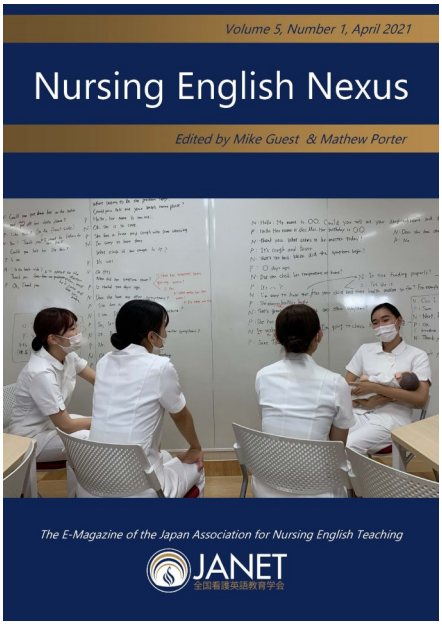
Nursing Workplace Culture: Where Have All the Young Nurses Gone? Three Case Studies

Margaret Chang
Miyagi University



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Margaret Chang, margaret@myu.ac.jp
Miyagi University

***Abstract**: This paper contains a collection of vignettes, gathered through semi-structured interviews, intended to provide a glimpse of the experiences of three young nurses working in hospitals in Japan in the early stages of their nursing career.*

Keywords: nursing education, nursing management, lateral violence, workplace harassment, professional development and training

As a university English educator, my work with young adults also carries over to interest and curiosity about career satisfaction and success of young university graduates in Japan. To my concern, the overall impression of the challenges faced by novice nurses has often seemed more discouraging than encouraging, making me feel an increasing need to gain a clearer close-up view of the details of the problems on a more personal, direct level. Through closer inspection, I endeavored to get a better grasp of the current workplace dynamics that lead to turnover among young nurses in hospital patient care environments. It is hoped that the following three case studies will give readers a richer, humanistic view and deeper understanding for where possible causes of the problems may be found, and thus, provide valuable insights in determining the best direction for further research about the realities of working in nursing—a profession which plays such a vital role in Japan's aging society.

When I ask my undergraduate nursing students, "Why do you want to be a nurse?" they often answer the question with reference to images of how they had been inspired by well-known historical figures in nursing such as Florence Nightingale; others make mention of a lasting impression of a nurse's dedication and kindness to them or a family member in a past personal experience that required being hospitalized, or of having survived a significant event that led them to want to work in a profession that helped the sick and injured. In other words, the aspiring nurses' stated reasons were usually selfless with the ideal of being motivated by the desire to directly assist and give care to others. Rarely did I hear answers that mentioned steady income, status, job security, or other economic variables. Motivated by this image of tending to the sick and helping to save lives, the students faithfully attend four years of classes, tests, observations, labs, practical trainings, and licensing examinations. Finally, they graduate and are overjoyed to find that they have passed all the various licensing requirements and look forward to starting their new careers in nursing. However, as detailed in the case studies of Nurses A, B, and C below, the path is not always smooth. In fact, young nurses find they must learn to manage unforeseen obstacles and endure many trials as they discover the gaps between their expectations and the realities of their new profession.

Three Case Studies

The following are the stories of Nurse A, who is at the start of her nursing career, Nurse B, who has been a nurse for more than five years, and Nurse C, who left the profession after one year on the job. All three worked, or are working in, hospitals which are categorized according to this classification system:

1. Small hospitals: 99 beds or fewer

2. Medium hospitals: 100 to 499 beds
3. Large hospitals: 500 beds or more

Information for the case study data was obtained through three 90-minute semi-structured oral interviews in Japanese with volunteer subjects who were at different stages of their young nursing careers. In an attempt to obtain sufficient substantive information for this exploratory research, purposive sampling strategies—mainly emergent and convenience sampling—were used in the subject selection process. The subjects were willing to speak openly and unguardedly about their experiences in hopes that their stories would contribute to dialogue among professionals by giving a close-up view of the current situation, and to help highlight the need for change. However, the subjects still feared loss of privacy and repercussions if their identities were to become known. For that reason, identifying details such as gender—interviewees as well as other players in the stories are all uniformly referred to as "she"—and specifics such as place of nursing study, description of workplace other than size of hospital have been purposely omitted. All subjects responded that they chose to go into nursing because of a desire to help others directly. Finally, I have refrained from making any interpretive statements in presenting the case information. The case studies were written in a manner to reflect the interviewees' responses as closely as possible, including affective expressions and their interpretation and understanding of the situation.

Nurse A's Story

Nurse A (NA) is in the first year of her career as a new nurse at a large hospital. In response to being asked whether her overall impression of her job experiences has been more positive or negative, she confided that it was half-and-half. When asked for more details, she explained that she felt she had to be constantly on guard about the hierarchy and what she said to her superiors and senior nurses. When she happened to be paired with a senior nurse who took the time to explain unfamiliar procedures kindly and was amenable to questions, it was a relief for NA as a new nurse, but there were also senior nurses who had a critical and impatient attitude. This gave NA much stress since she felt a great sense of responsibility to not let her lack of experience as a new nurse on the job result in harm or injury to patients, yet she was afraid and hesitant to ask questions for fear of evoking negative responses of annoyance, irritability, and exasperation from impatient senior nurses. She hesitated to ask because everyone seemed to be already overburdened and overworked with so many duties that she felt afraid to add to their workload or possibly risk an explosion of anger and frustration.

Notably, NA observed that those who adopted a hard-to-approach demeanor could protect themselves from the extra work of dealing with new nurses' problems and questions, so it was a strategy that selfishly but successfully benefitted those who adopted it. NA admitted that it was a harsh realization to find out that the hospital workplace was not one where selfless leadership, dedication, and hard work are rewarded, but instead, refusing to help and using tactics to lessen the workload for oneself were common strategies for survival.

Additionally, NA felt that there was no unified system for training new nurses for specific on-the-job duties. At best, it was piecemeal and lacked uniformity. Procedures sometimes varied depending on the trainer and there seemed to be no unified standard or protocol which new nurses like her desperately needed. NA noted that her basic training had provided ideal situations, but there was hardly any training on how to negotiate the unexpected and navigate obstacles within the actual work situation. Further, NA claimed that the in-house training that they did receive on the job often did not directly address *real issues* and was not *practical*. In contrast, much extra time and

work training at her hospital were spent on activities such as perfunctory meetings and extra work duties unrelated to patient care, in addition to homework assignments, such as practice report -writing about minutiae that, in her opinion, did not provide the necessary experience needed to give her the skills that were crucial for specific on-site situations. For example, NA noted how nurses were required to take inventories of medical supplies such as gloves and gauze. NA felt this could be assigned to non-nursing staff, thereby freeing up time for nurses to do more duties that were specific to nursing. In addition, she stated that there were rules that rigidly stipulated the only times when certain procedures could be done. As a result, she felt that the time was not spent efficiently, especially considering that there was already so little time available for activities such as ensuring that new nurses had adequate on -the-job training in caring for patients directly. There were also times when her senior partner would presume that she already knew how to perform certain procedures when she in fact had not yet had any such experience.

When asked if she had had the opportunity to voice her fears and concerns to supervisors, NA disclosed that there had been a formal interview with the head supervising nurse. However, she said the atmosphere seemed routine and superficial to her. She confided that she did not feel safe in opening up about her true concerns and the need for mentoring by more approachable senior nurses, and added that it seemed that the supervisor was not truly interested in hearing anything beyond confirmation that everything was "fine" and that everyone was "nice." In her view, they seemed to be unaware—or perhaps did not want to be —of the realities of the quality of the work environment and gaps in the system to be able to provide sufficient support for first-year nurses. She noted that, at the same time, the senior staff went through the motions of appearing to uphold standards such as quality performance interviews and follow-ups to maintain the image of the system being in good order and competently managed.

Finally, in response to what NA planned to do in the future, she revealed that she was not planning to stay in hospital nursing for more than two or three years. She stated that she wanted to move to another area, such as public health, where she hopes that the environment would be more supportive and less stressful.

Nurse B's Story

Nurse B (NB) has been working in a medium-sized hospital for five years. She is very conscientious about her work, and genuinely enjoys taking care of patients and nursing as a profession. However, her job satisfaction was greatly marred by an ongoing, distressing case of psychological harassment, also known as *horizontal violence* (Taylor, 2016) or *lateral violence* (Christie and Jones, 2013), at her workplace. The perpetrator was a nurse, henceforth referred to as Nurse X (NX), who held more seniority in the ward where NB had recently been transferred to. NX displayed passive-aggressive behavior towards NB. For example, NX would not be forthcoming in relaying pertinent patient information to NB about the patients under NB's charge for her shift. This caused both stress and performance problems for NB in terms of being able to care for patients safely and effectively, and at times caused NB to appear incompetent and unaware of necessary information including changes in doctor's orders or patient care schedules. NB noticed that NX would often refuse to talk to her, ignoring her presence whenever they had to work together on the same shift or not responding to NB's attempts to ask for information and clarification. NB observed that although NX was not an extrovert, she did behave in a more open and cooperative manner and was more conversant and amicable with other nurses or senior level staff.

NB tried to bring up her situation to other co-

workers by tactfully mentioning that NX did not talk to her very much. However, she would receive disinterested responses to the effect that NX was just "different" and did not talk much. From this, it appeared to NB that other nurses did not want to risk getting involved in NB's problems, or perhaps even incurring NX's wrath. NB later hesitantly brought her concerns to senior nurses in formal leadership positions, but these attempts were also met with apathy. The head nurse did not seem to be concerned about the seriousness or possible dangers for patients nor repercussions for the hospital should a case of malpractice result from NX's failure to convey crucial patient information to NB. They did not ask any further probing questions to get pertinent details, nor follow up on the situation. The nurse supervisor only responded with comments telling her not to worry so much, not to work so hard, and to try not to get overly stressed. NB's talk with another leader also yielded only superficial responses, such as noting that it would be hard to change anything and that change would take time, or unfulfilled promises, such as supervisors saying they would do what they could.

Continually upset and unable to eat or sleep as a result of her workplace situation, NB eventually fell into a state of clinical depression, and became unable to work for a period of time. While on sick leave, she felt guilty for the other nurses having to carry her workload while she was away ill. She constantly felt self-imposed mental pressure to return to work as soon as possible in order to relieve her co-workers of the burden of extra work that her absence imposed on them. Additionally, after this experience, she now feels that she can no longer trust supervisors and managers at her workplace, and is thinking about transferring to another hospital.

When prompted further, NB commented that she felt that leadership and selection standards for supervisors were a major part of the problem. She noted that supervising nurses are primarily chosen according to age and seniority. She further observed that there was negative financial motivation to be placed in supervisory positions since supervisors sometimes ended up seeing a decrease in pay from working relatively fewer night shifts, which pay a higher hourly wage. Consequently, the nurses who were designated to work in supervisory positions ended up seeing their paychecks go down since they no longer worked the higher paying night shifts. Head nurses often had no actual formal management training, and were usually overworked and too busy trying to survive day to day to be able to give time, attention, or care to anything beyond the routine. As a result, there was low efficiency as the system ran on an automated mode where meetings, scheduling, and other management and administrative functions were more a matter of mere form or routine rather than for sharing meaningful content or purpose.

NB sees a large gap between the ability of the system to handle very real and important issues and the overwhelming need for effective administrative and supervisory management, professional and mental support for staff, and healthcare safety for patients. She feels very alone as she continues to have nowhere official to go for consultation or to be able to confidentially report incidents such as those related to workplace harassment or situations that pose potential harm and risk to patients' safety and well-being.

NB's situation with lateral violence remains unresolved. She can only hope that she will be transferred to another ward soon. In the meantime, she is thinking about changing from working in a hospital environment to being a public health nurse, school nurse, or private nurse. NB concluded that she did not know many nurses at her workplace who could say that they truly liked the hospital as a workplace environment.

Nurse C's Story

Nurse C (NC) worked in a large hospital after graduating from university with a nursing degree and immediately passing the national exam to successfully obtain her license. However, she quit her nursing career after just one year. NC described how she felt tremendous pressure from the beginning of her job about the seriousness of her chosen profession and how there was no room for mistakes. She thought about her work incessantly, even after finishing her shift and returning home. Her ward had many serious cases and was a high-pressure environment. Furthermore, her ward was one where relatively new types of treatment were being performed. It seemed to NC that not only she but everyone else was highly stressed. As a result, she felt that she had no one to turn to for help as a first-year nurse. She had tried to consult with senior co-workers about her worries, but only received superficial, lukewarm responses that, to her, indicated that they did not want to take on any more responsibility by getting overly involved.

When asked for more explanation about the nature of how she felt unprepared for her actual job duties, she related the following. In her training, she had experienced controlled situations where conditions were manageable and ideal, for example, placing a catheter into a patient who was conscious and in stable condition. However, in her daily work situation, she found herself suddenly having to catheterize a patient who was in an immediate post-operational unconscious state and still on a ventilator. NC felt she did not have enough experience to handle this more serious situation as she did not know how to operate the ventilator correctly in case something happened to the patient during catheterization. Her primary focus upon patient safety and her strong sense of responsibility caused unbearable pressure and stress due to her being thrown into a situation where she could not open up about her concerns about her inexperience and the need for instructional help and guidance. She was repeatedly faced with sink-or-swim situations where patients' safety might be at risk. This eventually took its toll on her mental health and her new career. When she left her job, she was mentally and emotionally exhausted and suffering from depression.

Upon self-reflection, NC came to the conclusion that the constant self-blame that resulted from such situations was perhaps the single greatest source of her stress. She considers the possibility that her main problem might have been a lack of self-confidence stemming from her own inexperience rather than a lack of surrounding support. She added that it would have been helpful to have had a good role model. The nurse that she was paired with changed each day depending on her work shift, so she did not really have anyone close and familiar with whom she could openly consult about her fears and worries. On the occasions that she did try to reconfirm whether her understanding of orders and procedures was correct, she would sometimes be met with exasperation and impatience. Yet, she shared that she did not feel that she was being bullied or harassed, but rather that she was being scolded and reprimanded for her lack of experience. She reiterated that the main cause of her stress was the heavy burden of responsibility for feeling ill-prepared, even though she possessed a license to practice nursing.

NC, along with a few other new nurses, were able to give each other some degree of emotional support and empathy, but they could not help each other in terms of professional and technical support. NC had spoken with nursing supervisors about her concerns, but received a range of responses, from getting some degree of advice to being told to try to work it out herself. From her experience, NC concluded that support for first-year nurses should be made a major focus for in-house training. For her, the reality at that time was a hit-or-miss training system that was not

well thought out in terms of attempting to address the actual needs from the perspective of nurses with little on-the-job experience. At the same time, these new nurses had to bear the burden of awareness that the consequences of their actions could mean life or death for their patients. NC claimed that the feelings of dread towards going to work and of wanting to quit were the norm, rather than the exception, among new nurses.

Discussion and Conclusion

The above three case descriptions paint a grim picture of young nurses in Japanese hospitals feeling mentally overwhelmed by burdens and pressures due to lack of professional and psychological support at their workplace. Despite their best efforts, the nurses interviewed could cope only by planning to continue their careers in different environments, taking sick leave, or leaving the profession altogether.

Several common themes can be found among the three cases, such as disillusionment, overwork, rigid hierarchy, and an environment that is not open to questioning, which suggest the need for management and leadership training, effective in-house training, and a more explicit commitment to professional development. All these current conditions set the stage for lateral violence, which is described in the context of nursing as *nurse-to-nurse aggression* (Hanks, 2017, p. 2) or "behaviors intended to demean, undermine, and/or belittle a targeted individual working at the same professional level" (Sanner-Stiehr & Ward-Smith, 2017, p. 113). A quick review of literature soon reveals that lateral violence is not uncommon in nursing (Pilette, 2005; Christie and Jones, 2013; Taylor, 2016). One study even goes so far as to state, "Nearly all nurses experience lateral violence in their careers." (Rainford et al., 2015, p. 158).

Another relevant concept of note here is *presenteeism*, which is described as "employees being present at work but unable to be fully engaged in the work environment" (Lack, 2011, p. 77). It is a situation in which "people are physically present in the workplace, but are functionally absent" (Shamansky, 2002, p. 79), or succinctly rendered as "on-the-job productivity losses" (Goetzel et al., 2004, p. 399). Another study goes further to define presenteeism as "being at the workplace but not fully working due to health problems" (Vanni et al., 2015, p. 299). In two of the three case studies presented in this paper, the young nurses eventually developed depression.

Whether it be called bullying, power harassment, psychological terrorism, toxic work environment, power play, or horizontal violence– also described as *intergroup conflict* (Duffy, 1995, p. 5), there is no denying that there is a widespread problem of lateral violence and presenteeism in nursing that needs to be addressed through transparency, trust building, and an equitable system of evaluation and reward. Effective intervention requires strong leadership training and placement of dependable managers and supervisors with insight to be influential role models, and to oversee teamwork and promote cooperation among nurses.

It is not the intention of this paper to advocate an entire overhaul of the current system. However, while young nurses need to be made aware of and prepared for the realities of the job and workplace through effective orientation and ongoing support, nurses in training should not be given practice in only ideal caregiving situations and conditions. This is unrealistic and, at times, disadvantageous for the trainees. They need to be better prepared in terms of expectations and skills for managing everyday realities of the workplace. They need to be taught interpersonal communication strategies, effective ways to navigate the hospital system and its hierarchy, and to be provided with sufficient support and positive experiences in order to confidently make the leap from highly controlled textbook scenarios to real life

situations involving coworker interaction and patient care. At the same time, young nurses need access to a dependable advisor whom they can turn to and confide their difficulties and concerns to. In order to achieve this, hospitals must invest in better formal administrative and human resource training, development, and management. Nursing educators must also adopt a creative problem-solving stance such as, "What can we do to change the current situation?" rather than a protective or defensive attitude such as, "That's the way things are. We can't change the system." We must find ways to be able to effectively address the needs of future nurses and better equip them with the necessary skills while providing a supportive environment of approachability, openness, consistency, and trust.

Our role as educators must include follow-up in order for our education to be relevant. Our work does not simply end once our nursing students graduate and pass their licensing exams. Ours must be a role of holistic education that includes follow-up research continuing to inform our teaching for the sake of effective and meaningful education. In this era of new infectious diseases and a shortage of health care workers in aging Japan, I feel a great sense of urgency to increase research in the educational training and professional development of, and support for, young nurses. Educators, researchers, and hospital managers must focus on finding ways to reduce the incidence of lateral violence, presenteeism, and turnover among nurses by developing a system that will ensure their emotional and psychological well-being.

I invite fellow educators and researchers to join me in further exploring this challenging aspect of nursing education and practice that warrants immediate attention in order to stop the loss of young nursing professionals in the field.

The nurses in all three case studies expressed the desire to leave their current workplace, or in C's case, had already left the nursing profession. There may be a reluctance to take a deep look at the seemingly negative situation in favor of a desire to turn the other way and pretend that a serious problem does not exist, hoping that it will somehow sort itself out over time or go away. However, like the dentist's sign that warns, "Ignore your teeth and they'll go away," we also risk suffering similar unwanted consequences in that if we ignore our new nurses, they too, will "go away."

References

Christie, W., and Jones, S. (2014). Lateral violence in nursing and the theory of the nurse as wounded healer. *OJIN: The Online Journal of Issues in Nursing*, 19(1).

Duffy, E. (1995). Horizontal violence: A conundrum for nursing. *Journal of the Royal College of Nursing*, 2(2), 5–17.

Goetzel, R. Z., Long, S. R., Ozminkowski, R. J., Hawkins, K, Wang, S., & Lynch, W. (2004). Health, absence, disability, and presenteeism cost estimates of certain physical and mental health conditions affecting U. S. employers. *Journal of Occupational and Environmental Medicine*, 46(4), 393-412.

Hanks, M. L. (2017). *New nurses' experiences in the lateral violence zone: A grounded theory*. (Corpus ID. 149502304) [Doctoral dissertation, The University of Alabama]. The University of Alabama Institutional Repository.

Rainford, W. C., Wood, S., McMullen, P. C., & Philipsen, N. D. (2015). The disruptive force of lateral violence in the health care setting. *The Journal for Nurse Practitioners*, 11(2), 157-164.

Pilette, P. (2005). Presenteeism in nursing: A clear and present danger to productivity. *JONA: The Journal of Nursing Administration*, 36(6), 300-303.

Sanner-Stiehr, E. & Ward-Smith, P. (2017). Lateral violence in nursing: Implications and strategies for nurse educators. *Journal of Professional Nursing*, 33(2), 113–118.

Shamansky, S. L. (2002) Presenteeism…or when being there is not being there. *Public Health Nursing*, 19(2), 79-80.

Taylor, R. (2016). Nurses' perceptions of horizontal violence. *Global Qualitative Nursing Research*, 3, 1-9.

Vanni, K., Virtanen, P., Luukkaala, T., & Nygård, C. (2012). Relationship between perceived work ability and productivity loss. *International Journal of Occupational Safety and Ergonomics*, 18(3), 299-309.