger was a powerful tool: “I do well to be angry,” she said (Strachey, 1996, p. 31).

These words could easily be ours, as we look down the corridors of our own Scutari in the 21st century. Again, nurses are facing chaos, vast human need, lack of resources to give proper care, unresponsive bureaucracy, and a highly stressful work environment. Today’s nurses feel embattled, assaulted, and literally on the firing line. Notes RN Wanda Hooper, “Workplace violence was all but non-existent 25 or more years ago, but it is a very real part of the environment today. It takes many forms, and nurses have been injured, even killed, while practicing” (2003, p. 4). As I was writing this book, nurse Peter Wright was killed, while on duty, at a Georgia hospital, by a man who mistakenly blamed the nurse for his mother’s death (“Ex-teacher . . .,” 2008). Wright was shot in the chest and head as he tried to leave the hospital room where the gunman had cornered him. For the 6-year period between 1993 and 1999, there were 429,100 violent crimes against nurses on duty (U.S. Department of Justice, 2001). Nurses experienced workplace crime at a rate 72% higher than medical technicians and at twice the rate of other health care workers. Other safety issues have produced mounting concern. In the course of a day’s work, there could be a needlestick injury, a career-ending back injury, or exposure to virulent infectious diseases. Newly licensed RNs studied by Christine Kovner and her team (2007) provided fresh evidence of the hazardous work environment: In their first year of practice, 25% sustained at least one needlestick, 39% at least one sprain or strain, 21% a laceration, 46% a contusion, and 62% verbal abuse on the job (Kovner, Brewer, Fairchild, Poornima, Kim, & Djukic, 2007).

Even if we have escaped threats to life and limb, all too often we leave the workplace bone-tired and soul-weary, trying to shake off the sticky residue of moral distress—that awful realization that we could not give patients the care they deserved. It is not surprising that high scores on burnout were found in a study of more than 43,000 nurses from 700 hospitals in the United States and
four other countries (Aiken, Clarke, Sloane, & Sochalski, 2001). In fact, two in ten U.S. nurses told the researchers they planned to quit their jobs within the year. Among nurses younger than 30, one in three said they intended to leave. When they leave, an already critical nursing shortage will intensify, severely impacting the quality of patient care. By 2020, it is estimated that the United States will face a nursing shortage as high as 1.5 million (Bleich et al., 2003). Its timing couldn’t be worse, as 78 million aging baby boomers are beginning to escalate demands on the health care system (Jacoby, 2003). And simply producing more graduates is not the answer. Dispirited recent graduates are leaving the profession at rates even faster than their predecessors (Sochalski, 2002). They cite the stressful work environment as the cause.

Thus, we have a disturbing situation that calls for innovative ideas and constructive actions. Nurses’ anger about this situation is justifiable. We feel unsafe and unsupported. But our anger is not channeled into constructive actions. It eats away at us inside and takes its toll in fatigue, physical health problems, depression, and substance abuse. It spills over to our own peers, corroding relationships. It even spills over to students (the insidious phenomenon of “eating our young”), as we discuss in Chapter 5.

Like Nightingale, can we do well to be angry? Can we transform our anger into something positive? I think we can. Nightingale’s words challenge us to “do the thing that is good, whether it is ‘suitable for a woman’ or not” (Nightingale, 1859). She decried the societal characterization of nurses as self-sacrificing and subservient: “No man, not even a doctor, ever gives any other definition of what a nurse should be than this—‘devoted and obedient.’ This definition would do just as well for a porter. It might even do for a horse” (Woodham-Smith, 1951). Like the founder of modern nursing, today’s practicing nurses—women and men—must speak out passionately about our concerns. Our anger can be a catalyst for personal and professional empowerment. This book charts the course toward a reenergized, powerful, professional workforce. Like Nightingale, we must use sophisticated political strategies to accomplish our goals. Like Nightingale, we must mobilize the power of the pen—and more modern media—to galvanize the support of the public. Our voices have been silent too long (Buress & Gordon, 2000). Let us heed Nightingale’s admonition to carry on her fight: “I am now entirely a prisoner in my room from illness; but none the less I cry out to you ‘charge, charge! On, on.’” (Bishop, 1957).
A book is always birthed for a reason. This one is born out of the suffering of many of you, my nurse colleagues, all across America. After hearing your stress, fury, and pain in countless workshops and sifting through hundreds of pages of interview transcripts gathered by my research team, I knew that I must write this book. When I wrote the first edition in 1997, I hoped that my suggestions would prove useful. It seems that they were, because the book sold well upon its release in 1998 and upon the publication of its second edition in 2004. While I am honored that the book was well received, it is time to update some of the content. The societal context is different now.

New and very stressful challenges face all of us. Americans were stunned by the events of September 11, 2001, unable to grasp the awful reality that a small band of terrorists had succeeded in penetrating the most visible symbols of our industrial prominence and military power, killing thousands of innocent civilians in the process. My friends at Springer Publishing watched in horror from the roof of their building in New York City as the World Trade Center crumbled before their eyes. Across the country, millions of Americans were glued to television sets, trying to comprehend what we thought must be a “very bad nightmare” or “freak accident” (Thomas, 2003a). We were thrust into an era of unprecedented insecurity and a strange new kind of war with no predictable end point. None of us will ever be the same again (Thomas, 2003a).

Other disturbing trends are dampening Americans’ customary optimism. Violent crime has penetrated our children’s schools and bloodied university campuses—even a department of nursing, where three nursing instructors were murdered by a failing student. The economy has worsened. Health disparities between the insured and uninsured have widened. Too many children are going to bed hungry, and too many patients with mental illness languish in jails instead receiving the care they need in treatment facilities. Fewer than one-quarter (21.6%) of Americans between the ages of 25 and 74 are considered to be “flourishing”—that is, living enthusiastically and functioning well both psychologically and socially (Keyes, 2003). Confidence in business has eroded with each new revelation of unscrupulous behavior by executives, accountants, and board members. In the morning papers, we read of dishonest journalists, predatory priests, and corrupt politicians. In what—or whom—can we trust? How can we recover a sense of hope for the future?

Given the uncertainty of these times, many people are rediscovering existential philosophy. I have had an affinity for existential philosophy since I was an unhappy 16-year-old reading Sartre’s Being and Nothingness (1956). I was bedeviled by questions about meaning in life, death, isolation, and freedom—those
“givens” of existence that Irvin Yalom (2002) has addressed in much of his writing. What I gained from my study of the existential philosophers was a clear understanding that life is difficult, and we can never be completely free from anxiety. We are often thrown into dreadful circumstances that could sap us of hope. And the future is simply unfathomable. There is no guarantee that we will ever achieve our dreams. But we can choose to go on, one day at a time, imbuing our daily existence with meaning through fulfilling work and relationships.

Work is an integral component of a meaningful life. Yet Americans are finding their jobs more stressful than ever. In the American Psychological Association’s 2007 stress survey, 74% of respondents reported work as their number 1 stressor (compared to 59% in 2006) (Anderson, 2008). You and I chose the nursing profession because it promised to meet our need to make a contribution. It still does—in many ways. But a registered nurse today is three to four times as likely to be dissatisfied than the average American worker (Corbett, 2003). Dissatisfaction is especially acute for RNs on the front lines, delivering patient care as hospital staff nurses. Research by Sochalski (2002) found staff nurses to be the least satisfied among all nursing positions. Their dissatisfaction is driven by a host of factors that we examine in this book. One of those factors, sad to say, is conflict with other nurses. Although institutions are undertaking a number of measures to make the work environment more satisfying, only nurses can bring a halt to our own infighting (Thomas, 2003b). A transformation must take place in nursing, a transformation in the hearts and minds of individual nurses that ultimately creates peace and harmony in our relationships with one another. If we do not link arms to face today’s formidable challenges, nursing’s future could be in jeopardy. Nightingale warned us that “No system can endure that does not march.” And marchers must be in step with one another.

In this book, I share with you what I know about dealing with stress and anger. Much of what I know is drawn from my research on nurses and their work environment (see Epilogue for detailed information about the research). My studies on nurses were prompted by the discovery that nurses and other human service professionals scored highest among occupational groups on overall anger proneness. I wanted to know what this anger was about and how nurses handled it. Admittedly, I too, have wrestled with virtually all of the anger-provoking situations our study participants described. Much of my learning has been acquired in the crucible of tough life experience. In these pages, bits of my own story are interwoven with fascinating glimpses of the work lives of dozens of other nurses. This book is written to give you hope—and confidence that you can surmount the difficulties you are facing. Bad things are happening, but better things can be done.

In Part I, we uncover the causes and consequences of nurses’ stress and anger, then move on to more productive anger styles and empowerment strategies. But emotional healing cannot take place without mending relationships with colleagues, so in Part II we focus on connecting in deeper, more satisfying ways with other nurses and physicians. Forging alliances with patients is also crucial. Part III provides a wealth of suggestions to help you transcend the legacy of a painful or abusive past, in order to achieve healing. Caring for the self receives strong emphasis, because it is the self that nurses so often sacrifice. Part IV is all about claiming our power, solving the profession’s problems, and dreaming our future. I will tell you now that I think our future is a bright one, so this is unequivocally a hopeful book.
Introduction

Just a few more words of introduction, and then we’ll get right to our task. First, let me say that this book is useful for you whether you work in a hospital, outpatient setting, or educational institution. Maybe you do home health or telegenursing. Maybe you have a private practice. I would not even presume to list all of the diverse settings in which today’s nurses have found a niche. But nursing’s issues are not confined to any particular work site. Nor are they confined to American nurses. My international travels reveal commonalities among nurses around the globe. What we explore in this book are universal issues.

I also believe that you will find the book valuable whether you are male or female. As I wrote it, I was ever-mindful that not all nurses are women. Too much of nursing’s literature has been addressed to the “sisterhood” of women, ignoring the men in the profession. I have tried to avoid feminine pronouns, but do forgive me if I inadvertently slipped once or twice. Next, let me explain my use of the term “patients” for the recipients of nursing services. Although debates continue about the proper term (clients, customers, consumers), I mainly use the term patients. By using this term, I am not implying dependency or lack of ability to enter into a relationship of mutuality with caregivers. But think about it: Patients really don’t have the freedom of choice that a consumer has. Insurers and physicians often mandate the use of specified hospitals and diagnostic facilities. A hospitalized journalist wondered why patients came to be called “consumers” in the first place: “I can tell you that when you’re lying there trying to remember what feeling good feels like, you’re not a consumer. You are not shopping. You are spending, mostly expending, more energy than you have on things that you should not have to worry about. The crisis that brought you to the hospital is all that should be on your mind, not being safe, or clean, or ignored” (Abramson, 1996, p. 29).

Although RNs comprise my intended audience, hospital executives will also find this book enlightening. According to a report produced by the Health Research Institute at PricewaterhouseCoopers, hospital executives “are in a state of denial about nurse dissatisfaction” (Nelson, 2007, p. 19). After reading the words of dozens of nurses who vividly describe their dissatisfaction, denial cannot be sustained. Throughout the book, I will be drawing from several studies of nurses and patients in which I served as the principal investigator or as a co-investigator. Unless indicated otherwise, all of the nurses’ words are taken verbatim from interviews by my research teams or from stories spontaneously shared with me by nurses at workshops or professional meetings. Since publication of the first edition of the book in 1998, I have made presentations in more than 30 states. I hear stories everywhere I go. Often, these stories continue to tug at my heart as I wait for an airplane to take me somewhere else.

All names appearing in the text are pseudonyms unless individuals gave permission for their real names to appear. I am grateful to a number of noted nursing leaders from the American Academy of Nursing who contributed stories of transforming their own stress, anger, and pain. Contributors from the Academy included Angela Barron McBride, Wanda Mohr, Dan Pesut, Phyllis Stern, Rosalee Yeaworth, Dixie Koldjeski, Jeanne Quint Benoliel, Joellen Hawkins, Barbara Barnum, Sharon Valente, Luther Christman, and Hildegard Peplau. They gave permission for their real names to appear, and I thank them for allowing their wisdom to grace these pages.
Uncovering the Layers of Nurses’ Stress and Anger
American nurses are frustrated, stressed, and angry. And they are hurting. Seasoned RNs I talk with at conferences and meetings sound more weary, disheartened, and cynical than ever before. And new graduates become disillusioned very rapidly: Hospital turnover rates range from 35% to 61% for new graduates during their first year (Casey, Fink, Krugman, & Probst, 2004). In survey after survey, high percentages of RNs voice alarm about unsafe staffing and report decreased quality of care at their facilities. For example, 75% of nurses in an American Nurses Association (ANA) survey felt that deteriorating working conditions had impacted patient care; over half of them said they would not recommend the profession to their children or their friends (“Nurses concerned,” 2001). In a 2008 ANA survey, involving over 10,000 RNs, 73% reported insufficient staffing on their units, and over half were considering leaving their positions (see www.safestaffingsaveslives.org). Even during the upheavals created by Medicare’s DRGs in the 1980s and the misguided nurse layoffs during hospital “reengineering” and “downsizing” in the 1990s, there was not such
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widespread distress. What is fueling all this stress? Listen to the words of nurses:

You’ve always got at least 100 things going through your mind at one time. The frustration for me is when I know that I’m giving 100%, running 90 [miles per hour], doing everything I can possibly do, and I have not been to the bathroom in 10 hours, haven’t even thought about the possibility of a lunch break—that was out of my mind a long time ago—and you’re busting your tail end and people are still unhappy.

Patients are not receiving the quality of care that they should receive. We have a lot of patients who are on tube feeding and have diarrhea, sometimes constantly, sometimes around the clock. It takes more than one person to do the cleaning, and I find it really frustrating trying to find other staff who could take a minute or two to help you out. There are no techs to help us do these things, and patients do not get turned as often as they should have, do not get cleaned as often as they should have. It isn’t right. It isn’t fair to the patient or the patient’s family. I could be really sympathetic to the patients and the patient’s family because 7 years prior to graduating from nursing school, my mother died from lung cancer after a long battle with it… When I look at a patient lying there in bed, I see my mother in their eyes, and I expect the care for that patient to be what I would have wanted for my mother, and so often it isn’t.

When I first started in nursing 12 years ago, I thought it was a profession, and I don’t feel like it is anymore. I think the professionalism is pretty much gone, as in being the patient advocate and taking care of the patient and doing the best you can for the patient. With all the rules and regulations of insurance and TennCare [the Tennessee version of Medicaid], OSHA, Joint Commission, and the lawsuits and lawyers, it’s “Am I following this rule, am I following that rule, am I going to get sued over this or that?” You worry more about people complaining, wanting to file lawsuits or calling and complaining to your manager about their care, even when it was not warranted. I think it has turned tremendously away from the skills of nursing to the paperwork of nursing, and the covering your butt of nursing, and following the rules for so many commissions and agencies and hospitals. It’s just a very different environment than it was 12 years ago. When I first started, I had that nurse-itis where you think you can really make such a difference… now I realize I’m taking care of 5 and 7 people at a time, you do the best you can, you go as fast as you can, as hard as you can, for 12 hours, try to keep within all these guidelines and try to keep everybody happy, not just the patients, but fellow coworkers, management, hospital, patients’ family, physicians, and now you have so many sub-areas of the hospital: lab, X-ray, CT, ultrasound. I find it very, very trying to keep all these people in check.

It’s gotten too mechanized. Charting nowadays is not what it used to be, we get in a hurry, there’s check marks [for the vital signs], there’s a lot of times that you don’t think of the patient, what he looks like, how he’s feeling. You ask a question about pain, check boxes, it has nothing to do with what the patient looks like, what your instinct is telling you…. It’s not the hands-on feely touchy that nursing really has to be.
I’ve been a nurse thirty-some years. I can remember when we actually sat down and taught patients to give their own insulin and things such as that. Now, things seem to be so much more hurried. We have less staff. It’s imperative to get patients in and out, and we don’t get to sit down and talk to them and really explain things. We don’t have time to answer their questions. We used to educate them on every medication: If you give them Lanoxin, you tell them to take their pulse, if it’s below 60 don’t take it that day. Different things like that. Now, you don’t do that. You just hand them their leaflets and they go. And half the time if people come in with a pulse of 40 and they’re on dig, you say, “has anyone ever explained to you about this medication?” Most of them say “no.”

I don’t think nursing has changed but I think the other aspects of health care have changed. . . . Everything’s more cost conscious. . . . They have all the new equipment and machines to treat people with but after they find out what’s wrong, they just toss ’em to the wind, saying “go away.” A lot of these people, especially people who can’t read or write or have no family, can’t just be tossed to the wind. I get real frustrated because I know that they cannot be compliant, a lot of them do not have anyone to help them at home, and the way the laws are with home health, they won’t go in and check on ’em. . . . You try to talk to ’em but you’ve only got so much time, and then after they leave, you don’t have anybody checking on them in the community and [ascertaining] why they don’t want to take their medicine or the reason they keep smoking or why they’re so anxious or whatever. It seems like nobody cares about that anymore. They’ve got the big things solved but not the little things. Nobody really cares ’cause it’s all into cost containment now. I don’t think it’s just that way here. I think it’s that way everywhere.

The stories of these six nurses are just a few of the ones that I, along with the members of my research teams, have collected from nurses across the country. And there are thousands more RNs who have their own tales of injustice, outrage, and emotional pain. Undoubtedly, you have some stories of your own, whether you are a staff nurse, administrator, or educator. I do too.

Although it’s comforting to know that we’re not alone in our pain, this book is not about bemoaning our lot and licking our wounds. This book is about managing our stress and doing something positive with our anger. But, as we do in clinical practice, we must assess before we take action. We must unpeel the layers of nurses’ tangled emotions.

The nurses’ stories that we examine in this first chapter illustrate the complexity of RN stress and anger. The intertwining of stress-producing institutional factors (such as hierarchy, bureaucracy) and individual characteristics (such as RNs’ perceived powerlessness) complicates matters tremendously. Nurses know a lot about stress management. After all, we teach our patients relaxation, imagery, and other stress-relieving techniques. I argue, however, that simplistic stress management strategies will not work to address the disheartening work environment that nurses face today. Sorry, but deep breathing and muscle relaxation just won’t cut it. System problems will require system solutions, as
Transforming Nurses’ Stress and Anger

Where does anger come into the picture? Anger is the emotional response to stress. For example, our “anger titer” rises when we are stretched too thinly by multiple demands on our energy and time. Nurses’ anger is triggered for other reasons too, such as violations of our rights as human beings. Too many nurses are literally inflamed with anger that they cannot manage effectively, and it’s burning them out. Let’s examine the themes and patterns of nurses’ stress and anger that I’ve observed from Knoxville to Nevada. As you read the compelling words of your RN colleagues, reflect on your own experience. Do you resonate with the themes we discovered through our research?

Themes and Patterns of Nurses’ Stress and Anger

- I feel overloaded and overwhelmed.
- I am not treated with respect.
- I am blamed and scapegoated.
- I feel powerless.
- I am not being heard.
- I feel morally sick.
- I am not getting any support.

“I Feel Overloaded and Overwhelmed”

The first theme, not surprisingly, pertains to heavy workload, overwhelming demands, and constant time pressure. A foreshadowing of this theme was apparent in the first quotation used at the beginning of this chapter. Here are the words of other RNs:

_I had a ridiculous assignment. They were the worst patients on the floor. Some were on one end of the hall and some on the other end. One was totally confused. One was dying, and I had a lady across the hall that was a new stroke. And then I had an elderly lady that was 90 years old that had just had a fractured hip. And I said, “Wait a minute, now I am not an Olympic sprinter here. There’s no way I can do all these people.” So the secretary said to me, “What are you doing, causing trouble?”_

One nurse in our study recounted feeling like a robot “that somebody just pressed the button and said, ‘go’ . . . I just felt overwhelmed. I jumped from one room to the next trying to meet these patients’ needs. I couldn’t do this for this number of patients.” Another related: “Everybody expected Supernurses. I wanted to live up to the expectation. I tried hard, but I would go home frustrated. The patient load was so heavy. I don’t feel like I did the care they deserved. I would get really angry.”

Inability to take time for breaks and meals was a common complaint of our study participants. Even skipping breaks, many nurses weren’t able to complete their patient care within the specified hours of their shift. Some spoke of working
as many as 3 hours extra after a 12-hour shift and then returning the next day, tired before their new shift even began.

1.1. A sense of utter futility at meeting impossible demands was evident in the words of this RN:

“I think of the fairy tale Rumpelstiltskin, where they would put the person in the room full of straw every night and say ‘Produce gold!’ That’s how I feel. I feel like I’m in that room full of straw and I’m being asked to produce gold.”

Forced “floating” is a frequently mentioned frustration. Like medicine, nursing has become highly specialized, and nurses pride themselves on their clinical expertise and technical proficiency within their own specialty area. RNs are angry about being given responsibilities when they lack the knowledge to assume them. For many years, my specialty area has been psychiatric nursing. I remember my anger when I was pulled from the psychiatric unit one day and assigned a patient who was to have a blood transfusion. Frantically, I thumbed through the unit’s procedure books to refresh my rusty knowledge (we don’t give blood on the psych unit!). This story has a happy ending: I hovered over that patient, paying scrupulous attention to his vital signs, and he had no adverse reaction to the blood. But I remember thinking, “Why am I here? This is crazy! A nurse is not a nurse is not a nurse.” So, I readily empathized with all of you who told me stories about forced “floating” to units outside your specialty areas. Indignantly, one nurse told of being required to rotate among five units. Another sustained a leg fracture while scrambling to hook up a new type of monitor she had never been oriented to use. These accounts are illustrative:

I would be floated to orthopedics… given a 5-minute in-service on a complex drain, different kinds of medication, two different pumps… and left with that patient, plus eight other patients. And that really, really, really angered me.

My background was women’s health. I’d done intensive care before, but it had been a long time, and the particular respirators they were using were different from the respirators I had used.

Mandatory overtime is bitterly resented. Employers of RNs began this practice in the late 1990s; by 2002 two-thirds of nurses were being required to work some mandatory or unplanned overtime every month (Foley, 2002). Nurses are told they will be fired if they refuse to do so. This practice not only contributes to nurses’ fatigue and job dissatisfaction but also to the possibility of errors in clinical judgment that jeopardize patients. Research by Anne Rogers and her colleagues showed that when nurses work more than 12.5 hours, the likelihood of making an error is more than three times as high (Rogers, Hwang, Scott, Aiken, & Dinges, 2004). New York RN Julie Semente told a journalist: “After a 12-hour shift, you can’t see straight. You stand there looking at this medication sheet and then at the patient, and you’re saying, ‘May God help me. Please don’t let me make a mistake with a decimal point’” (Pekkanen, 2003, pp. 88–89).

Unquestionably, stress in the work environment has escalated because of the acute nursing shortage. As shown in the words of our study participants, the nurses remaining on the job must do more and more with less and less. Their
job satisfaction soon plummets. Nurses in hospitals with the highest patient workloads are twice as likely to be dissatisfied with their jobs and more than twice as likely to experience burnout, compared with nurses in better-staffed hospitals (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). As Unruh (2008, p. 64) pointed out: “It’s a vicious cycle: inadequate staffing leads to reduced job performance and diminished patient and nurse satisfaction; the resulting burnout and high turnover rates worsen staffing levels.”

Nurses in academia are encountering new pressures too. Faculty are expected to pull in research dollars or collect fees for clinical services in addition to their teaching, advising, and publishing. Remember the phrase “publish or perish”? That’s not the half of it in today’s financially strapped colleges and universities. Many faculty resonate with the it’s-so-funny-it-hurts comparison to the Pushmi-Pullu presented in a witty article by Judith Vessey and Susan Gennaro (1992). Borrowing from the menagerie of Dr. Dolittle, they selected this two-headed animal to represent the faculty member who must do two sets of tasks at the same time. The greater the amount of pushing and pulling on the beast, the greater the internal dissension and conflict. The number of Pushmi-Pullus in the halls of academe has increased exponentially in the tight fiscal environment of modern universities, and the species is not likely to become extinct in the near future.

Carol Carter has been a nurse educator for the past 5 years, but she still works part-time in her clinical specialty area in a hospital also. She enjoys caring for the patients but resents the university’s failure to give her time to do this work: “They don’t give you any time off. Your regular workload is still expected of you. You have to do it on weekends or evening shifts. It makes my evaluation look good, but it makes me angry that we’re in a rat race again. Some days, it’s like I’m between a rock and a hard place. I have all these student papers to grade and school commitments and family commitments. It’s running me down. Some days, some weeks I feel angry.”

“I Am Not Treated With Respect”

Uncivil or demeaning treatment provokes much anger within the nursing profession. When my research team conducted interviews with nurses, many narratives of being patronized, chastised, and scolded were elicited. Offenders included physicians, supervisors, faculty, and peers. Some nurses attributed such treatment to their age, race, gender, sexual orientation, or position in the institutional hierarchy. Others remained bewildered, unable to find any rationale for the disrespectful treatment they received. Mike Evans’s story is a good example. Mike is an ICU-CCU nurse with 12 years of experience. He told of a physician who “thrashed me verbally in front of my peers. . . . It was a bizarre reaction on his part. I didn’t feel deserving of any criticism. His outburst was totally unprofessional and unwarranted. I really had no idea what had set him off.” The incident was especially galling because the “thrashing” took place in front of his colleagues.

Bob Hayes’s story also took place in the ICU setting, but his attacker was a nursing supervisor, not a physician. Bob’s patient had been in an auto accident and had both arms in casts. The physician was examining the casts and the circulation in the patient’s fingers, when Bob’s supervisor came flying into the
unit and started yanking curtains around the patient’s bed, berating Bob for violating the patient’s right to privacy. Bob relates, “I didn’t feel the need [to close the curtains] because the patient was not exposed, there was no procedure. There was nothing going on that would be offensive to anyone. The patient was not bloody or gory. And she [the supervisor] comes in and makes this big fuss. Embarrasses me in front of the doctor, my coworkers, and the family members. She raised her voice and there was no need for that. She could have called me to the side. Raising her voice made me angry. I was feeling embarrassed and humiliated. I just wanted to clock out and head for the house.”

This incident was only one of many that occurred soon after Bob graduated. He grappled with feelings of incompetence when his rigid, stern supervisor continued to criticize his performance, and he thought seriously about leaving the profession: “I almost threw in the towel. I almost quit and went back to K-Mart. But I knew I would be wasting 4 years of my life.” Much has already been written about the crucial transition from the role of nursing student to new graduate. Plenty of research evidence shows that the graduate experiences “reality shock,” (Kramer, 1974), a “crisis of competence” (Cherniss, 1995), and self-doubt about the ability to perform procedures (Casey et al., 2004). But 40% of newly licensed RNs report that “seldom” or “never” did anyone show them how to work successfully in their institutions (Kovner et al., 2007).

Support from more experienced nurses could be vital to the novice in that important first year of practice. Yet, many new RNs in our study reported they had been treated disrespectfully, adding to their stress. For example, Eve Sanders vividly recalled being “picked on” by an older nurse in her first job as a new graduate: “I was still young, 23. And it was a very intimidating experience. She was a bit older, very pushy, bossy, telling me that is not the right way to make a bed…something I had been doing for some time…treating me in an infantile manner.”

Age is no guarantee of respectful treatment. Joy Carpenter was more than twice as old as Eve when a similar incident occurred during her master’s program in midwifery. Despite her maturity and experience, Joy was treated like a child by her preceptor: “One time, she had assigned me to a patient and told me to manage the labor and everything, and so I did vaginal exams when I thought they were appropriate. She called me aside and reprimanded me and scolded me as if I was a child: ‘How dare you do that when I am not in the room?’ I’ve done thousands of vaginal exams in my life, and then all of a sudden, because I’m in the student role I’m not competent to do that anymore.”

Although many of the foregoing stories took place in hospitals, disrespectful treatment of nurses takes place in other locales, as well. Irene Martin is a master’s prepared nurse practitioner who performs contract services for a physician. She was appalled when he questioned her invoice for her time:

_I was very angry because he was not treating me like a professional. He sent me a message through his office manager to tell me that if my invoices were not going to be consistent, then I needed to start to clock in. I can’t stand people to question my integrity. I requested to speak to him to discuss the issue, but he didn’t want to discuss it with me. When he refused to speak to me, that also made me angry._
Sexist Treatment and Sexual Harassment. Under the broad umbrella theme of disrespect, our analysis revealed a strong subtheme of sexist treatment and sexual harassment—frequently reported by both female and male RNs. Much more has been written about discriminatory treatment of females, because for most of the profession’s history, nurses have been female and physicians and hospital administrators male. Florence Nightingale was keenly aware of sexual harassment and noted that “no male hospital administrator or official … would intervene on the side of a woman [against] a higher status male, for example a physician or surgeon” (cited in Mrkwicka, 1994). Bullough (1990) calls sexual harassment a dominant theme in American nursing, noting how frequently incidents of it were reported in the biographies of noted nursing administrators and educators. In American Nursing: A Biographical Dictionary (Bullough, Church, & Stein, 1988), there are numerous accounts of female nurses running into trouble with male colleagues and either quitting or being fired. While I was in nursing school many years ago, I remember how frequently my classmates and I experienced physician harassment, including speculation about our sex lives and jokes about our bra size. It was not unusual for doctors to grab our breasts when we were scrubbing for surgery or to make propositions. Once a psychiatrist exposed himself to me in his office at the mental hospital where we did our psychiatric rotation. Most of these incidents were shared only with our classmates, because no one dared to confront a powerful male doctor.

Sexual harassment is illegal now, under Title VII of the Civil Rights Act, but studies document that it continues. More than 70% of the female staff nurses surveyed by Libbus and Bowman (1997) reported sexual harassment. Many episodes involved inappropriate touching, although the number one form of harassment was a sexual remark. Although nurses become angry at such offensive behavior, they still fear humiliation, retaliation, or job loss if they report the harasser. One study of nurses found that the greater the nurse’s distress, the less likely the incident would be reported (American Nurses Association, 1993). The nurse may fear that it is his or her fault for not setting appropriate limits—or may not understand what those limits are. Complicating matters is the unspoken norm on some units that a little flirting is useful in cajoling irate physicians. In the ICU, Bob Hayes observed a lot of physician–nurse “rubbing and massaging each other … in an inappropriate, nonprofessional way.” Similarly, in the labor and delivery department Joy Carpenter related, “I saw other nurses being touched in ways that were just totally inappropriate … physicians feeling that they had a right to do that…. Don’t ask me how I did it, but I just knew how to maneuver and get away from them.” Greg James resented a female colleague trying to use her “womanly wiles” on him: “She does it with doctors all the time, and they eat it up. I don’t. She can’t control me like that. All that did was make me very angry at her for being so unprofessional. She’s a thorn in my side.”

A 2003 study substantiates continuing sexual harassment of nurses and nursing students (Bronner, Peretz, & Ehrenfeld, 2003). Participants were queried about seven types of harassment, ranging from minor (dirty sex jokes) to more intrusive (physical touch) to severe (attempts to have sexual relations). Ninety-one percent of the participants experienced at least one type of harassment; 30% experienced at least four types. Seventy-five percent of the
perpetrators were men harassing women. But the male nurses in this study (20% of the sample) received more severe types of sexual harassment (being forced to touch someone intimately in a way that is not required by the nursing role, and suggestions to have sex against their will).

Disrespect of Men in Nursing. Men in nursing certainly have ample justification for anger. Historically, they have experienced rampant discrimination, including insinuations of homosexuality, denial of opportunity to practice in some clinical settings, and exclusion from the Army Nurse Corps for nearly half a century. They often face the double whammy of being discriminated against by other men as well as their female nurse colleagues. Although men had been prominent in nursing during the Middle Ages and the Renaissance, the modern image of the “ideal nurse” was feminized as the Nightingale system of training nurses swept the world. When Christian Hospital in St. Louis admitted a male nursing student in 1908, the Missouri State Board “declared that the ‘young man’ did not fit into the group, and as a result he left the school” (Aldag & Christensen, 1967, p. 375). Despite their chilly welcome, small numbers of men continued to enter the profession, mostly attending all-male schools such as the Mills School of Male Nurses. Even within schools such as these, men encountered discrimination. Legendary nursing leader Luther Christman, speaking of his student days at the School of Nursing for Men of the Pennsylvania Hospital, remembers:

*It did not take me long to realize that men were a minority in the profession and were viewed with suspicion by female nurses. . . . I was called a pervert for answering a urologist’s request to examine a specimen under a cystoscope while in the presence of a fully draped female patient and female nurse. A similar reaction occurred when I requested a maternity experience. . . . I was denied because of my gender.* (Christman, 1988, p. 45)

Males in nursing are often slotted into specialty areas that are seen as “masculine,” such as the emergency department or administration, rather than obstetrics or general floor duty. A man interviewed by Williams (1995) had always aspired to working in OB/GYN but was prevented from participating in that rotation in nursing school and assigned tasks that demanded physical strength instead. Donald Bille went on active duty in the Army Nurse Corps in 1966 after completing his BS degree. He requested the Army’s school for public health nursing when he finished basic training. But, the first day of the course he was told that the only public health care he could do was changing Foley catheters on the retired Army population, and any care involving women would require a chaperone. He asked for reassignment (Cooper, 1997).

Prominent nurse leader Tim Porter-O’Grady writes of “quiet, unspoken and insidious” reverse discrimination against male RNs (1995, p. 56). He says it is very challenging for men to break into the “old girls club.” Males are expected to assume leadership roles, but when they prove successful in these roles, that success is attributed to their maleness: “he is a man and . . . he is somehow advantaged because he is” (p. 57). Further reproach results from the assumption that he has prevented an equally qualified woman from obtaining that leadership position. Discriminatory treatment has undoubtedly been a factor in the relatively slow increase in the proportion of men in nursing (currently only 5.4%
of RNs) (Spratley, Johnson, Sochalski, Fritz, & Spencer, 2000). Even today, men in nursing hear comments such as, “Surely you’re going to pursue your MD!” or “Why nursing?” Data from the National Sample Survey of Registered Nurses showed that men were less satisfied in nursing than women were. Even those in advanced practice roles were less satisfied than women (Sochalski, 2002). This dissatisfaction, if widely communicated, could inhibit the recruitment of men to the profession. Men who participated in a study by our research team expressed anger over female nursing colleagues treating them differently because of their gender, calling on them for their “heave-ho-ness” rather than their knowledge (A. Brooks, Thomas, & Droppleman, 1996). Greg James, manager of a med-surg floor, reported that “if there’s anybody heavy to be lifted, even as a manager, I would be called to help lift them because I’m a male, instead of the carriers being called.” Some men felt excluded from the “sorority” of female nurses and compared themselves to members of other minority groups who are forced to try harder to validate their worth.

Disrespect of Minorities in Nursing. African American nurses surely identify with the feelings about discriminatory treatment expressed by the men. Many of those in our study talked of feeling excluded by the White majority and having to constantly prove themselves. Georgia Preston’s words were typical:

I first started out as an LPN. I was the only African American woman in the class. The instructor tried everything to encourage me to drop out. And I recall one OB test that I made 100 on. She just couldn’t believe that I made 100. She re-tested me. She said, “I just don’t see how you did this.” So, she gave me another test. I made 100 on that one. She never really let up. That continued on, through the 13 months…. Then, a year after that, I started RN school. I went through with a breeze. I was top in my class. I passed state boards with flying colors. And I’ve been a nurse now for a long time. And everywhere you go, you have to really prove yourself. If I go to a new hospital, I have to prove myself like this is my first day…. People judge you just by your color alone…. When I was with [name of hospital], there were two or three black RNs on the floor, and we were taking trays in to the patients. Even the doctors would say, “Oh there come the girls from the kitchen now.” You’d have the name tag on, you’d be dressed like all the others, why would you be the girl from the kitchen? Sometimes I get so mad I can see fire.

Elizabeth Barton, who termed herself, “young, black, and successful,” echoed Geraldine’s complaint of being mistaken for the kitchen help. On one occasion, although she was the instructor, she was questioned about being the student. She has also been mistaken for a nursing assistant. She feels that her colleagues do not respect her. When working with four White nurses, she is the last to be asked to attempt starting an IV. “They’ll say something like, ‘Well, so-and-so tried and she’s good.’ And then I’ll go in and get it on the first attempt. And that’s when they get a different opinion of my abilities. And it just makes me angry trying to figure out why they didn’t ask me in the first place. Was it because I was Black, or was it because I was young, or just what factors did they feel made me less capable of starting an IV? So, most of the time I have to prove myself. It makes me angry that I have to prove myself.”
Fannie Williams, now 58 and a clinical director, recounted a number of episodes of humiliation and abuse during 31 years of employment at the same hospital. She sums up the racism she has encountered in her career: “Racism is like rain; if it’s not falling in your location, it’s gathering force somewhere nearby.”

The “rain of racism” falls on other ethnically diverse nurses as well. Asian nurses—recruited to work in the United States by administrators scrambling to avert the crisis of the RN shortage—have experienced discrimination, marginalization, and exploitation (Xu, 2007). A Filipino nurse “sensed” an unwelcoming attitude from her American peers: “They hate our accent. That’s why they don’t want to work with us. Although they don’t say that, you just sense it” (Lopez, 1990, p. 84). A nurse from India sadly reported, “Nobody learned my name for four months when I first came, and when they did…they shortened it and pronounced it wrong. I finally stopped correcting them” (DiCicco-Bloom, 2004, p. 26). Drawing together the findings of 14 studies of immigrant Asian RNs, Xu (2007) called attention to “worst” patient assignments, harassment, and bullying inflicted by physicians, peers, supervisors, and even subordinates such as aides. The Asian nurses, mostly women, felt that respect was hard to earn. They felt vulnerable because of their soft voices, short statures, and unfamiliarity with many aspects of Western culture and the English language.

A final note about disrespect: By elaborating on the plight of some minorities in detail, I do not wish to minimize the struggles of other groups within nursing that have received egregious mistreatment. See, for example, the stories of lesbian nurses in Giddings and Smith (2001) and Chinn (2008). No one deserves to experience the disrespect that we have discussed in this section of the chapter!

“I Am Blamed and Scapegoated”

The next theme in our data pertained to scapegoating. As if nurses don’t have enough to deal with, just keeping up with their own workload, they also catch the blame for the mistakes and omissions of other health care workers. The lab hasn’t drawn the blood, dietary just fed the patient who’s N.P.O., X-ray didn’t come to get the fellow whose films were to be done before surgery—and the nurse gets the flak. We’ve all been there: it’s infuriating! Lisa Thompson, a clinical director with 30 years of experience, noted the tendency of physicians to attribute blame to “that stupid bunch of nurses on the floor.” She offered the following explanation: “I think somebody has to relieve the pressure, has to be blamed, and more often it’s nursing. They’re quick to be scapegoated. It is so easy to blame the nurse. And that’s especially true in acute care and labor situations. The physician says he’s not responsible: ’The nurse didn’t call me,’ but the nurse reported to him when the first little flicker happened on the fetal monitor. I’ve seen that quite a bit when the physician was not available. They’re quick to let the nurses take the responsibility and take the blame. I think nurses are getting smarter in the way they document and notify, trying to stay out of a bad situation, but there’s still a lot of them who do get caught up in a bad situation.”

Joy Carpenter questioned why a doctor couldn’t own up to his role in an incident that upset a patient’s family: “Why did he have to make us a scapegoat? I had done everything I was supposed to do and followed the rules. It’s
like you never know when you’re going to get the rug pulled out from under you.”

1.2. Mike Evans was devastated by a physician’s accusation of advancing a Swan-Ganz catheter, which he had not done, although he had no way to prove that he hadn’t done it. The situation was especially traumatic for Mike because the physician’s accusation replicated a childhood experience of being unfairly blamed:

“I can still remember a situation when I was barely 6 years old and my [grandmother] found a pair of pants in the living room and went off to my mom raising a big ruckus about how I just stepped out of my pants and left them there. And I hadn’t done it. I had no idea how they got there.”

Eve Sanders described being belittled by physicians and yelled at in the hall. When asked what provoked the physician ire, she related, “Well, I lay it on the line for the patients. I’ve had physicians be angry with me for telling a patient more than the physician wanted them to know at a particular time. I’ve borne the brunt of the physician’s anger, ‘Why did you tell her duh duh duh duh duh?’ ‘Because she wanted to know.’ I have to put myself in the patient’s place. I wish I had more guts to confront the physician. To say, ‘Now look, what you did really hacked me off. You have no right to talk to me that way.”

“I Feel Powerless”

Feelings of powerlessness were pervasive throughout the data we have obtained from nurse interviews. Nurses wanted someone or something to change, but they did not know how to make that happen. They spoke of their powerlessness in many different situations. RNs were angry about not being involved in the redesign of their units, not having a place at the table when decisions were being made, and not having sufficient resources to do their jobs. Some decried the repercussions when they tried to speak out, consistent with descriptions elsewhere in the literature. For example, Iowa RN Colleen Donlin repeatedly reported an electric bed that was shocking staff members. She was told that the hospital did not have the money for repairs in its budget, and a written reprimand was placed in her personnel file because of the way she spoke to her supervisor, which was allegedly “threatening” (Kittle, 2007). Psychiatric nurses in a large public hospital described a similarly intimidating atmosphere that constrained their attempts to change the way their unit was run. After observing negative consequences for speaking out, one RN admitted, “I keep my head low: Anybody that has complained or gone up and spoke their mind... We got burnt” (Shattell, Andes, & Thomas, in press).

Many nurses in our studies seemed to feel that the work environment simply could not be controlled. For example, Eve Sanders spoke about her lack of control when ancillary personnel were pulled from her unit by the supervisor: “Basically, my protest was a meek thing, a meek protest. I could not say to the supervisor, ‘No, you cannot take my aide.’ You know, they did not call to ask, they called to demand.” Likewise, another study participant perceived that there was no choice when her manager mandated her to assume a heavier assignment:
In ICU, your capacity is two patients at the most, because you have fully lined trach-ventilator patients. I walk in; they say "we don’t have anybody. You’re going to have to take these other two patients." And I talk to my manager, "This is a very, very dangerous situation. It’s my license you’re putting on the line.” And the only reply I got was, "You do it or you don’t have a job.”

Carol Carter felt pulled in so many directions, that she could not give good patient care:

I knew the stuff I was taught to do, but I did not have time to do it…. It is like a rat race. We are here to push pills and drugs, but no time to do patient care…. It seems I always fall behind on time and that makes me angry… It is like you are pulled in 20 different directions…. I have no control, no control over the situation.

Joy Carpenter decried the scarcity of resources: “They tell you to do the job, but they don’t give you the wherewithal to get it done.” Bonnie Hartman made a similar complaint: “We don’t always have the supplies we need, and certainly not the quality, because we always get the cheapest—whatever was the lowest bid on the contract.”

Lisa Thompson chafed at closed communication lines and political power struggles in the large teaching hospital where she works as a clinical director:

I have a lot of anger at those higher up in our establishment, because I feel like decisions get made without asking the right people. For Pete’s sake, we learn from the Japanese that even the person on the line can help with these decisions, but we still are not really doing that. Decisions are made that I am perplexed as to how I can make them work. You have to do it because so-and-so said. Communication lines are often closed that really should be open. And there are still a lot of political power struggles that overshadow what really needs to be done.

1.3. Public health nurse Bonnie Hartman decried the capriciousness of decisions that are made on the basis of politics rather than patients’ needs:

I get angry at the system—it’s that feeling of powerlessness. So many of the things we do in public health are tied to politics. We have money for whatever a particular administration wants us to have. We get a new program because it is a pet project of the governor or better yet, his wife! We had lots of money for prenatal care during Governor A’s administration. It was his wife’s project. As soon as the administration changed, the prenatal money was gone. Is this really fair to the people we serve?”

Often, nurses have the knowledge to remedy a problem, but lack the authority to act on it. For example, Ann Smith was well aware that the staffing pattern for her unit was unsafe, but “It took a doctor getting upset to change it and make administration realize that we were functioning unsafely. It’s frustrating to me that a doctor has to come and tell [administration] ‘The unit’s not safe,’ when the nurses are trying to tell that already.” The testimony of study participants
like Ann Smith is consistent with a national study of hospital RNs by Eileen McNeely (1995), in which 85% of the nurses reported “none to very little influence” over decisions about closing a unit to admissions, ordering agency staff, or refusing to float off their floors.

Research shows that nursing jobs with high demand but low decision authority produce stress, negative emotions, and emotional exhaustion, and result in reduced nursing performance (Johnston, Jones, McCann, & McKee, 2008; Steen, Firth, & Bond, 1998). The combination of high demand and low control also contributes to poor physical health, as shown in studies of workers conducted in the United States, Canada, and Europe (e.g., Kuper & Marmot, 2003). In a review of health records of workers in 130 occupations, Stringer (1990) found nurses to have a higher than expected rate of stress-related disorders. Not surprisingly, nursing fell into the group of occupations characterized by high job demands and low control. A study of 21,290 female nurses showed that the declines in health associated with high-demand-low-control jobs are as significant as those associated with smoking and sedentary lifestyles (Cheng, Kawachi, Coakley, Schwartz, & Colditz, 2000). A particularly dangerous combination of factors was identified by Duke researcher Redford Williams and his research team (1997). Women in high-demand-low-control jobs often had a pattern of increased negative emotion (anxiety, anger, and depression), along with reduced social support, and a preponderance of negative versus positive feelings in dealing with their coworkers and supervisors. These factors are known to be predictive of an increased risk of cardiovascular disease as well as mortality from other causes (Williams, Barefoot, Blumenthal, Helms, et al., 1997).

“I Am Not Being Heard”

I consider it the epitome of powerlessness when individuals feel that they do not even have a voice. A female nursing faculty member lamented, “In my particular work situation, we women are absolutely in the minority, a significant minority in a very paternalistic system. It’s a ‘good old boy’ system. It’s Southern, it’s male-dominated, we are referred to as ‘the girls.’ We don’t get the same ear as a unit that’s bringing massive grant money. We just don’t have a voice.” When nurses do try to make their voices heard, too often no one is really listening to them. Geraldine Vincent, an operating room nurse in Hawaii, repeatedly requested that her hospital hire aides to help with moving heavy equipment. Although she has been injured on the job twice in the last 7 years, she cannot get her point across: “There’s no acknowledgment that there has been a shift in the type of work we’re required to do in the operating room…it now requires heavy lifting and moving” (cited in Helmlinger, 1997). Geraldine’s job-related injuries exemplify a national problem—lack of federal legislation—even though nurses incur more strains and sprains than construction workers (Johnson, Martin, & Markle-Elder, 2007).

It was a bit of a surprise to the research team that men were just as likely as women to feel that they are not being heard. Mike Evans spoke of feeling helpless because he was dealing with someone who would not listen. Tom Parker was very frustrated and angry about a chronic problem of heavy assignments. His female colleague always took a lighter load. Over time, this inequity rubbed Tom the wrong way: “Sort of like an ill-fitting pair of shoes. You can get by with
them for awhile, but after awhile, they’re going to rub a sore on your foot, maybe eventually a blister.” When he tried to talk with the other nurse, nothing got resolved. She threw up her hands, saying “I don’t need this” and walked off. Her failure to listen really made him sore. He said, “I don’t like to be just blown off. What I say doesn’t necessarily have to be agreed with, but I want it to be considered. I can tolerate inequity to a point, if I feel like there’s been some kind of communication.”

In Linda Harvey’s case, it was the charge nurse who failed to listen—to her legitimate concerns about a patient’s condition. Linda relates, “I had a patient who had had a stomach stapling, and something happened that she wasn’t absorbing the nutrition. So, what they had to do was go back and redo some of that….After the surgery, I was her primary nurse. She got along pretty good, but when she was getting ready to go home, all of a sudden she started having God-awful stomach pain. This woman’s not ready to go home. And so I said this to the charge nurse. The charge nurse was a real flippant young girl. She says, ‘There’s nothing wrong with her, she’s always complaining about stuff.’ The woman was doubled up with pain, and I was giving her everything I could give her to try to get her some relief. What ended up happening is they discharged her but she was readmitted to another hospital, and she had a bowel obstruction.”

Joy Carpenter summed up what it meant not to be listened to: “I am most angry at the lack of being heard, that what I need and want does not matter…you are a nonentity….I would like the courtesy of being heard.”

“I Feel Morally Sick”

Nurses told many stories of situations in which they observed, or participated in, treatment of patients that was unethical, harmful, and/or dehumanizing. In some situations, the nurses were able to take action, but their actions did not always bring about the desired outcome. When circumstances were beyond nurses’ control, and they were unable to intervene, they were left with a terrible anguish that is termed “moral distress” in the literature (Corley, 2002).

The following account vividly depicts this distress:

_We had a young patient that died. And I was in the room watching the procedure. No one said anything to the doctor, just “Maybe…” or “Have you thought…” or “Could we stop?” I was very angry that day. And I broke out in a sweat, nauseated. I’ve never lost control at work like that in my life, in 14 years, but I did that day. I mean my heart was racing. She [the young patient] said, “That hurts,” and she was told “No it doesn’t” by the doctor. And that made me angry. I mean this was just a kid, she was my daughter’s age. And I wanted so badly to just spit in his face. I just felt like he had treated her in such a non-human manner….And then of course when she coded, oh, it was like there’s nothing that could be done, you know.”_

In the next situation, the patient was not given a proper opportunity to make her own decision and give informed consent regarding impending surgery. Linda Harvey became quite emotional as she recounted this incident that occurred when she was working evening shift on a surgical unit and went to get an elderly
patient to sign the permit for a scheduled mastectomy. Finding that the patient was barely literate, Linda read the permit to her and her daughter. But the patient still did not comprehend that removal of her breast was planned; she insisted, “They’re going to remove the lump. I don’t want my breast removed.” Linda called the physician, relating to him, ‘She understood that she’s having a lumpectomy, and that’s the only thing she wants.’ The doctor said, ‘No, she’s going to have a mastectomy. You must have said something to confuse her. Go back and get the permit signed.’ Linda refused to do so, and here’s the rest of the story:

When I left that night, I explained to the oncoming shift that the surgery’s going to have to be cancelled. Or else they’re going to have to make sure they’re only removing the lump. The next night, when I came back to work, she had had a mastectomy. The resident had talked to her, and she signed the permit. It was so upsetting. She was a vulnerable person. She was not real educated. It was like, you can dupe them because they don’t understand.

Basing care on a patient’s socioeconomic status was morally repugnant to the nurse who related this story:

I remember one particular situation, and this was a diabetic patient who came for prenatal care…to a resident clinic which is supposed to be overseen by staff physicians. And that just wasn’t done in this case. And this patient was very brittle, eventually lost the baby. She kept getting different residents, and nobody took that assertiveness to step in and manage her care…And this patient needed that badly. That was the most angry that I believe I’ve ever been. I went to the chairman of the department and laid it out. And he says, “Well, we just can’t give that kind of one-on-one care to all patients, you know. This is a patient in the clinic, it’s not a patient who’s a paying, private patient.” I was furious.

In the final example, the nurse still ponders the death of a child after a fierce conflict between two physicians. She is unable to achieve a sense of closure:

It was a 7-year-old drowning victim, brought in by ambulance…We got his heartbeat back but really not good response pupilwise or anything else. It was Dr. S. working on the child, and at the time we did not know it was another physician’s child. And the other physician came storming in and wanted us to stop. He saw the pupils were pinpoint and such, and he did not want us to continue. Dr. S. did not realize that the father was a physician; he was on the phone to the children’s hospital with Dr. W. asking what else we could do. It was a very uptight time. The father grabbed the child off the table and said, “No, let him go.”

I found out later that Dr. S. had almost drowned as a child. Someone had gotten him back, and he was fine. He really did not want to stop…. We thought we had done fairly well in getting the child back. We didn’t know what the neurological prognosis would be, but felt we should give the child a chance…. I felt we should have given him a day or two on the respirator to see if he would come back. They wouldn’t go ahead and give him a couple of days. That was
This nurse, like others in a recent study by Gunther and Thomas (2006), was left to wonder, "Could I have done anything else?" Webster and Baylis (2001) assert that unresolved moral distress can result in moral residue, which can exhaust one's ability to deal with future situations. Moral distress could prove to be an important contributor to burnout. In one recent study, 25% of nurses left a position because of moral distress (Corley, Minick, Elswick, & Jacobs, 2005).

"I Am Not Getting Any Support"

Lack of support was one of the most poignant aspects of the nurses’ anger stories collected by my research teams. Joy remembered the sarcastic retort of her night supervisor when she called to ask for help: “I needed help desperately in Labor and Delivery. The night supervisor said, ‘Well, where do you think I’m going to get these nurses, cut out paper dolls?’” Linda, speaking of nurse administrators, asserted that “I have never seen where they will be your advocate. They sell you down the tubes. They have totally lost sight of the nursing side. And you shouldn’t be at sides or at war.” Many nurses spoke in the language of war as they talked about their work. They used an incredible number of military metaphors and similes: “It’s like being on the firing line,” “We feel sabotaged,” “It’s like an armed camp,” “We really don’t know how to fight back,” “I don’t know if I’ll ever muster all that it takes.” It became clear to the research team that nurses yearned for some allies in their daily battles. They especially wanted affirmation from managers. But affirmation is not what they got.

Nurses were angry because they were always being told what they were doing wrong. No one mentioned what they were doing right. A woman in one of my anger workshops described her first evaluation conference on a new job. Her supervisor told her only negative things. “Much to my embarrassment, I cried,” she told me. “I felt bad with no positive affirmations.” Bob Hayes provided a graphic description of his autocratic nurse manager who walked through the unit “like a stick stirring up rattlesnakes,” getting all of the nurses “in an uproar and tense . . . pointing out these small things . . . . She would only let you know when something was wrong. And that was quite frequently in her opinion.” Sue Green believes she is doing some good things but “nobody will remember it.”

Lack of support from management has been a consistent theme in studies by other researchers, too. Fewer than half the nurses in Linda Aiken’s massive five-country study felt that management listened to their concerns, acknowledged their contributions to patient care, and provided opportunities for them to participate in decisions (Aiken et al., 2001). Other evidence of dissatisfaction with management support appeared in the report of the NurseWeek/AONE National Survey of Registered Nurses, which involved more than 4,000 randomly selected American RNs (Brown, 2003). In a Pennsylvania survey, nurses thought their managers cared more about pleasing upper administration than about their needs—or the needs of patients (Trossman, 2005).

Nurses want support from colleagues as well as managers. In the following excerpt from our interview data, the nurse had a powerful spiritual experience...
with a patient and wanted to share it with her colleagues. She was hurt and disappointed by their response:

I had a little guy, and we were doing neuro checks every 4 hours. I did one at 4:00, which was normal, and then at 8:00 he was completely unresponsive. He wouldn’t track, pupils were very sluggish, BP dropped significantly. I had to call the neurologist, who sent him for a stat MRI of his head. He came back from this MRI and was still basically unresponsive. He was out of it for over an hour—and then it was like he just snapped out of it! He just totally came out of it. I called him by name, “Mr.—, you really scared us there. What happened?” He pulled my hand, and pulled me nose to nose with him and said, “I’ve been to see Jesus,” and I said, “Yeah,” because I believe that kind of thing can happen, but this was the first and only time I’ve ever had this happen to me. I said, “Do you remember me talking to you?” and he said, “No, I’ve been to see Jesus, and I have a message for you.” That kind of scared me, but I listened. I remember it being a very peaceful thing. It was just the two of us in the room because his family had stepped out in the hall to talk to the neurologist. He says, “God is gonna richly bless you.” And within the next couple weeks, I found out I was pregnant. That may be coincidence, but it touched me.

I saw the change in that patient myself. I was kind of excited about it. This just doesn’t happen all the time, that somebody has an experience like this. I went out there and told some of the other nurses. They laughed and acted like he was crazy and confused, and that really hurt my feelings. I feel like there is an afterlife. I feel like there is a heaven and there is a God. He was talking about the light and how it looked. And of course when they laughed and acted like he was crazy and confused, that was really disappointing.

Throughout our studies of nurses’ stress and anger, the longing for support has been expressed by nurses at all educational levels—from AD to PhD—and at many diverse practice sites. Although a few nurses described a coworker who could be counted on for an encouraging word or a hug, many did not seem to have a workplace support person. Sue Green ruefully acknowledged, “One of the biggest voids in my life is peer support.” Many RNs were reluctant to ask for support from others, even from those they trusted. It was not unusual for a nurse to be going through a life-changing event of major proportions—such as a divorce—without sharing the news. This reluctance to ask for collegial support is common in the helping professions, because the usual (and more comfortable) role is to be a giver of help, not a receiver of it. Asking for support is somehow equated with inadequacy or weakness. Nurses say they do not want to burden others. Carol Carter explains: “I was brought up that you don’t burden other people with your problems. I’ll be there for someone else, but it’s like I don’t feel like I have the right to burden other people with my problems.”

I contend that it’s time for us to lay down some of our burdens. Most of us, as shown in the stories throughout this chapter, are carrying too heavy a load of stress and anger.
The rest of this book is devoted to the unpacking and transformation of that stress and anger. Some of the work we must do alone, because only we know exactly how we got all that stuff packed in the bag. But we cannot do all of the work alone. We need to enlist some helpers. In some cases, they may be friends, family, or therapists—but remember that your nurse colleagues will have the best grasp of the unique frustrations and anger provocations in this profession of ours. Don’t leave them out. As you do the assignments in this book, watch for “Steps Toward Healing” in every chapter. Find a partner or a support group to go on the healing journey with you. The bag won’t be nearly so heavy if its load is divvied up.

A Last Word

In my view, we cannot give the care that society needs us to give to hurting people unless we:

■ care for ourselves, which includes acknowledging and acting on our real feelings,
■ and care for each other, which includes making a daily effort to be supportive to our colleagues.

As Lynda Carpenito phrased it: “When you go out in the nursing world, hold hands before crossing the street and stick together.”