2019

Nurses' Lived Experiences of Oppression and Power Dynamics in the Hospital Setting

Khadijatu A. Leary
Walden University

Walden University

College of Health Sciences

This is to certify that the doctoral dissertation by

Khadijatu A. Leary

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee
Dr. Lee Bewley, Committee Chairperson, Health Services Faculty
Dr. David Duncan, Committee Member, Health Services Faculty
Dr. Magdeline Aagard, University Reviewer, Health Services Faculty

The Office of the Provost

Walden University
2019

Abstract

Nurses' Lived Experiences of Oppression and Power Dynamics in the Hospital Setting

by

Khadijatu A. Leary

MBA, University of Maryland University College, 2011

MHA, University of Maryland University College, 2010

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

August 2019

Abstract

The persistent and chronic nursing shortage presents an urgency to understand the root causes of nurses' increasing mobility and movement within and outside of the nursing workforce. A key to understanding nurses' dissatisfaction is to explore the work environment in which they practice. The purpose of this heuristic, phenomenological study was to understand nurses' experiences of oppression and the power dynamics in the hospital setting, which may provide insight to nursing turnover. The conceptual framework was Harvey's civilized oppression theory. Data were collected from semistructured interviews of 9 registered nurses by phone that met inclusion criteria of having more than a year of experience in a hospital setting. The data were analyzed for codes and themes. Study findings showed all participants had perceptions and experiences of civilized oppression and claimed that power and ability to influence their work environment resided with groups other than nursing. Lastly, participants also had a perception of an ideal work setting with shared governance and civility at all levels and all nursing roles within the nursing profession. This study has a direct impact on strategies to address population health, community wellness and global health as the nursing workplace plays a role in shifting the paradigm of care from a sickness model to a wellness model.

Nurses' Lived Experiences of Oppression and Power Dynamics in the Hospital Setting

by

Khadijatu A. Leary

MHA, University of Maryland University College, 2010

MBA, University of Maryland University College, 2011

Dissertation Submitted in Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Health Services

Walden University

August 2019

Dedication

This work is dedicated, first and foremost, to God Almighty and my Lord and Savior. Without Him, nothing will be possible and without Him, nothing is worthwhile.

Secondly, I would like to recognize my amazing parents who are responsible for providing me the basics and inspired me to move to higher heights.

I would also like to recognize my husband, the love of my life, Colonel Melvin Leary (ret.) who has been my lifeline in more ways than one. He pushes me every day to be a better person and stop complaining. He always "held it down" and never complained with so many of my obligations that pull me away.

My children, Dr.Tariq Jah and my beautiful dancer, Nasciya, who are the best kids any mother could ask for. My siblings, AJ, Sally, Issa Jr and Aisha have been the backbone to everything I have been and they prop me up and support me and my children whenever needed.

Lastly, I would like to dedicate this to my professional family and my personal "village", who insisted on calling me "Dr", while I was a candidate that pushed me to work harder and faster so this dream could come to pass.

Acknowledgments

I would like to acknowledge my committee. My chair, Dr. Bewley, thank you for your support and pulling me through to the finish line. You were the one that responded "yes" to me after I received 17 "no's" and you never wavered in your support. To my committee member, Dr. Dave Duncan, you stepped in graciously when my last committee member disappeared, and I am forever thankful. Dr. Magdalene Aagard, thank you for the extremely high bar that you set. I always held my breath waiting for your feedback but realized that it was for integrity of the work and I appreciate it. Dr. Jenn Rounds-Bryant, you helped me through when I got stuck and I always appreciated your tough, honest and brutal feedback.

I am passionate about nursing and the power of nursing in a very challenging healthcare environment. I hope that this research will continue to reveal new opportunities to help the nursing profession heal itself so that nursing can truly focus intently on healing the world. I would also like to publicly state my appreciation and admiration for a true role model that was the first nurse Ph.D. that I ever met and who inspired me to embark on this journey.

Finally, a huge thank you to my family, my friends, and extended family who have all shaped me into what I have become. Your love and support lifted me to unimaginable heights and I thank God for you all.

Table of Contents

List of Tables

List of Figures

Chapter 1: Introduction to the Study

The provision of fair, right, and just provision of care is considered to be healthcare equity and an objective of all heath care institutions, entities, and systems; however, nurses tend to experience situations of equity or inequity within the institutions that nurses practice (Rooddehghan, ParsaYekta, & Nasrabadi, 2015). Merriam Webster (2018) defined oppression as the unjust or cruel use of authority or an excessive exercise of power coupled with a sense of being weighed down in body or mind. Oppression is manifested in the nurses' workplace as feeling powerless within the work environment, which impacts nursing practice and presents a need for administrators, nurse researchers, and nurse leaders to explore, understand, and address this phenomenon (Roberts, 2015).

There are approximately 4 million nurses practicing in the United States; yet, the demand for nursing talent continues to grow while there are concerns about nurses leaving the professional altogether due to job dissatisfaction (American Nurses Association [ANA], 2018). The number of registered nurses who are dissatisfied with the profession has a direct impact on organizations. When nurses exit the profession completely, it depletes the workforce in a market that is already to meet the demands for this profession (Mazurenko, Gupte, & Shan, 2015). According to the ANA (2018), there will be an abundance of available registered nurse positions through 2022, more than any other profession with more than 500,000 expected to retire. However, there will be a need to produce 1.1 million new registered nurses to meet demand and avoid a nursing shortage.

The purpose of this heuristic phenomenological study was to explore nurses' lived experiences of power dynamics in the hospital setting. The nursing shortage is a global issue as job dissatisfaction is common among nurses, resulting in high rates of nurse turnover (Read & Laschinger, 2017). In this study, I explored the practice environment to understand whether there are any experiences with powerlessness or oppressive behaviors that are negatively impacting nurses practicing in the hospital environment. Power differences and chasms, along with challenging power dynamics, have a tendency to fracture the social fabric of hospital actors, along the lines of key relationships and interfaces within the hospital setting (Barasa, Cleary, English, & Molyneaux, 2016).

This chapter includes the background, problem statement, purpose of the study with the research questions, conceptual framework, nature of the study, definitions, assumptions, scope and delimitations, limitations, and significance of the study. The background section includes the scope of this study; the problem statement section provides insight on knowledge gaps regarding power dynamics, relationships, and oppression in the nursing profession.

Background

Nurses play a role in the delivery of health care as the largest healthcare workforce. A nursing shortage can cripple an entire health care system (Snavely, 2016). Interprofessional relationships are predictors of job satisfaction (Regan, Laschinger, & Wong, 2016). Low job satisfaction is correlated with increasing intent to leave the job, which also correlates with nurse turnover (Tuckett, Winters-Chang, Bogossian, & Wood, 2015). In 2014, 187,200 nurses indicated their intent to retire or take a nonnursing job

when economic conditions improved, and 82,000 nurses had plans to move to part-time employment adding up to 270,000 registered nurses planning to leave full-time employment (U.S. Department of Health and Human Services [USDHSS], 2014). Nurses from all levels of education, experience, specialty, and locations had planned to exit the nursing profession due to retirement and age. More than a million nurses planned to exit the profession due to job dissatisfaction (Allnurses, 2017).

Tinsely and France (2004) conducted a phenomenological study to explore why experienced nurses were choosing to leave the profession. Five nurses with 12-23 years of experience were interviewed, and themes of oppression and unity emerged from the data analysis, which led the researchers to explore the concept of oppression (Tinsely & France, 2004). Tinsely and France recommended further research with a more diverse group of nurses to understand the prevalence of oppression as the nurses in the study practiced within oppressed environments that culminated in the sustained exodus from the profession, causing a chronic shortage.

Scholars who have studied oppression, power dynamics, and equity in nursing have revealed that these are ongoing and continuing challenges in the nursing practice environment. There is mounting evidence focused on incivility in the workplace and the impact on nursing, patient care, and healthcare organizations (Luparell, 2011). Cortina (2008) suggested that incivility is modern day discrimination and a common type of antisocial behavior that tends to be ignored and unaddressed by leaders as the behaviors are typically subtle acts. Chachula, Myrick, and Yonge (2015) conducted a qualitative study to explore associated factors and basic psychosocial processes that impacted the

decisions of newly graduated registered nurses in Western Canada to permanently leave the nursing profession within 5 years. Ebrahimi, Hassankhani, Negarandeh, and Azizi (2016) interviewed 18 experienced nurses in Iran to explore what new graduates experience while transitioning to the clinical from the academic setting. Rooddehghan et al. (2015) explained the nurses' experiences of equity in healthcare provision in Iran. Questions from the survey were regarding perceptions of experiences of equity in healthcare, relating tasks indicating equity in healthcare, and beliefs that impacted equity in healthcare (Rooddehghan et al., 2015).

The modern version of oppression is mundane and normalized in work environments (Boyd, 2010). Callahan (2011) identified oppression in the work setting as incivility caused by marginalization and power distance. Similar oppressive and bullying environments were found in nursing schools and nurses' subsequent work environments, which was normalized and was a part of the culture, causing the nurses included in the study to leave the profession of nursing altogether (Chachula et al., 2015). Another key finding was the challenge with negotiating social relationships, hierarchies, behaviors, and hierarchal and horizontal violence (Chachula et al., 2015).

Like many other professions, nursing is also affected by the dominant culture of the society, and there is an oppressive quotient that is impacting professional relationships within the healthcare setting (Ebrahimi et al., 2016). It is essential to review undergraduate curriculums, develop support programs that make up for the existing failures, and eliminate sources of distress to protect the personal and professional wellbeing of new graduates (Ebrahimi et al., 2016). According to Rooddenhghan et al.

(2015), feelings of submissiveness, work dissatisfaction, and impressions of favoring physicians over nurses and oppression occur within the work environment.

Problem Statement

The growing aging population and more comprehensive health coverage sets up an increasing demand for nursing care that will continue to worsen the current nursing shortage, creating an unstable workforce (Blegen, Spector, Lynn, Barnsteiner, & Ulrich, 2017). The nursing shortage caused by high turnover from toxic work environments, job dissatisfaction, emotional fatigue, and increasing intent to leave is not only a national issue but it is also a global one (Nantsupawat et al., 2017).

In Thailand, Nantsupawat et al. (2017) investigated how nurses' work environment affects job dissatisfaction, burnout, and intent to leave and found a positive correlation between positive work environments and lower rates of job dissatisfaction and intent to leave, which in turn, improves patient care and lowers burnout. There is a need for additional research to investigate how nursing environments and working conditions can be improved for hospitals to deliver high quality care (Nantsupawat et al., 2017).

There is further research on the hemorrhaging of top nursing talent with the increasing number of skilled nurses leaving the profession earlier than expected (Armmer & Ball, 2014). Nurses ultimately refuse to practice in poor working conditions. However, negative experiences with the prevalence of horizontal violence and oppression and oppressive behaviors persist, which also bears social, financial and professional implications (Armmer & Ball, 2014). There was also a perception of nurses that conflicts occur when nurses feel that they are systemically excluded from the power structure in

terms of decision making (Armmer & Ball, 2014). D'Ambra and Andrews (2014) indicated that uncivil, aggressive, and oppressive behaviors are initiated in the nursing academia setting between students and between students and faculty. Intervention studies need to be conducted that will empower nurses to break the cycle of oppression evidenced by horizontal violence (Armmer & Ball, 2014).

Armmer and Ball (2014) argued that hospital and nurse administrators are accountable for the hospital environment; however, sometimes nurse administrators are also victims or perpetrators of the oppressive work culture within the hospital setting. Moral distress and feeling psychologically unsafe and powerlessness are a prevalent experiences and emotions with chief nursing officers who are typically the highest-ranking nurses in hospitals (Prestia, Sherman, & Demezier, 2017). There is a need to understand gaps in research regarding nurse leaders' experiences of oppression given the role of these leaders to build and sustain healthy and productive work environments.

Other gaps in existing research are noted with homogenous sampling with past research and a need for studies to be conducted across a range of healthcare organizations and numerous types of nursing roles (Rodwell, Demir, & Flower, 2013). Roberts (2015) suggested a need for further exploration of the power dynamics as it may provide an empirical explanation for the oppressive behaviors that continue within the nursing profession.

Purpose of the Study

The purpose of this phenomenological, qualitative study was to explore nurses' experiences of oppression and power dynamics within the hospital setting. These issues

may explain how these dynamics may be impacting local, national, and global efforts to sustain and build up the nursing workforce, which has continued to endure shortages across the globe, creating implications for population health and wellness in communities.

Research Questions

1. What are nurses' experiences with civilized oppression in the hospital setting?
2. What are nurses' experiences with power dynamics and equity in the hospital setting?
3. What are nurses' perceptions of an ideal, safe and empowered work environment?

Conceptual Framework

The conceptual framework for this study was civilized oppression. Civilized oppression is a set of actions in cultures that are entrenched in unquestioned and unchallenged norms, habits and symbols, and in assumptions underlying institutions and rules; they are not easily visible to the agent or the victim (Harvey, 1999). Civilized oppression is more difficult to recognize, even by its victims. It is often subtle but pervasive, and understanding it involves detecting the kinds of mechanisms used, reflecting on the power relations at work, the systems controlling perceptions and information, the kinds of harms inflicted, and the kinds of moral wrongs underlying them (Harvey, 1999).

Civilized oppression theory was coined by Harvey and does not include physical violence or law, and it is insidious and systemic and commonly found in the workplace setting (Harvey, 1999). Harvey (1999) depicted civilized oppression as concealed weapons of abuse that victims do not anticipate or expect, and in some cases, perpetrators are not aware of inflicting. Harvey argued that the analysis of the mechanisms, power relations at work, systems that control perceptions and information, and the types of harm inflicted on victims are reasons that make this phenomenon hard to see and study. This concept guided the development of the interview questions and framed the research questions that arose from the gap in recent research studies.

Smythe (as cited in Diekelmann, 2002) explained that there is a phenomenon called *everyday violence* that suggests that healthcare providers are victims of violence, the ensuing entrapment of not being able to afford the time and resources to be more caring to their patients. Civilized oppression is pertinent to explore the power and relationship phenomenon in the hospital setting as the behaviors that I explored in this study are nonviolent. The concepts associated with civilized oppression are centered on social, emotional, and psychological harm that is inflicted systemically, which are best suited as a framework for this study.

Rogge and Greenwald (2004) explored the life experiences of 13 obese individuals and five family members with an interpretive phenomenological design. Themes from the interviews were that participants experienced stigmatization, denigration, condemnation, and discrimination from family, peers, and providers and were treated in an inferior manner that was linked to civilized oppression (Rogge &

Greenwald, 2004). Civilized oppression was identified as a concept in this study offering some insight into interpersonal relationships and the impact on individuals' feelings of powerlessness, disregard, and inequity (Rogge & Greenwald, 2004).

Dong and Temple (2011) provided an alternative concept of civilized oppression as oppressive group theory. Dong and Temple indicated that there is an importance to understanding more subtle forms of oppression in the form of a burdening cumulative and insidious type of oppression that are often difficult to identify. Like obesity, the stigma and societal norms of the hierarchical relationships that exist within the nursing practice environment leave many behaviors unaddressed and unmanaged, which continues to negatively impact nursing practice and the profession (Dong & Temple, 2011).

Creel and Tillman (2011) conducted a phenomenological study to explore the phenomenon of nurses' stigmatization of obese persons to contribute to the development of nursing practices and practice environments to better serve obese persons seeking care and improve access to health care and outcomes. Eight participants were selected based on criteria with a BMI over 30, having experienced stigmatization from nurses due to their weight (Creed & Tillman, 2011). Unintentional harm from nurses, presuppositions based on weight, care provided reluctantly, and shame and marginalization were themes identified, revealing interactions that were identified as civilized oppression (Creel & Tillman, 2011). A hallmark component of civilized oppression from Creel and Tillman and Rogge and Greenwald (2004) is the societal acceptance and rationalization of marginalized treatment in addition to the insidious nature of this variation of oppression.

Contextual Lens

Nonphysical violence and incivility occur in the healthcare environment and are widespread within nursing as actions taken against them as a group and towards each other. Bidirectional violence is a hallmark for oppressed groups (Friere, 1968). Oppression exists in environments that have a systemic imbalance of power (Friere, 1968). Civilized oppression is a more modernized form of oppression that is mostly found in workplace settings. There has not been enough focus, attention, and research on the nonphysical forms of violence within the nursing profession and the hospital setting.

A key dynamic in any oppressive relationship is power and lack of equity (Harvey, 1999). Key facets of civilized oppression are that it is hidden to both the agent and the victim, it is socially structured, humor can be used as a masque, there is diversity of relationships setting up peer and nonpeer interactions, and there is an existence of a socially privileged group and a socially powerless group (Harvey, 1999).

Nature of the Study

A heuristic, phenomenological design was used for this study. A heuristic, phenomenological scholar seeks the obtainment of qualitative presentation that addresses the heart and depths of a person's lived experience and a recreation from the experiencing person's frame of reference (Moustakas, 1990). Heuristic design also opposes typical phenomenological detachment from the phenomenon by emphasizing and promoting connection and relationships with the phenomenon being investigated (Moustakas, 1990). In this study, I investigated experiences of oppression from nurses from different levels of work within the hospital setting from more than one organization as a means to

understand how this phenomenon may be negatively impacting the nursing workforce. The data were collected using purposive sampling of eight-10 bedside nurses and administrators with 35-40 minute, semistructured interviews by videoconference that were analyzed using heuristic methodology.

Definitions

This section provides a list of definitions of key terms and concepts used throughout the study. Phenomenological concepts' definitions were taken from Husserl (1931/1965) and Moustakas (1990). Other definitions stemmed from recent literature or commonly accepted explanations.

Civilized oppression: The subtle and insidious version of exertion of power and influence of one social group or individual over another that is not always noticed by either party and is embedded in cultural norms in the environment (Harvey, 1999).

Incivility: Spence, Laschinger, Leiter, Day, and Gilin (2009) described incivility as low intensity behavior with the ambiguous intent to create harm towards a target violating workplace norms for dignity and mutual respect.

Oppression: Stahl (2017) defined oppression as self-perpetuating systemic or institutional practice that causes unjust harm and constrains some individuals by creating obstacles and challenges that makes it disproportionally costly for them to exit or change behaviors or practice environments in comparison to other groups.

Power dynamics: Systemic or individual allocations of influence over others impacting relationships (Li, Matouschek, & Powell, 2017).

Work environment: The location and other locations where employee/s are working or are present as a condition of their employment and includes not only physical locations, but also necessary resources used by the employee/s during the course of his or her work (Occupational Safety and Health Administration [OSHA], 2001)

Assumptions and Limitations

There was an overriding assumption that the participants were honest and candid about their experiences during interviews. The approach and design were selected to allow for openness and flexibility using a semistructured format and allowing for privacy and confidentiality. A theoretical assumption with civilized oppression is that although it is insidious, it was impactful enough for participants to recall and share their experiences during the interview.

The limitations are that using a phenomenological approach with small sample sizes impacts generalizability. Another limitation was that my passion, past experience, and energy for this topic may add bias to the study. The member checking process and interrater reliability approach to coding and analysis helped to limit bias including engaging in peer review with experts on this topic. Another limitation was that the insidiousness and sensitivity identified with victims of civilized oppression or oppression overall may impact participants' ability or willingness to identify or indicate these behaviors or dynamics exist. The semistructured, one-on-one video interview process helped with addressing concerns of confidentiality and provided a safe environment for participants to speak openly.

Scope and Delimitations

The scope of this study included participants who identified as bedside and administrative registered nurses at all levels of education who currently worked in and had been employed for more than 1 year in the hospital setting. Participants were excluded if they had practiced in a hospital for less than 1 year or were employed in a nonhospital setting. The delimitations were individuals in other nursing positions including licensed practical nurses, licensed vocational nurses, and certified nursing assistants. Participants without access or reluctance to participate by phone interview were not included in the study. Qualitative research is mainly about situational uniqueness (Krefting, 1991) as the group may not identify with the same issue presented as raw data but there will be enough representation in the sampling given the various roles intended to be included in the interviews.

Significance of the Study

This study has the potential to reshape the hospital environment as a systemic issue rather than the myopic lens on lateral violence between nurses. The hierarchal environment and the historical anchors within the hospital environment sets up a breeding ground for inequity. The results of this study may be used to increase awareness for hospital administrators and draw more attention to an issue that may be a contributing factor to the nursing shortage. This study also provides insight for nurses to identify this issue as a group and work within their respective systems on building structures for more empowerment and adding their voice to improving their work environment. Nurse administrators could also have awareness and engage in a different manner with their

teams for an improved work environment. This research will hopefully, in turn, improve the nursing practice environment and improve patient outcomes. This study could have a revealing impact on nurses, administrators, providers, and patients to improve the hospital environment to improve quality care.

Summary

This chapter included the introduction, background, problem statement, research questions, conceptual framework, nature, assumptions scope, limitations, delimitations, and significance of the study. The methodology was a heuristic, phenomenological research approach. I interviewed and analyzed data from nurses practicing in hospital environments to understand power dynamics and perceptions of civilized oppression. The research will potentially address a gap in the existing literature and contribute to increased education and awareness of what is ailing and impacting the sustainment of a highly experienced, engaged, and talented nursing workforce that is in high demand. Chapter 2 includes the literature review.

Chapter 2: Literature Review

Introduction

The purpose of this qualitative study was to explore the lived experiences of oppression and power imbalance in nurses employed within the hospital setting. The conceptual framework was civilized oppression, which is a covert form of nonphysical violence inflicted on others and related adaptive behaviors exhibited by oppressed groups. Oppressive work environments are pervasive in nursing and they continue to manifest with horizontal violence, bullying, aggression, and incivility (Roberts, 2015).

Roberts (2015) studied multiple databases between 1990 and 2010 on lateral violence, bullying, and incivility in nursing based on Friere's theory of oppression and oppressive group behaviors. Roberts validated the oppressive group behaviors in nursing, which is critical to understand given the negative impact of this phenomenon on patient care, job satisfaction, and retention. Roberts indicated the need for future research on clarification of these concepts and understanding the etiology to solve nurse recruitment, retention, and job satisfaction.

Rooddehghan et al. (2015) revealed themes of submission related to work dissatisfaction, discrimination, perceptions of favoring physicians over nurses in terms of resource availability, and oppressive group behaviors. Nurses tend to move between states of oppression and submissiveness in practice settings, which has irreversible effects on quality care, patient safety, and satisfaction status (Rooddehghan et al., 2015). Patient care, patient safety, and job satisfaction statistically correlates with nurses' satisfaction, their occupation, and social status (Rooddehghan et al., 2015).

This section will include a background review and the literature review that includes subsections of oppression, power dynamics, and strategies for improvement. I will also present a review of civilized oppression as the conceptual framework that provided a foundation for this study.

Library Databases and Key Words

A search of the literature was performed using the Academic Search Complete, CINAHL, Medline, and Google Scholar using combinations of the following terms: *oppression, nursing, nurse, aggression, bullying, incivility, civilized, oppression, oppressed group behaviors, empowerment, powerlessness, marginalization, discrimination, marginalized, aggressive, power, dynamics, hospital environment,* and *health care workers*. Articles from peer-reviewed journals were selected that were published within the last 5 years, and book chapters were referenced to provide foundational background and historical context on the conceptual framework and theories on oppression and civilized oppression within the healthcare environment.

Conceptual Framework

The conceptual framework for this study was civilized oppression, which is defined as a more insidious but systematic modern-day version of oppression (Harvey 1999). This section provides a review of oppression theory from Marx, Aveling, Engels, and Moore (2001) and Friere's (1970) oppression in the workplace, oppression in healthcare and the hospital setting, concluding with civilized oppression.

Marx's Oppression Theory

Marx (as cited in Russell, 2001) stated that oppression is a byproduct of the economic system with the rise of capitalism that causes deprivation, increased disadvantages, and exploitation of the poor working class. Marx saw a connection between capitalism and exploitation, which depresses the value of labor of the oppressed managed by the oppressors (as cited in Carling, 1987). According to Marx (2001), with the initial capitalist system and setup, wages impacted quality and intensity of labor, but piece wages then became a by-product of domestic labor, which is a hierarchical and structured system of exploitation and oppression. It created opportunities of a subletting of labor in a division of labor structure in a capitalist system that became fertile ground for exploitation, oppression, and racism (Marx et al., 2001).

The capitalist system enabled a system that exploited, extorted, and oppressed people but also lauded the opportunities the division of labor system created for a growing working class that was united, organized, and provided discipline within that system (Marx et al., 2001). Nevertheless, the capitalist economy created antagonism between labor, wages, and capital and between the owners and workers who were forced into a situation to sell their labor for wages, thus creating a widening divide between the wealthy (owners) and the poor (workers; McLaren & Farahmandpur, 2002).

Marx (as cited in Fornas, 2014) insisted on the need for social change of capitalism from the inside dealing with the inner conflicts of the system rather than an external top-down approach by imposing norms, rules, and ideals on the workers who were most impacted by the system. Marx (as cited by Nemetz & Christensen, 1996)

addressed oppression in a civilized society through radical structuralism being a new version of societal organization, as a latter-day transmutation of inequalities and discrepancy in power and oppression. Harvey (1999) coined the term civilized oppression to address civilized society's version of oppression that is not rooted in violence or law but in concealed weapons of interactional nonphysical violence.

Freire's Theory on Oppression

Freire accepted Marx's theory and definition of oppression and the claim that humans are rooted in historical struggle, but expanded on Marx's theory on the humans' refusal to be powerless while facing oppression and channeling hope for ultimate liberation (Friere as cited by Leonard & McLauren, 2002). Freire (1970) contributed to the concept of oppression with an initial focus on dehumanization, which then wove through the dynamics of alienation, violence, attachment, fear, violence, and possible liberation. Freire defined an oppression situation as *A* objectively exploiting *B* and/or hindering the oppressed pursuit of self-affirmation as an independent and responsible individual; this dynamic can be found in the freest and most developed societies and communities. Duality and internal conflict present struggles for freedom from oppression as that in itself presents new and unchartered challenges for the oppressed. The oppressed experience self-hate and identify with oppressors, which also leads to violence that impedes efforts for liberation from an oppressed system (Freire, 1970).

Freire's (1970) oppression theory had universal application that transcended cultures and continents. Freire (as cited by Fernandex, 2016) allowed for processing of emotions and dialogue for an internal release and a physical release or separation

between the oppressed and the oppressor. Oppression theory remains relevant today; however, it offers an all-inclusive approach to the identification or classification of the oppressed. Although oppression has more historical context and was birthed in developing and underdeveloped societies, it continues in developed, democratic, and capitalist societies (Friere, as cited by Berault, 2003).

Oppression in the Workplace

Cortina (2008) argued that incivility can be identified as modern-day discrimination with it being one of the most pervasive approaches to antisocial behavior in the workplace. Present day oppression is most significantly manifested in a mundane fashion within organizations by management and in normalized daily activities of work where it is accepted "as is" by employee and managers alike (Boyd, 2010). Andersson and Pearson (1999) defined incivility in the workplace as "low intensity deviant behavior with ambiguous intent to harm the target, in violation of workplace norms for mutual respect" (p. 454). Callahan (2011) addressed oppression in terms of civility and incivility causing marginalization and power distance in the workplace.

Incivility has also been described as a way to gain favor and assert superiority, which plays into the attainment of social advantage to soften the divide between rich and poor and employers and employees (Andersson & Pearson, 1999). According to Callahan (2011), power is wielded by corporations that set policies around labeling behavior as uncivil even though corporations can be uncivil themselves. Power is also held over the less powerful by those in higher status, and power can be enacted by lower status people in response to oppressive, inequitable, and unfair practices that turns power

over to the powerful (Callahan, 2011). Workplace incivility dynamics mirror many of the behaviors found in oppressive systems in terms of the unfair advantage over others, which tends to impact social dynamics and relationships and impacts the organization as a whole (Harvey, 1999).

Unintentional, unconscious, and subtle forms of discrimination are not new concepts to understand, but the awareness of incivility as a form of discrimination, marginalization, and abuse is no longer overshadowed in the modernized workplace (Cortina, 2008). D'ambra and Andrews (2014) evaluated the incidence of incivility on the new graduate experience and found that incivility is a predictor of job dissatisfaction in the workplace. D'ambra and Andrews also revealed the need for further research to address incidences of incivility experienced by new graduate nurses.

Oppression in Healthcare and Hospitals

The incidences and nature of violence in the workplace setting is becoming increasingly concerning in the healthcare setting leaving primary, secondary, and tertiary victims working in those environments with posttraumatic stress disorders (Rippon, 2000). In every oppressive situation or relationship, there is at least one oppressor, who tends to be the aggressor or the one who displays aggressive type behaviors towards others. Rodwell et al. (2013) examined the prevalence and antecedents of aggression and related behaviors within the healthcare work environment by nurses and administrative staff. Rodwell et al. measured four types of violence – threat of assault, physical assault, emotional abuse and verbal sexual harassment from patients, visitors, coworkers, and supervisors. Rodwell et al. that revealed 26% of the nurses and 27% of the

administration staff reported having experienced some form of bullying while 29% of nurses and 20% of healthcare administrators reported experiencing emotional abuse. Rodwell et al. exposed a need for future research to include medical practitioners in comparison to lower hierarchy healthcare workers to understand oppression and their relative impact in the healthcare setting. According to Rippon (2000), there is also a lack of empirical research on aggressive type behaviors due to a lack of an agreed upon definition, unwillingness to report due to peer pressure, limited support, and gender bias as nursing is generally a female-dominated profession.

Perceptions of Oppression in Nursing

Research and evidence of oppression in nursing is well established (Roberts, 1983). Scholars have built on groundbreaking research as a means to understand group dynamics, work environment, and the impact these oppressive cultures have on patient outcomes, quality, and safety. Researchers have used research as a means to stress the importance of building nurse leaders who will engage and empower nursing staff to have and use their voice more effectively.

Nurses' Academic Setting

Swartz (2014) defined the nursing academic setting as a learning environment to meet the goals of academic nursing to enrich, teach, and improve the practice setting through conducting research to generate new knowledge and scholarship to improve delivery of quality patient care. Nursing programs have the preponderance of studies regarding academic incivility with student to faculty and faculty to faculty incivility resulting from pressures, interprofessional dynamics, power struggles, and the

hierarchical design of those environments (Wright & Hill, 2015). Understanding constraints and challenges within the system that may negatively impact health care delivery and the ability to simulate nursing care in the academic setting would better position faculty to overcome oppressive obstacles that will benefit nursing students and patients (Swartz, 2014).

There is evidence of incivility in nursing programs (Aul, 2017; Ibrahim & Qalawi, 2016). Sauer, Hannon, and Beyer (2017) explored experiences of peer incivility in the nursing school setting between students and the impact on physical and mental stress measuring stress levels. Based on the definition of civilized oppression, studies on incivility are the closest studies to civilized oppression as it relates to nursing and the professional healthcare environment.

Ibrahim and Qalawi (2016) examined incivility levels between 186 nursing students and 66 faculty members in Egypt to understand the impact of this type of peer incivility. Ibrahim and Qalawi indicated that uncivil behaviors were minimized as irresponsible and inappropriate behavior (60.2%), and more than half of the participants self-reported that they engaged in these behaviors with 47.8% reporting aggressive behaviors.

Aul (2017) explored perceptions of uncivil behaviors among 159 nursing students and 14 faculty members in four prelicensure nursing programs to determine whether there are correlations with age, gender, race, and parental level of education. Aul found that 73% of faculty and baccalaureate 2nd year students reported concerns of incivility while lesser reported similar concerns. Aul revealed that incivility was a more visible and

palpable issue in nursing academia but there was no predictability with experiences or perceptions of incivility based on demographics.

Most participants reported peer incivility with the common forms of incivility occurring with communication by speaking over or interrupting others and using condescending tones (Sauer et al., 2017). There were also correlations between high levels of classroom incivility with peer incivility and high stress levels (Sauer et al., 2017). There is a need for further examination and awareness that could prevent these behaviors from continuing its manifestation in the professional environment.

New Nurses' Transition Experiences to Practice

The newly graduated nurse is most vulnerable and susceptible in the hospital environment to lateral violence and oppression from other nurses and physicians given his or her limited competency at the start of his or her career (Roberts, 2015). The inexperience and cultural normalization of incivility in nursing makes new graduate nurses vulnerable to being victims of these negative behaviors (Laschinger & Read, 2016). D'Ambra and Andrews (2014) examined the impact of incivility on newly graduated nurses to explore organizational strategies to mitigate and manage opportunities for improvement. Chachula et al. (2015) explored factors and the decision-making process involved with new nursing graduates in Canada who permanently leave the profession within 5 years. Chachula et al. revealed that the bureaucratic and backed up health system with poor working conditions had stifled nursing practice. These behaviors were carried out and experienced by nurses and physicians with public criticism, blaming, ridiculing, and humiliation as normalized into the culture (Chachula et

al., 2015). In extreme cases of oppression, it was identified that the stressors outweighed the benefits and gratification of practicing nursing, which culminated in nurses leaving the profession altogether (Chachula et al., 2015).

Ebrahimi et al. (2016) examined acts of violence by experienced nurses on graduate nurses in Iran and found that there was also a hierarchy with oppressive and bullying behaviors mirroring their experiences in nursing school and exhibited in the work environment. Ebrahimi et al. identified two concepts of violence: lateral violence which is frequent, humiliating, and intentional, and hierarchical violence, which is verbal, marginalization and intimidation. Newly graduated nurses (NGNs) were identified as particularly vulnerable given the immediate power distance, reliance, and dependence on experienced nurses (Ebrahimi et al., 2016).

Most organizations focus on strategies that are directed toward adaptation and acculturation versus strategies that would directly address and break the cycle of violence inflicted upon and in some cases carried out by newly graduated nurses (D'Ambra & Andrews, 2014). There is a need to have a standard definition and concept mapping of these behaviors to support future research. There is a lack of generalization given the lack of a standard definition of concepts related to incivility used by previous researchers (D'Ambra & Andrews, 2014).

Experienced Nurses' Experiences Within the Work Environment

Gulzar, Vertejee, Khan, Amarsi, and Macfarlane (2015) explored nurse leaders' perception of empowerment among Pakistani nurses. The five themes that emerged from the data collection process included the status of a nurse, nursing profession, power

relationships, value belief system, and leadership and management in the private and public sector, which revealed the importance of improving public perception, regulatory agencies, educational systems, and educational opportunities (Gulzar et al., 2015). Oppression was identified as a pattern among nurses, along with a need for meaningful change and the need to increase awareness of this dynamic (Gulzar et al., 2015).

Rooddehghan et al. (2015) explored equity and inequity in the healthcare system. Nurses who are oppressors fluctuate between being an oppressor to an oppressee (Rooddehghan et al., 2015). Themes of submissiveness related to work dissatisfaction, discrimination between nurses, and favoring physicians over nursing staff and oppression being transferred to others (Rooddehghan et al., 2015). Similar themes were also found in clinical nurses and nurse managers within the work environment, highlighting the dynamic oppressed nurse and the oppressive nurse in most cases being one and the same (Rooddehghan et al., 2015).

Roberts (2015) examined studies from 1990 through 2010 on lateral violence, incivility, and bullying in nursing with the alignment of oppression theory concepts and behaviors. Roberts recommended better clarification and definition of concepts for standard application and the need to understand the relationship of power, leadership, and lateral violence to develop evidence-based interventions to reduce or eliminate these occurrences. Leadership is also seen as an inflictor of violence given the nature of their work to manage the team and are seen as oppressors themselves or engage (intentionally or unintentionally) in oppressive behaviors (Roberts, 2015). Oppressive behaviors are

experienced in nonviolent forms not only at the staff nurse level and from physicians but at the leadership level as well with leaders as oppressors and also as the oppressed.

Nurses' Experiences of Power Dynamics and Control

Having a sense of power and control are key ingredients to nurses' feeling positive about the environment that they practice within. The essences of power, that is, knowledge, experience, competency, self-confidence, and having a voice, are concepts worthy of further exploration of nurses' lived experiences of their work and practice environment (Fackler, Chambers, & Bourbonniere, 2015). Power is a key component to oppression and incivility as powerlessness and fear are drivers in aggression and anger, which are found in oppressive work dynamics (Roberts, 2015). If nurses have the ability to attain their own goals which results in positive patient outcomes, power is a key concept to understand to improve nurses' work environment, to help nurses feel powerful, and improve quality patient care (Fackler et al., 2015).

Power dynamics in healthcare settings were researched by Fackler et al. (2015) and Lancaster, Kolakowsky-Hayner, Kovacich, abd Greer-Williams (2015). A hermeneutic phenomenological study, grounded by Ponty's theory, was used to explore nurses' embodiment of power with a sample size of 14 clinical nurses employed in intensive care units and on medical floors in two major medical centers in the northeastern United States using semistructured interviews (Fackler et al., 2015).

Other phenomenological researchers explored perceptions of collaboration for interdisciplinary care with a convenience sample of 12 physicians, 13 nurses, and 11 unlicensed assistive personnel (UAPs) in a New York metropolitan hospital (Lancaster et

al., 2015). Galbany-Estragues and Comas-D'Argemir (2016) conducted research on nursing discourse with providing care and explored whether there was a correlation between autonomy and gender within a hospital system in Spain. A study of 163 nurses in adult intensive care units explored issues regarding power distance and perceived power between nurses and physicians (Georgiou, Papathanassoglou, & Pavlakis, 2017).

Power dynamics are important to understand and explore, particularly in the health care setting as it correlates with autonomy and freedoms to practice (Lancaster et al., 2015). Physicians and leaders with formal authoritative authority easily take the form of oppressors in the eyes of a bedside nurse (Rooddehghan, et al., 2015). Power dynamics are shifting with nurses feeling more empowered. Power balance is shifting and improving, but it is challenging to do so given the societal cultural imperialism associated with physicians compared to nurses (Gulzar et al, 2015).

An analysis from interviews revealed that there were themes of feeling powerful with advocacy, power from relationships and collaboration with other providers of care (Fackler et al., 2015). Lancaster et al. (2015) revealed that even though there is positive movement in terms of the power matrix towards nonphysicians, there is a clear hierarchical structure where physicians are seen as the main decision-makers. There was also evidence that the expansion and application of strong nurses' knowledge may pose a conflict with physicians as it was perceived as endangering the traditional power dynamics (Georgiou et al., 2017).

A few nurses stated that it was their impression that physicians felt they were superior and ordered nurses around with a nurse stating that a physician overtly "pulling

rank" over a nurse which indicated that old subservient impressions of nurses and power struggles still existed (Lancaster et al., 2015). Nursing practice had become more and more technologically advanced which has resulted in bureaucratic identified invisibility in the profession (Galbany-Estragues & Comas-D'Argemir, 2016). The implications for practice were that a collaborative environment with every member of the health care team feeling valued was conducive for effective and high-quality patient care (Lancaster et al., 2015).

In as much as there has been relative progress with nurse autonomy, nurses still did not feel comfortable with challenging or confronting physicians with concerns about quality care (Galbany-Estragues & Comas-D'Argemir, 2016). However, many nurses' descriptions of the space where they felt powerful were mainly confined and existed at their patients' bedsides (Fackler et al., 2015). There was a determination of asymmetrical value between medical acts and nursing care which contributed to and reflected the asymmetrical power with the profession and gender (Galbany-Estragues & Comas-D'Argemir, 2016). Clarification about nurse-nurse lateral violence is important to diminish disruption in the healthcare setting (Embree, Bruner, & White, 2013).

Nurses' power struggles extend beyond the bedside. Woodward, Smart, and Benavides-Vaello (2016) conducted exploratory literature search of 32 articles to understand the lack of participation of nurses in the political arena. Woodward et al. identified that nurses' inability to adequately staff hampered their ability to become more involved politically and that they do not see themselves as influencers because they do not generate revenue. Findings were that there was low nurse-physician collaboration,

satisfaction with care decisions, low work environment influence and moderate perceived autonomy (Georgiou et al., 2017). Only 20% of nurses are involved in a professional organization (Woodward et al., 2016). Nurses should be able to call out and deal with their own bureaucratic hierarchies and cultural stereotypes that promote civilized oppression while also challenging a U.S. health system that also supports care based on social status, gender and race (Woodward et al., 2016).

Nurses' Perceptions of Creating a Positive Work Environment

There is an urgency to develop and implement interventions that alter the imbalance of power to forge a different nursing workplace culture and environment (Roberts, 2015). Researchers have identified numerous failed hospital policies that use mandatory reporting as a strategy to manage bullying behaviors as there is a fear and lack of support that any change will happen given typical workplace dynamics (Roberts, 2015). Laschinger and Read (2015) underscored the importance of addressing this negative environment which necessitates ongoing support and oversight of nursing management.

Researchers of a qualitative study exploring Australian hospital practicing nurses' experiences and their perceptions of turnover and strategies to improve retention, performance and job satisfaction support previous research that a poor work environment impacts their ability to enjoy their role (Dawson, Stasa, Roche, Homer, & Duffield, 2014). A systemic review of databases for research from 1980 to 2015 was performed to review common domains of culture improvement strategies, assess effectiveness to improve surgical culture and determine the impact of these improvements on patient

outcomes and efficiency (Sacks et al., 2015). A descriptive qualitative study based in Iran from nurses' perspectives to improve workplace incivility with nurses practicing for at least one year and with a bachelor's degree (Abdollahdez, Asghari, Ebrahimi, Rahmani, & Vahidi, 2017).

Nonfinancial initiatives, like reward and recognition, career and professional development, role clarification, staff engagement, model leadership ,and flexible employment options were themes from the data collection which was analyzed from responses from 362 nurses (Dawson et al., 2014). Barriers to improvements were hierarchical relationships, reverting to traditional norms and behaviors, were identified which could be mitigated with a multimodal and inclusionary approach for all stakeholders and members of the team (Sacks et al, 2015). Nurse empowerment and professional development were key components for progression and positive change (Dawson et al., 2014).

Sacks et al. (2015) identified 47 articles that met inclusion criteria listed interventional strategies that included briefings/debriefings (23), team-building (22), educational campaigns (21) and checklists (15) with limited success as 30 out of the 47 studies indicated no marked improvement to the work culture. Themes from another study indicated that 34 nurses identified raising awareness or improving teamwork among themselves as a major tool or key to mitigating workplace incivility (Abdollahdez et al., 2017). Improved relationships and support from managers, collaborative relationships with physicians, communication skills courses, improving the quality of

nursing education, and introducing new caring approaches were also seen as strategies for positive change (Abdollahdez et al., 2017).

Nurses' Empowerment

Provision of equal conditions for nurses is crucial to equal care provision (Rooddehghan et al., 2015). Both nurse education and management should encourage nurses in innovativeness and problem solving, and these could also be included in the competencies of nursing curricula (Kuokkanen et al., 2016). Giving newly graduated nurses' sense of empowerment during their first years of practice, cementing a strong professional identity and supporting their transition to their profession successful happens with education, nurse managers and support from colleagues (Kuokkanen et al, 2016).

Goedhart, Oostveen, and Vermeulen (2017) indicated that empowering structures were strongly correlated with work effectiveness and nurse empowerment leads to more effective quality patient care. When there is interprofessional conflict and incivility, nurses tend to feel they that cannot ask colleagues for help, particularly when it is truly needed, the quality of care provided and the quality of nurses' work related to their own decision-making, generally, suffer (Boateng & Adams, 2016). High concerns for anonymity and fear of repercussion impacted sample size and lack of understanding of concepts in past research.

There is an urgency to mitigate these issues with the professional culture given the associated attrition of top talent and the negative impact on patient care. Education needs to start in the academic environment to mitigate the foundational breakdown of the nursing structure and prepare future nurses on how to champion through these issues in

the workplace not with acculturation but with advocacy and action (Woodward et al., 2016). Strategies to eliminate, mitigate, and permanently transform these cultures are not well studied nor are there many recent studies addressing these behaviors out as oppression and as civilized oppression.

Nurses' Awareness of Oppressive State

Gulzar et al. (2015) used Friere's theory to attain empowerment starting with awareness through the unveiling of the existence of an oppressive culture and expulsion of myths which requires a rejection of the current negative perceptions by the oppressor and the oppressed to replace with positive truths, pride and a sense of autonomy. There is positive movement and progression in the profession (Gulzar et al., 2015). The research is strong that these uncivil, oppressive and aggressive behaviors start in nurse academia settings between nursing students and nursing students and faculty (D'Ambra & Andrews, 2014). This is behavior that is understated as a cause of moral distress and stress in nursing students (Aul, 2017). Gulzar et al (2015) identified the importance of empowerment as a positive outcome to an oppressed culture. There is collective agreement among researchers to call out these dynamics and raise awareness within the nursing body to start the healing and mitigation process for all stakeholders.

Themes of limitations of the majority of qualitative studies included in the study were low sampling, lack of participation and limited scope of the research being limited to homogenous groups based on place of employment, work roles, geographical region, culture and gender. There is an indication of a need for an expansive and representative sampling of various levels and roles in nursing, various hospitals, genders and in different

locations. Gulzar et al. (2015) also indicated a need for future research to have more male representation to understand the gender dynamic and perception of oppression or feeling oppressed. Incivility in the workplace, bullying, and lateral violence are concepts that need further review, definition, and clarification now that the prevalence in the nursing workplace has been established (Roberts, 2015).

Major themes from the literature search also signify the persistent culture of submissiveness and subservience of nurses within the hospital work environment that transcends cultures and countries across the globe. There were also themes of oppression, oppressive group behaviors and typical dynamics of an oppressive culture with relative powerlessness, marginalization and lateral violence that are insidious in many cases or is normalized behavior in overt circumstances given the cultural impressions and hierarchy setup up internally within organizations and externally in regular society as well.

Roberts (2015) suggested that the relationship of leadership and power needs to be further studied to potentially correlate with the continued existence of lateral violence. Lancaster et al. (2015) identified the need to understand power dynamics between nurses and physicians as there is an assumption of improvement in these relationships without a true measure of any change. There is also a need to understand nurses' perceptions of power and empowerment since it is one of the fundamental concepts of providing quality care (Kuokkanen et al., 2016). Boateng and Adams (2016) suggested that future research must continue to explore intra-professional conflicts to offer insight into internal inequalities within professions and opportunities for professional development. Feelings of oppression and powerlessness based on ethical conflicts, exists in the form of moral

distress in chief nursing officers which has also impacted attrition at the executive level which needs to be explored further to understand prevalence (Prestia et al., 2017).

Summary

The aim of this study was to explore perceptions of oppression, power dynamics and strategies for improvement will provide more current insight on these perceptions and the inclusion criteria will address the gaps in current literature with a wider range of roles, competency, organizations, geographical distribution, and more male representation in sampling as most study participants in past research are female. Understanding oppressed group behaviors and any dynamics around the concept of oppression has tremendous implications for the current and prevailing nursing shortage (Roberts, 2015). The next chapter is an explanation of the methodology and design of the study, and includes the approach, steps, processes and analysis.

Chapter 3: Research Method

Introduction

The purpose of this study was to explore nurses' lived experiences with civilized oppression, inequities, and imbalances of power that could have an impact on nursing practice environments. Nurses' impressions of power, incivility, and creating the ideal work environment are key to understanding their perceptions of oppression (Georgiou et al., 2017). A heuristic, phenomenological approach was selected for this study to understand the lived experiences of nurses and impressions of their work experiences and interactions. It is essential to interpret the meanings and perceptions of nurses' work experience to create, foster, and sustain a positive work environment (Gulzar et al., 2015).

This chapter includes an overview of heuristic phenomenology and the design application for this study. This chapter is structured into six major sections. The first section provides a review of the qualitative heuristic phenomenological tradition and data collection and analysis approaches that were selected for this study. The second section includes my role as researcher with the entire data collection process. In the third section, prescriptive information regarding the selection of participants and the justification of the sampling strategy for the methodology are provided. The fourth and fifth sections include instrumentation and trustworthiness of the study, and the sixth section includes the ethical considerations of the study.

Research questions for this study were

1. What are nurses' experiences with civilized oppression in the hospital setting?
2. What are nurses' experiences with power dynamics and equity in the hospital setting?
3. What are nurses' perceptions of an ideal, safe and empowered work environment?

Research Design and Rationale

The driver for this heuristic phenomenological approach was the need to explore the existence of nurses' lived experiences of oppression within the hospital environment. Qualitative researchers explore the meanings, interpretations, and perceptions that individuals ascribe or attach to a social or human issue (Creswell, 2008). The research design is the plan or proposal for conducting research, and it involves the coordination points for the philosophy behind the approach, strategies for inquiry, and methods (Creswell, 2008). The intent of qualitative research designs is not to prove, disprove, or test theories; it is an iterative process that allows for the theory to emerge once data are collected in an inductive manner (Rudestam, 2014). There are five types of qualitative research: phenomenological, grounded theory, narrative, ethnography, and case study (Creswell, 2008).

Grounded theory design is a strategy that the researcher uses with multiple stages of data collection to derive from a grounded view of participants' data collection a theory of a process, interaction, or action (Creswell, 2008). Narrative inquiry involves the researcher using interviewing skills to pull out the thoughts, interpretations, and feelings

of the narrator to construct and organize previous life experiences (Rudestam, 2014). Ethnography is a strategy where there the researcher observes and studies a homogenous cultural group in a natural setting over a period of time through observations and interviews (Creswell, 2013). Case studies inquiry is a strategy in which the researcher explores a program, activity, process, or event or individuals using in-depth data collection (Creswell, 2008).

Phenomenology

The design of this qualitative study was heuristic phenomenology with an underlying philosophy of social constructionism. Phenomenology is the understanding of phenomena that occurs through a person's consciousness to experience, develop, and share his or her worldview (Duckham & Schrieber, 2016). The philosophy and approach of phenomenology is a focus on the actual experience and how that experience transforms into consciousness (Merriam & Tisdell, 2016). Phenomenology allows researchers to develop new understandings of lived experiences that relies mainly on first person accounts that are obtained through participants' interviews (Gentles, Charles, Ploeg, & McKibbon, 2015). A thorough understanding is a result of exploration using phenomenology (Knecht & Fischer, 2015). The underlying philosophy of this study was social constructivism, which is about people's unique experiences and the way individuals have an impression of how they make sense of the world (Patton, 2015).

A phenomenological approach was appropriate for this study given the lack of standard definition of concepts related to oppression in past research and the lack of awareness of this phenomenon in nursing. Phenomenologists attempt to get beneath the

surface to allow participants to describe their own experiences that may underlie consciousness (Rudestam, 2015). Phenomenology has multiple forms: transcendental, existential, and heuristic (Patton, 2014). Husserl's transcendental phenomenology is mainly about intentionality and the orientation of the mind to an object in an intentional way (Patton, 2014). Existential or interpretive phenomenology is about the variability between individuals' interpretation of the same event (Rudestam, 2014).

Heuristic Phenomenology

Moustakas (1990) defined a type of research that was pertinent in "investigations of human experience" (p. 9). Moustakas coined the term heuristic from the Greek word, heuriskein, which means to discover or to find with an incorporation of self-awareness and self-discovery. The heuristic process is originated from the researcher but later in the process tends to include others with similar experiences. Participants are referred to as coresearchers given their active involvement in the discovery process and analysis (Haertl, 2014).

When describing heuristic inquiry, Moustakas (1990) explained that it is a process that begins with a question or problem and a researcher who seeks to illustrate or provide an answer. The heuristic process requires researchers to move between the internal worlds and the external worlds they experience life within (Haertl, 2014). Heidegger suggested that a philosopher cannot investigate "things in their appearing" to identify their essences while remaining neutral or detached from the things; it is not possible to bracket off the way a person identifies the essence of a phenomenon (as cited in Langdridge, 2007). Patton (2002) separated heuristic research from phenomenology in

terms of focus, personal connection to the topic by the researcher, analytical tools, and approaches with paying high respect to the person in the experience and bringing it to the forefront.

Self-dialogue allows for the movement between both worlds that entails two qualities: (a) for researchers to understand an experience, they must start with themselves to be receptive to all aspects of the experiences being explored as they are occurring; and (b) this self-disclosure exercise allows for the researcher to be more open to others (Haertl, 2014). The fusion of these two qualities creates an authentic product for further analysis and rigor. Self-dialogue creates an opportunity for development of a body of scientific knowledge that is useful to the research community (Moustakas, 1990). Self-dialogue and discussions with others are the final process of heuristic inquiry, which is identified as the "internal frame of reference" and allows for illumination and focus on the internal frameworks of researchers (Moustakas, 1990). The six phases of heuristic inquiry are initial engagement with a topic leading to a research question, immersion into the topic being researched, incubation for a break for a period of time, illumination for the researcher to be more open to tacit knowing to understand data collection, explication that is full examination of all the layers with full consciousness, and eventual culmination of the research process in creative synthesis (Moustakas, 1990).

Sampling refers to the approach or logistics employed to gather information to answer research questions from individuals included in a study related to a group, event, place, or period of time (Ravich, 2015). Qualitative researchers depend on purposefully selecting participates or sites that will best position the researcher to understand the

problem and research question (Creswell, 2008). Phenomenological sampling traditionally focuses on the selection of individual participants who are the experiential experts of the phenomenon resulting in criterion sampling (Rudestam, 2015). Participants in heuristic inquiry are considered to be coresearchers due to the participatory nature and their relationship as joint contributors to the research (Moustakas, 1990).

In purposeful sampling, sample size is based on informational considerations (i.e., if the purpose is to maximize obtaining information, termination occurs when no new information is forthcoming from new participants and there is redundancy; Merriam & Tisdell, 2016). Convenience sampling is based on access. The researcher having easy access is so important that researchers sometimes will choose the site or the research problem because of the access they have to participants (Rubin & Rubin, 2011). Snowball sampling is used to locate information-rich participants obtained by other participants' referrals (Patton, 2014). The research question impacts the site, the organizations, groups, or participants chosen as it must be relevant to the research question (Rubin & Rubin, 2011). Research questions and the intended points of view needed are needed to consider selecting and achieving an intentional sampling strategy (Ravitch, 2015). Purposive or purposeful sampling is the primary sampling approach for qualitative research (Creswell, 2008). Purposive sampling was the method used for this study.

Role of the Researcher

The role of the researcher in heuristic research is a seeker of knowledge and investigator who will set aside notions to avoid tainting the data being collected from participants. The researcher's self is present throughout the process while exploring and interpreting the phenomenon, with the researcher growing self-awareness and self-knowledge (Flood, 2010).

In heuristic research, the researcher is intimately and autobiographically connected to the research question, and the question is infused in the being of the researcher (Moustakas, 1990). Understanding the power of heuristic research is in recognizing the processes of self-searching and the value of personal knowledge as being essential for the exploration and comprehension of human experiences (Moustakas, 1990). The researcher grows in self-understanding and in self through the heuristic process that uses reflection and intuition to accurately depict and report human experiences (Moustakas, 1990).

My interest in exploring perceptions of oppression in nurses derived from my personal experience. I have practiced nursing for almost 24 years, and I have witnessed patterns and themes of behavior that were catalysts to researching oppression in nursing. In my past roles as a staff nurse, nurse manager, and nurse executive, I have been and experienced both sides of behaviors of oppression equation and have been marginalized as much as I have possibly engaged in similar acts towards other nurses and clinicians. Heuristic reduction involves allowing an attitude or openness to wonder and letting things

speak as they are without tainting of opinion or subjectivity from the researcher (Heinonen, 2015).

I have also experienced situations that showed imbalance of power and influence that impacted decision making and slanted towards the opinions of the people who were bringing revenue to the organization. As a nurse leader, I can also attest to inflicting oppressive-like behaviors on nursing staff for them to comply with procedures and policies. Having not had a full understanding regarding this phenomenon, I was not aware of this experience for nurses or what I was attributing to as a manager. My goal was to explore the human experience of oppression in nurses in numerous roles that can impact the level of care delivery of patients.

As the researcher for this study, it was my intent to place controls for objectivity and removal of bias at every step of this process and design. I screened all prospective participants to make sure that I did not include nurses who I have had a past working or personal relationship with. I have led nurses in many roles (i.e., staff nurses and nurse leaders in coordinator, manager, and nurse executive positions) currently and in the past. I also partnered with deans in three schools of nursing in associate and baccalaureate programs in the state of Maryland to support and in advisory capacities.

Study participants were not employed by me, any organization that I was affiliated with, or had any direct professional oversight by me. I had no power or control over the participant, so their responses were objective and independent of my perceptions and impressions related to this study. Heuristic design requires my inflection and self-

discovery, but I was open to data and insights offered by participants for an authentic merging of the two perspectives for validity and rigor.

I did not have any supervisory or management oversight relationships with participants selected for this study. Peer review and member checking for validity was central to this research to control for bias. I also maintained a reflective journal of my own thoughts and impressions at the conclusion of every interview to understand my personal impressions and validate findings without revealing personal identifying information to validate my assumptions against their own for proper bracketing.

Methodology

Sample Size and Sampling Strategy

Moustakas (1990) argued that "it is possible to conduct heuristic research with only one participant" (p. 47). Although thick, rich descriptions and meanings can be obtained in heuristic research from one participant, more deeper meanings can be obtained with more participants (i.e., 10-15; Moustakas, 1990). Creswell (2014) suggested a sample size of three to 10 in qualitative studies.

The purpose of this heuristic inquiry was to explore nurses' experiences of power dynamics and oppressive behaviors in the hospital setting. The participant group was defined as nurses who had more than 1 year of experience in the hospital setting. My sampling strategy entailed advertising on a social media platform, LinkedIn, with a target of 10, which was reduced after further screening and potential loss of engagement or interest of participants over time. Individuals were selected based on meeting screening criteria (years of experience, working in the acute setting, and not having a previous

working or personal relationship with me). Potential participants were contacted via e-mail after responding to the advertisement or through referrals and were provided pertinent information, including the purpose of the study, how the data gathered will be used, study procedures, confidentiality procedures, risks and benefits of their participation, and informed consent.

Saturation is reached when the researcher is not receiving new information with the identification of similar themes (Malterud, Siersma, & Guassora, 2016). The goal of purposive sampling is to establish a rigorous, ethical, and thorough answer to research questions for a complex and multilayered understanding (Ravitch, 2015). Phenomenological methodology is typically associated with small sample sizes due to the in-depth approach to interviewing (Gina-Marie, 2004).

Participant Selection

Detailed inclusion criteria was as follows: (a) registered nurses currently practicing and leading in the field of nursing in the hospital setting for 1 year; (b) registered nurses with an active or retired license in the state of Maryland; (c) registered nurses who are fluent in the English language; and (d) registered nurses willing to discuss his/her experiences, perceptions, attitudes, and behaviors about incivility, power dynamics, and equity in the acute care setting in a semistructured phone interview using video-conferencing applications with me not to exceed 45 minutes in duration.

The exclusion criteria for individual interview participants were as follows: (a) registered nurses who do not have an active or retired license in the United States, (b) registered nurses not fluent in the English language, and (c) registered nurses who have

had a working relationship me within the last 5 years. A full review of the number of participants' responses, rationale for inclusion, and exclusion of participants were included in the study.

Recruitment Approach

I utilized LinkedIn to recruit participants by posting my research study with an advertisement with specific inclusion criteria to nurse social network groups. I created a page on LinkedIn titled "RN Study on oppression and power dynamics in hospital settings." I advertised to nurses on LinkedIn for a finite period of time until I reach 10-15 participants that will be screened to meet criteria (Appendix E). The advertisement or post (Appendix B) also included information regarding:

1. The need for Registered Nurses from a variety of roles- bedside RNs, nurse leaders and nurse executives to participate and there will be an IRB approved token of approval for participation.
2. Time commitment of 45 minutes maximum.
3. Remote interview approach using conferencing applications –telephone interview.
4. The fact that there will be an informed consent, audio recording, confidentiality
5. $50 gift card will be provided at the start of the initial interview.

All prospective participants that responded to the advertisement received a response from me via LinkedIn, thanking them for their interest, then requested an e-mail address to forward presurvey questionnaire that will include questions about the setting they are currently practicing, years of practicing in that environment, validation that they are a licensed registered nurse, four dates and times of availability for 45 uninterrupted

minutes over the following week for the actual interview (Appendix D). A consent to participate (Appendix C) was also included in the email along with information and a $50 gift card and that it will be provided at the conclusion of the initial interview. Participants were provided my direct contact e-mail and cellular phone number to call me if they have any questions and I requested theirs as well to check in as needed.

Each prospective participant that met inclusion criteria were forwarded a consent (Appendix C) via e-mail that included my contact information, the scope, and intent of the research and was scheduled for an interview upon identification with the categories mentioned (Appendix A) and signed agreement to participate. My contact information included my name, affiliation with Walden University, my cell phone number, and e-mail address where participants could reach me for any reason regarding the survey. Nonresponsive individuals received follow-up calls or e-mails within 5 days after initial invitation information were sent in order to assess interest level or answer any further questions. Participants that did not meet criteria were contacted via e-mail to thank them for their interest and informed that they will not be included in the study and the rationale.

Participants were selected based upon voluntary interest to participate, meeting inclusion criteria, and their ability to participate in an interview within a month for a maximum of 45 minutes and a follow up review. Participants were assured about confidentiality and blinding of personal and identifiable information by deleting their names and personal information on documents once all data collection is completed. Participants that did not meet criteria were excluded and notified via e-mail and the

rationale for excluding any participants will be documented in the study for transparency. All participants were advised of their rights to participate or decline participation at any point during the study. The informed consent forms were reviewed in detail and forwarded electronically for ratification which were completed by signing and forwarding by e-mail or indicating in an e-mail reply by the participant by typing in the words, I consent to participate in this study and typing in their full name.

Site and Setting

Parameters to conduct the interview at a time, date and place that is open and free from interruptions for the 45-minute time frame that needs to be allotted for the study were communicated via e-mail after the participant agrees and meets inclusion criteria. This was the expectation for the researcher as well. All participants were advised not to engage in the study while at their place of employment but in private spaces or locations that are quiet with no distractions. These requirements were communicated via e-mail or phone to all prospective participants that meet criteria prior to scheduling. Participants were also be advised that the interviews would be tape-recorded and as the researcher, I took field notes. All interviews were conducted by telephone which were communicated to participants in advance.

Procedures

Instrument development. A conversational interview or dialogue is the best method of interviewing for heuristic exploration (Moustakas, 1990). Interconnections and interrelationships in heuristic research allow for a fuller understanding out of internal perceptions, meanings and feelings (Moustakas, 1990). Keeping the meaning of the

phenomenon as the subject of the research question is the artful work of heuristic researcher (Heinonen, 2014). Questions were asked using the responsive interview model which allows for more context and depth for strong theme extraction (Rubin & Rubin, 2011). Research semistructured questions, probes and follow up questions collectively form the style of responsive interviewing (Rubin & Rubin, 2011). Typical methods of gathering data in heuristic investigations is with extended interviews that become dialogue with the researcher and coresearchers (Moustakas, 1990).

My study was centered on three key concepts – oppression, power, and equity. The central question of my study was focused on understanding the lived experiences of oppression, power balance, and equity in the hospital setting. In heuristic phenomenology interviewing the researcher may start with a general plan for the interview but it is suggested that interviews run through three structured phases: (a) establishing and understanding the interviewee's experience, (b) the construction of the experience by the interviewee, and (c) reflection on the meaning (Flood, 2010).

There were very few published peer-reviewed research articles in the last 5 years that focus on the more insidious civilized oppression in nursing. There were several research articles on lateral violence in nursing and oppressive type behaviors on newly graduated nurses entering the work setting and in the academic setting. My discussion with Roberts, a nurse researcher and author, who had published many articles on oppression in nursing validated the need for more research to be done on power dynamics and inequity (Roberts, 2018). There was a gap with clarifying concepts of oppression for participants regarding oppression which is typically perceived as a form of physical

violence anchored in America's history of racism and prejudice (Roberts, 2015). The nine question instrument (Appendix A) was field tested with 2 to 3 experts whom have conducted similar research.

Instrument content validity. The power of heuristic research is in the recognition of the importance of self-searching and the value of personal insight and knowledge as being essential components to understanding human experiences (Moustakas, 1990). Key questions in heuristic instrument design are: (a) what does the participant know about the topic being studied? (b) What qualities or dimensions of the experience emerge? (c) What examples remain alive and vivid? (Moustakas, 1990). Effective interview questions are open-ended and illicit descriptive data, mostly in the form of stories (Merriam & Tisdell, 2016). The purpose and problem statement which address relevancy of the research topic, the conceptual framework of civilized oppression and my personal experience with power and oppression in the hospital setting served as a foundation provided context for the instrument construct. The next step was determining that the questions will be open-ended to allow for an in-depth presentation of impressions and perceptions that fits the qualitative design of this study. Nursing researchers in nursing oppression and lateral violence reviewed the questions for validity, clarity, and appropriateness and questions or concepts that are not applicable were revised or eliminated. A methods expert reviewed the tool for heuristic study approach alignment.

The content validity process was completed to clarify any confusing concepts, eliminate redundancy, and maintain focus on the research questions. I conducted a field test which served as validation using experts to challenge the questions within interview

protocols is a necessary step in questionnaire tool development and optimization of the questionnaire design for optimal data gathering (Ravitch, 2015). I decided on a field test because the tool was researcher-developed and I needed validation that the questions were in alignment with the purpose of the study.

The experts on my study sought to validate understanding and analysis to control for bias. Background information of the external content reviewers will be included in the study and will be included in the IRB request. The instrument was reviewed with two researchers, Roberts and Armmer, who have conducted related studies. This testing is important to establish the content validity of an instrument and to improve questions and format. Key aspects of the field test would be length of interview, eliminating redundancy clarification of questions, alignment with research questions and purpose, addressing the gap in literature and appropriateness of interview questions (Ravtich, 2015).

I held a phone conference with Armmer, who is an associate professor in the Department of Nursing and a coresearcher on a 2015 study on the perceptions of horizontal violence in staff nurses and intent to leave, to provide insight on my interview questions in relation to the purpose of my study. She provided feedback on the following:

1. Length of the interview needing to be adjusted to no more than 30 minutes
2. Offering a $50 gift certificate for participation versus $25
3. Shortening survey further to less questions and more clustering of questions

4. Adjusting and eliminating yes or no questions and suggested clustering of questions

   -eliminated the question “have you heard of oppression in nursing?”

   -clarified question regarding “perceptions of where power lies” for better phrasing

   -being specific regarding inter-professional relationships question to state fellow nurses, physicians and leadership

   -adjusted question regarding “what does an ideal environment look like

Adjustments were made to the interview tool based on her recommendations.

Original Version Feedback

Roberts is the Professor and Director of the Adult Gerontology and Northeastern University School of Nursing and author of numerous articles that focus on this topic in the profession of nursing. She advised me that it would be most important to explore oppression from a standpoint of power and influence from the bedside nurses’ standpoint. She reviewed a summary of my proposal via e-mail which included my purpose, research questions, and interview questions and forwarded a response that my interview “questions were good ones for the research questions and that I was off to a good start” (Roberts, 2018).

Interview Protocol

The interview protocol (Appendix D) allows for standardization, organization and efficiency in the interview process (Patton, 2014). It was important for there to be as much consistency as possible asking similar questions of all participants as the interview protocol provides a foundation of validity and reliability in social science interviewing

(Patton, 2014). The interview protocol was a worksheet or document for me as the researcher to make notes during the actual interview with participants.

Interview

Once I received participants' signed consent, they were contacted via video-conference using the participant's preferred application at the pre-arranged scheduled date and time. Once contact was made between me and the participant, the first step was to introduce myself and confirm that the participant had a maximum of 45 minutes available without disruptions. Once confirmed with the participant, I reminded the participant about the confidentiality, intent of the study, the fact that the interview was to be audiotaped and their rights as a participant. Once the participant stated that he/she had no concerns, the interview started. Each interview started with demographic questions (name, years of experience, current role, length of time worked in hospital environment) followed by an icebreaker question regarding how and why he or she became a nurse.

The interview questions were aligned with my research questions regarding nurses' experiences with civilized oppression, power balance and equity in the hospital setting and their perceptions of what an ideal and balanced work place. Anticipating variability with responses and behaviors from numerous participants, alternative follow up questions were prepared seeking similar information but worded differently to stay within alignment of the research question. The interview questions were exploratory in nature and began with an opening question about themselves and the participant's work experience and concluded with asking whether there was anything the participant wanted to share related to the purpose of the study. I also employed and engaged tactics of

clarification and elaboration in order to elicit more insight, for thorough understanding, and comfort of the participant (Rubin & Rubin, 2005).

Conclusion of interview. All data collection started from the initial introduction to the conclusion of journaling. All participants were thanked for their participation and reminded of their rights from an ethical perspective. The participants were reminded of the confidentiality of the process and protection of identifying personal information, that is, name, place of employment was blinded. Gift certificates of $50 for participating in the study as outlined in the invitation were provided to the participant at the beginning of the interview for each participant.

Follow up. An e-mail was forwarded to each participant at the conclusion of each interview. The e-mail included a thank you for participation in the study and to request to schedule a 15-minute telephone call for validation member checking of data collected for each participant at the conclusion of data analysis, which occurred a few weeks after the initial interview. The follow up call for member checking was a review of data gathered and impressions from field notes and journal.

Member checking. Transcripts were forwarded to participants via email to review their interview transcript and for them to provide feedback. Participants were reminded that the same standards apply as did for the initial interview and were reminded them of their rights as participants and that their identity would be protected for confidentiality. I had my notes, transcript, and the interview protocol for reference during the follow up interview. At the conclusion of the initial interview, the participants were

thanked and informed of the member checking process which concluded the interview process.

Heuristic phenomenology is concerned not only with interpreting concealed meaning which emerges from participant feedback, but also with understanding the meaning of the phenomenon without suspending the viewpoint of the researcher (Bradbury-Jones, Irvine, & Sambrook, 2010). The final report of the data analysis was provided to the participant to review and provide insight.

Data Sources

Verbatim transcripts of audio taped interviews are the most usual data source in phenomenological research (Priest, 2002). An intensive engagement with data (audiotaped interviews, transcripts, and written accounts) followed by review of transcribed data starting with the first participant to highlight themes with continuous review and reflection with each participant (Priest, 2002). The data sources were mainly the verbatim transcripts, memo writing documents and audiotaped interviews along with similar data from member checking.

Rigor

Confirming validity and trustworthiness in qualitative research entails the methods that researchers affirm that researchers' findings have fidelity to participants' experiences and addresses the quality and rigor of a study (Ravitch, 2015). Achieving rigor is methodological validity that brings credibility to a study (Ravitch, 2015). A key aspect of validity in heuristic research is whether "the ultimate depiction of the experience derived from one's own rigorous, exhaustive self-searching, and from the

explications of others present comprehensively, vividly and accurately the meanings and essences of the experiences" (Moustakas, 1990, p. 32). Ravitch's (2015) checklist for reflexive validity was utilized to test the design for credibility, transferability, dependability, confirmability and intra-intercoder reliability. Constant checking and re-checking the data in the interest of pursuing knowledge, deeper understanding and verification with participants are key to validation (Moustakas, 1990).

Positionality of the researcher is an important aspect of understanding the control for bias in qualitative research which is addressed in depth in the role of the researcher section. A key part of any study is understanding the role of the researcher as one of the challenges of data saturation is regarding the use of personal lens which could carry personal bias (Fusch & Ness, 2015). The role of the researcher is important for clarifying the relationship between a proposition and the broader theoretical context and previous studies (Rudestam, 2015). Given the centrality and criticality of the role of the researcher in qualitative inquiry, the researcher is the primary instrument in this design (Ravitch, 2015).

Ravitch (2015) asserted that positionality and social location are key components of researcher identity and key to understanding the role of the researcher at every stage of the research process. Positionality is the role and identity of the researcher in relationship to the context and setting of the research (Ravitch, 2015). Social location is similar to social identity which includes the researcher's gender, race, sexual identity, culture, and any other identity markers that pertains to the research being conducted (Ravitch, 2015). Qualitative research requires emotional maturity and strong interpersonal skills for

appropriate data collection and to hear the stories of the participants and describe the phenomena of the study in their words (Collins & Cooper, 2014).

Data Analysis

Data were collected multiple sources including transcripts from interviews, member checking, researcher's journal notes, and field notes were utilized for data analysis. The data were segmented from memos gathered during the interview process. The research design of this study interlocked the data collection and analysis process. Key words were used to draw themes and codes for inductive analysis by highlighting and categorizing themes.

Data analysis occurred following the interviews and transcription. An essential component of heuristic analysis is a comprehensive and intimate knowledge of all data collected materials from each participant and the group overall as the process requires exhaustive immersion, breaks and returns to the data (Moustakis, 1990). Early analysis entails recognizing and identifying concepts, themes, events, and examples while paying attention to variation, different emphasis areas ad meanings beyond number counts of themes (Rubin & Rubin, 2011). Data were extracted from transcripts, field notes, and audio recordings. Data was transcribed by the researcher using inductive analysis which is an approach that primarily uses detailed readings of raw data to arrive at concepts, themes or a model through interpretations made from the raw data (Thomas, 2006).

I adopted Moustakis' (1990) outline of an effective and thorough heuristic analysis process following steps:

1. Gathering the data from one participant (transcript, notes, journal, recordings)
2. Researcher enters into timeless immersion of the data until fully comprehended.
3. Setting aside of the data for a later review with intervals of rest in between. After iterative reviews, researcher engages in note taking to identify themes
4. Researcher returns to the original data from the participant to understand themes and sharing depictions with the participant
5. Researcher then completes on participant's analysis and then assumes the same process for other participants.
6. Data collected from all participants at the conclusion of each individual participant's review and enters into another immersion process similar to previous steps above for a composite depiction of data.
7. Researcher returns to the raw material from each individual and individual depictions extracted from the raw material to select 2 or 3 participants that exemplifies the collective participant group.
8. Researcher engages in final step of presentation and handling of the data by creating a synthesis of the experience which allows free range of

thoughts and impressions that support the passion, knowledge and passion of the researcher.

I followed the Moustakas (1990) approach and merge these various approaches and based on the Moustakas (1990) approach, I will complete three to four readings of each transcript, initially to obtain an overall sense of what the participant feedback, then to draw themes and structure of meaning, and conclusively to understand what was stated during the interviews at a deeper and more comprehensive level. I utilized composite textural descriptions wherein different themes were studied to shed light on life experiences of the group and provide a structural description that allows for understanding of how participants as a group experienced from data collection at interviews (Moustakas, 1995). As the primary investigator of this research, I fully completed this process without deletion or engagement of a contracted party or assistant. I shared any discrepant cases that surfaced as a result of this process.

Coding

Heuristic analysis requires a thorough understanding and knowledge of all materials for each participant (Moustakas, 1990). Analytic memo writing was implemented for efficient reflecting for emergence of patterns, themes, categories and concepts. Analysis of pertinent statements, meaning units created thick descriptions. Themes and categories were generated starting from the general to the specific (inductive) which was identified by Creswell (2013) with raw data that were organized, reviewed and coded by creating themes and descriptions and aligned with the conceptual framework and phenomenological approach and then interpreted. Validation and testing

for accuracy occurred throughout the process for rigor. Heuristic analysis requires breaks and returns to the data collected for characterization of the phenomenon which allows the researcher free reign with interpretation (Moustakas, 1990).

Issues of Trustworthiness

There was a process to ensure rigor in this study with transparency in this study indicating all processes and steps taken, results, analysis and implications of this study. Ethical considerations and steps were taken along with removal of any bias from the researcher. Credibility, transferability, dependability, confirmability and inter/intra coder reliability were addressed in the design.

Credibility

Credibility or internal validity involves the researcher's ability to extract meaningful information and inferences and is directly related to the overall design of the research and the researcher's instruments and data (Ravitch, 2015). Credibility is assured through using triangulation, member checking, presenting thick description and utilizing an external resource for editing (Ravitch, 2015). Attention to the research design, sampling and site selection, aligning methods with the research questions, giving participants a role in shaping and challenging and connecting data for theme formation were central to the research design for this study.

Triangulation was achieved by using interviews and other documents to cross check information used for data collection. Member checking or respondent validation was required of all participants prior to the start of data collection for verification of data collected. Member checks were conducted after the interviews.

Transferability

This process entails making a study applicable and transferable to broader settings while securing the richness and context of the research (Ravitch, 2015). Even though the sample size is relatively smaller compared to quantitative studies, there was enough context and rich data through semistructured interviews. Providing detailed instructions of the methods and descriptions of the design and findings of the study and transparency to allow for transferability to other contexts were addressed in this study (Ravitch, 2015). Detailed and prescriptive instructions and strategies were provided for review and understanding of the design process. Quotes and presentation of findings from interviews will be provided. Careful attention to the selection sample and listing the approach was also key to transferability or generalizability. Ozertugrul (2017) argued that the experience of one individual provides information that is relevant to society, but it can be further illuminated through an accurate and honest depiction of that experience.

Efforts were made with the sampling process to intentionally seek variation were taken as indicated in the sample selection of different types of nurses to include gender, age, years of experience for transferability. The most important approach taken for transferability was to provide thick rich descriptions for researchers to consider in the future for further studies. Sufficient information was provided in the study to allow readers to apply this study to future studies conducted by others where findings could be transferable.

Dependability

Dependability parallels reliability and has a focus on the process to ensure the process and design in logical, traceable and documented (Patton, 2014). Describing the research methods, mapping out the methodology, anticipating and addressing potential limitations, and vetting my research design with advisers and experts were key actions to managing the dependability factor (Patton, 2014). The methodology section was expansive and prescriptive with orderly details of the approaches taken in this study.

Dependability was addressed by detailing how and why I selected the research design, mapping the methodology with the research questions, reflexivity with the pursuit of rigor in this study and understanding the challenges and limitations with the design, data collection and analysis. Peer review vetting with key advisors and colleagues to challenge the design and analysis of data were also included in this study. The strength of the research design was defended and detailed in the study. Triangulation and the methods taken were provided in detail for outsiders along with an appropriately selected data collection and analysis plan.

Confirmability

This process is about removing any impression or summation that interpretations were subjective with researcher bias and allows for linking assertions, interpretations, findings (Patton, 2014). Auditing verified findings and inferences made from data collection with primary data sources along with member checking which was communicated to all participants prior to the start of interviewing. Peer review and debriefing with advisors and experts on findings were outlined in the design as well.

Confirmability provided linkages from the data collected to the analysis and findings in a verifiable way so that there is no impression of bias (Ravitz, 2015).

Intra and Intercoder Reliability

Taking breaks from the data and the iterative review of the raw data allowed for validation and verification of interpretation. Full immersion into the data is required for this process. Member checking expectations were set as inclusion criteria for all participants and any members that do not participate were excluded to validate raw data that was coded for analysis. Reflexivity is key to the self-discovery and self-dialogue process which allows for introspection which is a primary objective of the heuristic process (Ozertugrul, 2017).

Ethical Considerations

Ethical routines must be incorporated into the design as researchers need to be familiar with the code of ethics and ethical behavioral situations that will continue throughout the journey (Patton, 2014). Ethical issues in qualitative research occur in regard to data collection and dissemination of findings (Merriam & Tisdell, 2016). A naturalized transcription process was undertaken for a transparency and cross check review. Procedures were employed for confidentiality and for the ethical protection of the participants after approval for the study is obtained from Walden University's IRB office. Personal data were kept separately whenever possible from data collection with the use of identifiers of A, B, C, and so on. Written personal identifying information were kept in my home office drawer under lock and key. Recorded information was under lock and key in the my home office when not in use.

Ethical considerations to recruitment were taken by ensuring confidentiality and the voluntary nature of this study to all potential participants. Every participant were provided an IRB approved consent form (Appendix C) that will explain the intent of the study, procedures for data collection, confidentiality measures, address the lack of risks associated with study participation and the fact that the study was voluntary and the ability for the participant to withdraw at any time for any reason.

All other data concerns associated with data design for this study followed Patton's (2015) ethical issues checklist that has 12 items for consideration with qualitative research which included explaining the purpose, maintaining fidelity with promises, outlining risks, maintaining confidentiality, managing informed consent, walling off access to data, addressing impact of the study, disclosing any confidants or counselors involved in the study, approach to push for data and the ethical framework being used. Data collected were stored electronically on my password protected personal computer that were always be in my possession and any data reviewed by any other individual will not scrubbed of any personal identifying information prior to their review. I have primary and sole access to raw data and all files were kept locked and secured, including all electronic files. All data will be kept for a minimum of 5 years and at that time it would be held securely and destroyed at disposal.

Summary

This aim of this study was to explore perceptions of oppression in nurses in numerous roles from a newly graduated nurse to a nurse executive. The methodology section covered the sample and sampling process, data collection and analysis and

measures for validity and reliability. It also addressed my role as researcher being a tool in this process and not clouding the data analysis and findings with any bias. As the researcher and given my position as a chief nurse executive and having experienced some levels of oppression myself, it was important for this study to have rigor, validity and elements of trustworthiness to remove any potential bias or impression thereof.

Rigorous data collection and analysis methods, aligned with professional integrity measures provides a universal, detailed description of the phenomena through validated identification of themes and relationships between those themes for proper coding (Moustakas, 1994). Other resources for peer review, advising and participant checking for validation were central to the strength of this process. Ethical considerations were taken into account with the recruitment process, data collection process, protection of information and voluntary nature of this study. Finally, a strong focus and attention were paid to the accuracy of the findings, through consistent procedures with effective qualitative data analysis.

Previous chapters explained how data were collected through interviews, observations and other sources. Chapter 4 is a description of the approach taken for data collection, organization, management and analysis. Data collection and analysis are simultaneous and iterative in qualitative research (Merriam & Tisdale, 2016). The approach taken to effectively analyze the data were extensively reviewed in this section.

The conceptual framework of this study is civilized oppression which is inconspicuous and are inherent subtle acts of omission by a powerful person or a group on another (Harvey, 2010). The opportunity that this study presents was to show that

most violence in nursing comes in more insidious forms, whether it occurs in all levels of practice and the impact. Small acts in the form of nonviolent oppression create long lasting systemic dynamics of exclusion, degradation and subordination that are cumulative and interferes with the psychological well-being of victims and their ability to progress and fulfill opportunities (Harvey, 2010).

Chapter 4: Results

Introduction

The purpose of this qualitative study was to explore nurses' perceptions of civilized oppression and power dynamics in the hospital setting using heuristic phenomenology. Nurses' perceptions of power, influence, and control in their work setting is an important dynamic to explore given the potential effect of these factors on the work environment, nursing practice, patient safety, and outcomes. The research questions were the following:

1. What are nurses' experiences with civilized oppression in the hospital setting?
2. What are nurses' experiences with power dynamics and equity in the hospital setting?
3. What are nurses' perceptions of an ideal, safe, and empowered work environment?

This chapter includes a review of the setting for the study, demographics, data collection, data analysis, evidence of trustworthiness, results, and a summary of the findings. The results of the study include themes extracted from the lived experiences of nine registered nurses with at least 1 year of experience in the hospital setting. The findings of the study are illuminated, explored, and presented with a phenomenological lens. The primary goal and intent of the study was to understand nurses' lived experiences of power and influence in the hospital work environment. Regular themes

that emerged from the participants' data described the lived experiences of the participants and answered the three research questions.

Setting

Once participants showed interest in being interviewed for the study and met inclusion criteria, a mutual agreement was reached on a date and time for the interviews scheduled at the convenience of the participant. All interviews were conducted over the telephone after validating that the participant was able to participate in a private and quiet space and was able to spare 45 minutes of uninterrupted time. Interviews lasted an average of 38 minutes. Prior to all interviews, I asked participants questions about themselves to make them comfortable. All participants had signed a consent form prior to the start of the interview, and their understanding of the consent was verified. All interviews were audio recorded using two smartphone devices, with permission to record obtained prior to the start of the interview.

Demographics

The participants were all registered nurses employed at several levels and in different roles and positions within hospitals. There were nine participants, all female, ranging in age from 23 to 59 years. Pseudonyms were assigned to all participants to protect their identity (see Table 1). Two participants had bachelor of science degrees, five had master's degrees, and two had doctorate degrees. One participant was a staff nurse, two were team lead/coordinators, one was an informaticist, one was an educator, one was a nurse manager, two were nursing directors, and one was a chief nursing officer.

Table 1

Participant Demographics

Participant ID	Current Role	Practice Setting	Gender	Tenure in Current PositionRole	Years of Experience	Reporting Manager
P1	Staff RN	Wellness Clinic	Female	6 months	2	Nurse Manager
P2	Analyst	Information Technology	Female	5 years	30	Manager
P3	Director	Transplant Services	Female	5 years	28	Admin Director
P4	Coordinator	Operating Room	Female	6 months	8	Nurse Manager
P5	Manager	General/Nursing	Female	1 year	19	Director
P6	Chief Nurse	Administration	Female	3 years	30	Chief Executive Officer
P7	NP/RN	Emergency Services	Female	1 year	9	Nurse Director
P8	Director	Emergency/Intensive	Female	2 weeks	22	Chief Nurse
P9	Manager	Neuro/Med/Intensive/ Intermediate	Female	7 months	12	Director

Participants were practicing in seven different states: Maryland, Virginia, Florida, California, Illinois, Minnesota, and Rhode Island. Participants worked in academic, community, and community/teaching settings. Three participants reported working in an American Nurses Credentialing Center Magnet Designated facility, with one facility reported as having a pending designation. Years of nursing experience ranged from fewer than 5 years to more than 21 years. Three participants had less than a year in their current positions or roles, and the remainder had been in their roles for fewer than 5 years. Three participants reported to a nurse manager, three reported to a nursing director, one reported to a nonnursing director, one reported to a chief nursing officer, and one reported to a chief executive officer.

Data Collection

IRB approval was obtained from Walden University on December 11, 2018 to begin the data collection process. An electronic advertisement poster was then created, titled "RN Study on Oppression and Power Dynamics in Hospital Settings." The poster appeared on the social media platform, LinkedIn, addressed to registered nurses with more than 1 year in the hospital setting and who had no working relationship with me (Appendix A). The flyer also included my Walden e-mail address and remained online for 3 weeks on my personal LinkedIn page. Approximately 1,600 connections occurred in my network, and the post then extended to other LinkedIn connections not a part of my network. Twenty-three people responded to the advertisement, of whom 13 expressed interest on my LinkedIn page or messaged me directly. I then validated their LinkedIn profiles, history, posts, and activity on the network to confirm that the 13 individuals were registered nurses. All eligible respondents were then contacted within 2 hours. After 13 potential participants were contacted, a notice was posted to LinkedIn that the recruitment process was closed. The potential participants received screening questions for response via e-mail (Appendix E). Eleven individuals who met the inclusion criteria responded within 48 hours and received the informed consent form by e-mail for review. Nine of the 11 respondents indicated their consent to participate and agreed to the terms of this study (Appendix C). The e-mail also included a request for the prospective participant to provide a date and time to schedule an interview that required a minimum of 45 minutes of undistracted and uninterrupted time. The remaining two respondents did

not reply to the e-mail despite numerous reminders that continued until the nine respondents had been interviewed, after more than 2 weeks from initial contact.

Each of the nine participants was greeted with an introductory statement and confirmed a willingness to participate. Participants reviewed their electronic signing of the consent and granted permission to record the interview. Participants were made aware of their rights to stop the interview at any time if they felt uncomfortable. Participants who terminated were thanked for their participation (Appendix B).

A semistructured approach was used during the interview process. Interviews began with an icebreaker question asking for participants' stories on how they chose nursing as a profession and their tenure and background practicing within the hospital setting (Appendix B). All interviews were conducted by telephone using my smartphone for the actual phone call, along with a second smartphone used for recording.

Data were collected over a period of 6 weeks. Interview sessions lasted for an average of 38 minutes, with the shortest interview lasting 35 minutes and the longest lasting approximately 1 hour. The participants were all at their homes during the interviews. I confirmed with participants prior to starting that they were in a private space with no interruptions. At the conclusion of each interview, participants were thanked for their participation and were notified that a summary, including some of their verbatim statements, would be forwarded to them via e-mail to validate the accuracy of the data collected. Participants were advised to provide their personal e-mails instead of their work e-mails, because the data were specific and sensitive. In this way, participants were not unintentionally placed at risk with their employers.

All data were recorded in a recording app on my Apple smartphone. I then hand-transcribed the interviews by reviewing memos and adding information after listening to the recordings. Each recording was reviewed at least twice to edit and compare with memos for accuracy. Memo notes were documented on each interview protocol (Appendix D) for each participant.

Memos were used for recording key information and any other aspects from the interview process. A protocol was completed for each participant that included the initials of each participant, the duration of the interview, and any information that was important to highlight during the interview. The transcription process entailed transferring the data from the recorded interview and memo notes into a written document. I created notes from the interviews, which were also added to create a full summary for the participants to review and provide edits for any corrections. Transcribed information and summaries for each participant was forwarded via e-mail for review and feedback within 2 weeks of the date of the interview. I received feedback from all participants within 1 month. Two participants were reminded to provide their feedback on their summaries, and the remaining seven participants complied within 24 hours of the reminder. Two of the nine participants offered corrections that pertained to their roles and stories regarding being a nurse. None of the participants offered any corrections to the data regarding their experiences related to the research questions.

Variations in Data Collection

Advertisement was conducted solely on LinkedIn and not Facebook, because at the time of data collection, media outlets had been reporting that Facebook was unreliable

in terms of its representation of people or computer systems. Facebook did not provide any ability for me to validate or verify the biographies of the people on that social network. Second, interviews were conducted via telephone instead of Skype, WhatsApp, or Facebook messenger because there was a risk that those systems might be unreliable, the data collection process might be inefficient, and the difficulty of guaranteeing the 45-minute window as advertised. No unusual circumstances were encountered other than one interview that lasted 70 minutes because of the complexity of the participant's organizational structure. The participants were all willing and eager to share their stories and clarified points when asked**.**

Saturation

The first participant interviewed established a baseline of data collection with the interview protocol. By the conclusion of the fourth interview, themes and trends had emerged, as coding was initiated at the conclusion of every interview. Data collection through interviews continued, with the remaining participants indicating key themes of nonphysical violence and powerlessness. The intent was also to include a range of nurse participants with various levels of responsibility, titles, roles, and responsibilities in nursing. However, LinkedIn is used largely by professionals in leadership roles. Therefore, most of the participants occupied leadership positions in this study.

Data coding was conducted manually, along with subsequent analysis after each interview. Themes emerged during the data collection. Thematic saturation of nonphysical violence, powerlessness, and other concepts were trending starting with the fourth participant. After the eighth interview, data saturation had been achieved, given

the similar responses, themes, and codes emerging, and reopening the advertising process on LinkedIn became unnecessary.

Data Analysis

All interviews were recorded using a voice memo application on an Apple smartphone. Notes were taken during each interview, and a preliminary analysis was done immediately after each interview. After all summaries were validated and edited based on participants' feedback, analysis was continued by hand coding. A decision was made against using NVIVO for data analysis because hand coding would permit a deeper immersion in the data to discover themes for proper interpretation. NVIVO is recommended to save time when analyzing large amounts of data (Basit, 2010), but these gains were unnecessary given the relatively small sample size and cost for the current study.

Raw data were plotted into an Excel document. First, columns were created for the demographic data, including roles/positions, years of experience, geographic location, tenure, and academic preparation. Another tab was created to plot the interview data. Columns were then created for the three research questions, the corresponding interview questions and responses, including verbatim statements that corresponded with interview questions. All responses were entered with identifiers for each participant.

The recordings were reviewed three time for completeness and compared with all transcripts and member-checked summaries. An additional column was then created next to the responses to indicate the frequency of certain words and phrases from the interviews that connected with the conceptual framework, interviews, and research

questions. The next step entailed creating categories from the frequencies and codes, leading to the identification of themes and subthemes. The spreadsheet was printed and reviewed regularly to connect codes, categories, themes, and subthemes. Color coding was used for association and matrixing of the concepts back to the research questions. Similar phrases and repetitive words became codes, with outliers noted for each question. Similar words and phrases were color coded based on similarity, positive versus negative, and uniqueness. All codes were arranged in different categories. Themes subsequently emerged and were developed from the categories, which reflected the responses of the majority of the participants. Prior to the finalization of emerging themes, the transcripts and summaries were revisited for accuracy and connection to the conceptual framework. More verbatim quotes were added to the spreadsheet from this review.

Codes identified in the data included bullying and lateral violence between and toward nurses, inability to speak up, subtle forms of control, verbal nonphysical violence, hierarchical relationships, inequity, repeating issues with negative behaviors, nonsupportive and unmanaged behaviors, and systemic issue and opportunities. The categories created were nonviolent forms of violence, not being heard, incivility, submissiveness, powerlessness, system failures, and pervasiveness. The first theme that emerged from the study was powerlessness. Additional themes emerged that related to a lack of belief in participant power or influence in the environment and the harmful effects of working in those environments.

Discrepant Cases

One experience was identified as a dissimilar code and listed in the analysis by creating a column in the coding spreadsheet for each interview question. All discrepant data are identified and presented in tables in the findings section. Discrepant data were identified as data that were singularly inconsistent with other data collected during the interviews. As an example, one participant responded "Yes" to the question regarding considering leaving the nursing profession. This response differed from other responses among the participants.

Evidence of Trustworthiness

The results were evaluated for credibility, transferability, dependability, and confirmability. Following is a discussion of each evaluation.

Credibility

Credibility is key to making the study findings believable. Credibility is enhanced with evidence of confirming the conclusions by participants, merging multiple sources of evidence, controlling unwanted influences, and testing for theoretical fit (Suter, 2012). Triangulation, member checking, bracketing, and thick descriptions were used to enhance credibility in this study. Member checking was performed by means of phone interviews, follow-up text, and e-mail messages. All nine participants validated the data collected. Two participants submitted corrections to the transcripts, which were edited in the final data collection and resent to the participants.

To ensure bracketing, I allowed the data to drive my summaries and memos without injecting personal biases. All of my impressions were included in the summary,

which was reviewed by all participants. Triangulation was achieved by reviewing memos, audio recording, and reviewing transcripts three or four times prior to the analysis process.

Transferability

To ensure transferability, rich and thick descriptions of the data collected from semi structured interviews provided strong context in the study. Transferability is important for applicability and the ability to transfer to broader settings while protecting the rich context of the research (Ravitch, 2015). The relatively small sample size of nine participants provided considerable amounts of rich data for analysis. Quotes and verbatim responses from the interviews will help future researchers to apply the findings to other settings. The inclusion criteria were clearly outlined for review, which indicated sampling methods. The demographic data also reflected the sampling process.

Dependability

Dependability is achieved by ensuring that the research design and methodology remain in alignment with the research questions. The process was followed as outlined in the initial proposed except for the decision not to use NVIVO to analyze the data. The steps for manual coding were prescriptive and clearly illustrated, and the steps clearly outlined the process for any future research to be conducted and replicated. Peer review vetting was also used to ensure that the processes outlined were followed and can be defended.

Confirmability

Confirmability entails the mitigation of any impression that interpretations reflect the researcher's bias (Patton, 2014). Confirmability was ensured by member checking with each participant. Cell phone numbers were obtained for each participant to remain in continual and appropriate communication before and after the interviews. Confirmability was also ensured by means of peer review and debriefing with advisors and experts. All steps and processes for design, data collection, and analysis are available for any interested party to review to confirm results and findings.

Results

Several themes emerged from the interview responses. These themes reflect consistent words, phrases and statements, treated as repeated codes from the interviews. These themes are also directly aligned with the conceptual framework of civilized oppression in the nursing profession. Concepts of submission, powerlessness, marginalization, lateral violence and the negative effects of these experiences on the nursing profession are found in the literature. Additional related themes emerged from the data, thereby helping to illuminate challenges within the nursing workforce.

For the first research question, two themes emerged: (a) nonphysical violence and harm, and (b) feelings of powerlessness. Following is an analysis of the themes. The research question was the following: What are nurses' experiences with civilized oppression in the hospital setting?

Theme 1: Nonphysical Violence and Harm

Nonphysical violence and harm is a classic symptom of civilized oppression (Harvey, 1999). There was clear evidence of negative behaviors suffered by participants from other groups within the work setting that created a lasting emotional impact and affected their ability to feel empowered and be on equitable footing.

All participants were asked whether they had experienced or witnessed any incivility and, if affirmed, they were asked to provide an example. Participants showed emotions during their interviews with some pauses and changes in tones with their voices, along with lengthy and repetitive words to emphasize how they were feeling. There were no mentions of physical violence, but the majority of participants indicated witnessing or experiencing numerous and pervasive verbal acts of nonphysical violence. Codes derived from the data included verbal and nonphysical violence (14 codes), witness or victim of bullying (12 codes), lateral nonphysical violence between nurses (five codes), pervasive incivility/micro aggressions (14 codes), and subtle acts of control (seven codes). There were no codes for physical violence from any participants.

Participants provided vivid and descriptive accounts of their experiences, about which they seemed to harbor strong feelings. One participant e-mailed that reading the summary forwarded to her for member checking brought a lot of her negative emotions back. Relationships with physicians were reported to be volatile. Words used to describe the relationships were *positive, awkward, resistant to change, rough, pushy, fantastic,* and *partnering*. Two the responses were positive, and the remaining seven were mixed or negative. The following are examples of incivility provided by the participants.

- Upset surgeon had asked for one of the peers (team leaders) to talk to him in the OR, expecting to be "reamed out," and the leader was afraid to go alone, so team leads implemented a strategy in which all the department nurse leaders went with her to meet the physician to provide support. This support diffused the situation.
- A participant was being bullied and filed a complaint that went nowhere. VP colleague was a direct report to CEO, who targeted the participant. The ordeal lasted 7 months. The participant filed a complaint with Human Resources. The VP finally left the position when there was an extreme incident with a public display of inappropriate behavior.
- A participant in a staff role decided to meet with Chief Nurse to discuss turnover in the department. The Chief Nurse was preoccupied with another call during the visit and also shared that there was not a focus on tenured staff because "intel" is making them more focused on newer hires. The reason is that tenured staff members are vested in community and are not expected to leave organization.
- Annual staff bonuses are awarded based on performance metrics, but staff members were never made aware of the metrics, which included nurse satisfaction, patient satisfaction, and cost of supplies. Staff members didn't receive bonus and were criticized for not having high nurse satisfaction scores.
- A lead physician typically cursed and yelled at nurses.

- Physician leader, who was co-chair, was late to a meeting that participant started after waiting. Physician yelled about starting without him and stormed out of the meeting with numerous witnesses, which embarrassed the participant.

The participants also shared how these experiences made them feel. Their responses reflect how difficult the experience was. Participants said that the hurt feelings still had an impact on them.

Textual descriptions for Theme 1. Following are direct statements made by participants applicable to Theme 1.

- "I was being knocked down and made to feel like nothing. I was flabbergasted that this was happening, and this cannot be healthy."
- "I distanced myself from projects even though those projects aligned with my skills and expertise, just to avoid him."
- "I felt demeaned, embarrassed, and publicly shamed in front of peers, staff and team. Apology didn't take the hurt and shame away."
- "I had to detach from the situation, and I feel weary of making myself the sacrificial lamb and since then, many times, I do not speak up out of fear."
- "Mean girls at all levels including in leadership" (P5).
- "Tension between nurses and educators causing dissatisfaction" (P3).
- "Hard to break in as a newbie, one particular manager challenging to work with" (P5).

- "A lot of incivility with older RNs feeling threatened and generational tension" (P7).
- "Intimidation within groups and friction, generational dynamics" (P9).
- "Experienced nurses feeling like failures that remain at the bedside as a staff nurse and feels disrespected by newer nurses that advance and pursue advanced degrees" (P9).

All nine participants indicated that nursing incivility was a real concern in their current work environments. Participants reported numerous dynamics occurring between groups, between nurses, between nurse leaders, older generation versus newer, nurses pursuing higher degrees and nurses choosing to stay at the bedside, educators and nurses, and nurses and nursing leaders. In spite of these conflicts, most participants reported that their peers were a main source of support during difficult times and against external forces such as administration, leadership, and physician groups. There seemed to be a banding together and identification of team during challenging times.

Two participants also identified some generational conflict between newer entrants into the profession and more experienced incumbents. Three participants responded that the more recent and younger physicians were relatively easier and more collaborative, compared to the older generation of physicians. There was also a single "tough cookie" bully identified by four participants. Uniquely, one participant (P7) reported feeling more respected from nurses and experiencing significantly less conflict within the same organization when she worked as a nurse practitioner compared to when she worked part-time as a staff nurse.

Theme 2: Feelings of Powerlessness

Harvey's (1999) definition of civilized oppression was mainly about power relations in the work setting related to nonphysical violence, marginalization and submissiveness, fear of speaking up or questioning, system failures and management, and social acceptance, and rationalization. The next theme that emerged from the data was powerlessness. Powerlessness is defined as the lack of ability, influence, or power (Oxford, 2019). Conceptually, powerlessness is captured in civilized oppression theory as a dynamic with people who transgress norms and subsequently experience powerlessness in the form of alienation, as well as overt and covert forms of retaliation using social power (Harvey, 1999).

The codes for powerlessness in the current study included a perception that nurses lacked a voice, did not speak up, or were not heard (24 codes); top-down decision-making, lack of autonomy (10 codes); and others not held accountable for actions (four codes). The data coding revealed participants' perceptions of who held the most power and influence in the hospital work setting. Participants perceived that power and influence resided with groups outside of nursing. One participant believed that the power was primarily with managers and directors, three participants believed that the power was primarily with physicians, and the remaining five participants believed that the power was primarily with administrators. One participant (P8) stated that power and influence was with nurse leaders, but the participant still believed that power ultimately rested with administrators within the organization.

It was evident from the analysis not only that the theme of powerlessness needed to be understood and explored but also that this phenomenon had a strong impact on the overall impressions and experiences of the participants. The sense of powerlessness was pervasive. Most codes that connected to the theme of powerlessness were related to feelings of not being heard, not speaking up, and feeling silenced as a result. All nine participants shared having mixed or negative impressions of their work environment. Participants used conflicting terms such as “not ideal,” “strong relationships,” “family atmosphere,” “evolving,” “chaotic and numbers driven,” “top down,” and “collegial” to describe their work environment.

Participant (P8) described her previous employer’s work environment as positive. She had been with her new employer for only 2 weeks at the point of her interview. This timeframe was too soon for her to describe the environment, but she stated that her first exchange with her new manager was not a positive experience. It was not clear from the statements in the interview whether the term “administration” included the Chief Nursing Officer or Executive, but in either case, the participants expressed feeling disconnected from the executives, who had a heavy influence on their work environment.

It is important to note the relationships of key groups in the hospital setting. As with the responses regarding the work environment, the participants’ perceptions were mixed. Four participants reported positive working relationships with their managers, three participants reported mixed relationships, and two participants reported negative relationships. Strained relationships were attributed to a perceived lack of support and a failure to step up at critical times. All participants reported either mixed or negative

relationships with other nurses at the frontline peer level, supervisory level or administrative level. .

Textual descriptions for Theme 2. Following are direct statements made by participants applicable to Theme 2.

- "Nurses have little power and influence" (P3).
- "Expectation is to work through issues with little or no support. I will be surprised if we achieve designation" (P7).
- "Majority of the nurses are good people and most nurses want to do the right thing" (P6).
- "Feels very top down with administration. (P2).
- "System Chief Nurses are a strong team but not as independent as they would prefer, we do not even have a say with our education and expertise as a group. They felt helpless when participant was struggling with bullying situation with one of the vice presidents and were not able to influence situation but provide support" (P6).

Participants were asked to rank their key working relationships from most to least positive. The most positive relationships were with managers and nurses, whereas the least positive relationships were found among physicians. Managers were ranked as the second least positive relationship compared to their relationships with peers, nurses and physicians. Three of the participants asked to include their peers in their ranking order response, as they have relied heavily on this group for support and guidance which was added to the table in the "other" column.

Table 2

Ranking of Relationships

Participant	Most Positive	Mixed	Least Positive	Other
P1	Physicians	Nurses	Manager	
P2	Manager	Nurses	Physicians	
P3	Nurses	Physicians	Manager	
P4	Manager	Staff	Physicians	Peers (1st)
P5	Manager	Nurses	Physicians	
P6	Physicians	Nurses	Manager	Peers (1st)
P7	Nurses	Physicians	Manager	
P8	Manager	Nurses	Physicians	
P9	Nurses	Manager	Physicians	Peers (3rd)

Participants made the following statements about their working relationships:

- "Very supportive, helps with navigating interpersonal relationships and steers me in the right path" (P4).
- "Seems to be looking for his next role. Not using influence and power when needed to leverage contract language for physicians to meet obligations. I feel alone with managing challenging issues" (P3).
- "Positive relationship until views or ideas do not align with her vision" (P9).
- "Very positive with a great Chief Medical Officer who cares about every staff member. Elevates the culture of nurse physician relationships and holds physicians accountable" (P8).
- "Very awkward with some easier to work with and others seem to make it difficult. Witnessed a physician talking down to a nurse" (P5).
- "Fantastic and figures out how to make things work. Physicians view some nurses as not being engaged which creates conflict" (P3).

For the second research question, four themes emerged: (a) feelings of marginalization and submissiveness, (b) fear of backlash and negative reactions, (c) social acceptance and rationalization, and (d) intentional and unintentional systems failures. Following is an analysis of the themes. The research question was the following: What are nurses' experiences with power dynamics and equity in the hospital setting?

Theme 3: Feelings of Marginalization and Submissiveness

Marginalization refers to peripheralizing individuals and groups from a dominant or central force, which produces both vulnerabilities (risks) and strengths (resilience; Hall, 1999). Marginalization in this study was reflected in responses that indicated that feedback was not requested, considered, or factored into decision-making. Submission occurs within power dynamics and tends to be a reaction from the marginalized group to avoid conflict and can be maladaptive, causing more social conflict (Maner, Miller, Schmidt, & Eckel, 2008).

The data reflected sentiments of feeling ignored, not having feedback considered, and behaviors of recanting or relenting concerns after conflict. Coding also reflected participants' impressions that feedback from physicians and managers was favored heavily over theirs. There were 19 codes for feeling ignored; six codes for relenting, recanting, and giving in post conflict; and 14 codes for other groups' ideas and concerns taken into account.

Textual descriptions for Theme 3. Following are direct statements made by participants applicable to Theme 3.

- I had two female Middle Eastern patients scheduled in the clinic who were not treated in a culturally sensitive manner even after I made numerous arrangements for them to have a female interpreter. A male interpreter was provided, which impacted their communication during their visit. The patients were forced to undress with a male in the room, which had a negative impact even though the male interpreter was behind a screen. I tried to intervene and discuss with my manager afterwards but was brushed off. (P1)
- "I spoke up about the patient being in wrong level of care taking up a needed bed. The physician responded, 'It is my decision and it is final.' You are heard as a nurse if your views support theirs" (P9).

Marginalization and submissiveness were reflected in all participant responses from their experiences with speaking up and challenging, followed by either a lack of response or a perception of a refusal to consider or reconsider a different course of action. These experiences were due mainly to interactions with administrators, physicians, and nurse managers or directors towards the participants.

Theme 4: Fear of Backlash and Negative Reactions

Fear is a common emotion felt by the oppressed, not simply because of what the individuals may have experienced themselves, but also because of what they may witness in others from pushing back on systemic strongholds (Friere, 1970). Participants expressed experiences of not questioning or challenging actions, behaviors, or systemic policies and processes, for reasons of fear. Furthermore, this reluctance to challenge,

question, or provide feedback was reflected in disengagement and apathy from some of the participants.

When participants were asked to share any negative encounters they had had in the work setting, regardless of the source, they commonly described fear of interacting and avoidance with an aggressor. Twelve codes were associated with this response. There was also evidence of recoil and avoidance after such events and interactions, affecting participants' ability to engage in further and function effectively in their work settings. None of the participants believed that they were currently working in an ideal or balanced work environment. P7 stated that she did not believe that her current work environment was ideal and balanced, but she had experienced an ideal and balanced work environment with her previous employer.

Participants generally revealed a consistent theme of fear of speaking up and challenging individuals they perceived as having the most power and influence. Just as relationships with managers and physicians were ranked as the least positive and relationships with nurses were ranked as the most positive, nurses reported feeling the most comfortable with peers, and least comfortable with managers and physicians, in terms of asking questions. All participants believed they were victims of negative reactions or bullying events, leading to fear and subsequent withdrawal from situations to prevent a recurrence and continued embarrassment.

Textual descriptions for Theme 4. The following are direct statements made by participants applicable to Theme 4.

- "Weary of making yourself the sacrifice and many times I do not speak up out of fear" (P9).
- "Nurses need an environment where they can take risks without having fear" (P8).
- "Nurses need to be able to practice in an environment where there is less fear of being wrong and fear of approaching leaders, physicians, or asking questions. Intimidation limits the ability to speak up" (P1).
- "You remember the slights the most. Working with physicians to get them to comply requires a lot of pregaming" (P3).
- "Sometimes I do not feel they are interested in making things work" (P5).

Theme 5: Social Acceptance and Rationalization

Regarding the social dynamics and rationale of the current work environment and working relationships, many participants believed that being treated in an uncivil manner was accepted. Participants also described the social acceptance of a hierarchical structure, with physicians and leaders at the top. These findings emerged consistently throughout the data. Coding was high for an overall feeling of apathy, acceptance, and need to adapt to current negative situations and environments. This finding revealed an acceptance of incivility within nursing, particularly with intractable situations with specific individuals who were well known within organizations and departments as being bullies with challenging, difficult, and inappropriate behaviors.

There were seven codes for a normalization of incivility; eight codes for a hierarchical system affecting feelings of equity; and 15 codes for a generalized feeling of

apathy, acceptance, and adaptability. Five of the nine participants identified an individual who made acculturation and acceptance as a new or valuable member of the team difficult.

P4 identified a staff nurse who was difficult to work with but who was a strong clinician considered to be an informal leader in her department. The participant further stated that she went out of her way to ensure that this nurse had a good day even after the staff nurse had been less than welcoming and supportive to her as a new leader. After asking why the staff nurse was being unsupportive, the participant stated that the nurse was justified in her actions, as she had a vested interest in ensuring that high-quality care was provided for her service. Following are similar dynamics reported for a single individual perceived as a bully:

- One registered nurse was perceived as a go-to by all nurses and a "tough cookie" engaging in bullying toward the participant, who was a manager. This toughness was difficult for preceptees. The participant went to extra efforts to help her have a good day. (P4)
- “Breaking in as a new hire is difficult, and working with a nurse presents particular challenges. The bullying behavior was experienced similarly to what was experienced with the previous employer” (P5).
- “I have one nurse who is particularly challenging to work with. (P7).
- A participant was being bullied and filed a complaint that went nowhere. VP colleague was a direct report to CEO, who targeted the participant. The ordeal lasted 7 months. The participant filed a complaint with Human

> Resources. The VP finally left the position when there was an extreme incident with a public display of inappropriate behavior. (P6)

With the exception of P3, all participants were considering a change in the employment situation. However, only P5 was considering leaving the nursing profession. Two participants, P8 and P6, had just changed employers because of bullying and a perceived lack of support from their managers, only to find similar situations in their new jobs.

Theme 6: Intentional and Unintentional Systems Failures

Numerous codes emerged related to intentional and unintentional systems failures. These codes included 11 codes for a lack of action or reluctance to follow up on uncivil behaviors and concerns, 16 codes related to the system culture and a lack of structure and accountability to manage inequity, and 10 codes related to a perception of lost opportunity on the part of the administration to reset the culture. Five participants identified administrators as the group that had the most power and influence in the hospital setting and work environment, whereas one participant believed that most power and influence was held by managers and directors. There were no specific questions regarding the response of leader to concerns of incivility. However, seven participants were asked follow-up questions regarding leaders' response to those concerns. Participants complained that administrators and managers ignored their concerns, did not hear them properly, did not follow up or respond, and did not take concerns. Most of the codes related to systems failures were regarding organizational culture and a lack of structure and accountability to manage inequity. Eight participants identified an issue

with a lack of proper follow-up with their manager, director, or administrator regarding examples of incivility.

Most participants also believed that nursing leaders and administrators did not consistently support nursing. Administrators were defined by all as individuals in C-Suite and executive roles. Participants reported that nursing managers and directors were able to affect the environment to an extent, but that efforts could be thwarted or unsupported by administrators. Eight of the nine participants believed that the administrators had the most influence and power of any group to affect the work environment. Nevertheless, there was a general perception that administrators had ignored and failed to act on complaints of lateral or horizontal violence on the part of peers, managers, or physicians. The overall impression was that administrators had the most power to address and improve hospital work environments. Most participants believed that there was not enough awareness and effort by administrators to improve the work environment.

Textual descriptions for Theme 6. Following are direct statements made by participants applicable to Theme 6.

- "There were managers who will beat us down due to their relationship with key folks in the hospital" (P5).
- "Physicians seem to be listened to more than nurses. Previous manager was let go when she questioned physicians, and there is a top-down push from the CEO and CMO to improve metrics" (P7).
- "These administrators are not on the floor but makes policies and decisions that impact operations and relationships. Nurse managers do not

have much autonomy themselves, and they execute directives of the administration" (P2).

- There was a member of the executive team who was a direct report of the CEO who targeted me, and it was brutal for 9 months. Did not like me, and he did everything he could to try to get rid of me and was going to take me down and was terrible. There was yelling, pointing fingers in my face in public, which finally forced my manager to act. Our CEO didn't do anything about it for about 9 months. My boss is lucky that I still speak to him. (P3)
- "Physicians are money makers for the hospital, and hospital administrators sometimes choose profit over patient safety" (P2).
- Sent an e-mail to manager questioning a policy. Manager took a while to respond but shared email with physician leader and me. Later received a lengthy email that included leadership from physician, where I was personally attacked and was confronted by the anesthesiologist for questioning their judgment. Considered escalating to HR. Eventually I wrote an email to apologize and requested resolution. Previously had a good relationship with this MD. Was sick over the email and offered to resign. Concerns about working with MD again. (P4)
- "Too many broken promises" (P7).

For the third research question, one theme emerged: call for structural empowerment and civility. Following is an analysis of the theme. The research question

was the following: What are nurses' perceptions of an ideal, safe, and empowered work environment?

Theme 7: Call for Structural Empowerment and Civility

Many participants called for structural empowerment and civility in various ways. These ways included true shared governance (two codes); the establishment of core values, standards, and principles (four codes); advocacy (two codes); feeling valued (two codes); stronger nurse leaders (one code); and collaboration (three codes). Participants were asked to explain what would be necessary to shape the culture into one that was positive and balanced, where all voices were heard and everyone believes there is equitable footing with decision-making. Participants emphasized the importance of shared governance and the need for nurse leaders to implement sustained structures that supported nursing with decision-making that would not be later overturned or changed in response to other political pressures related to physicians. There was a mix of perceptions as to what would be required for an equitable environment, but all participants indicated a need for shared values and principles, more collaboration, and advocacy. Perceptions were mixed regarding designations from the American Nurses Credentialing Center, which provides structural blueprints that focuses on a positive work environment and patient outcomes. Participants were divided as to whether a Magnet or a Pathway designation would improve relationships and reduce or eliminate perceptions of power, influence, and oppressive cultures in the hospital work setting. Three participants (P3, P4, and P6) believed that such a designation would improve the work setting; two

participants (P2 and P7) believed that it would not; and the remaining participants believed that it might or did not know.

There was an overall consensus that an ideal and balanced work environment required equal say and an improved voice for nurses to be heard and not ignored. There were also responses that indicated the importance of training nurse leaders on the principles of methods of shared governance. A need for strong implementation of care principles, standards, ethics, and values, along with improved teamwork, support, and collaboration, were perceived as top qualities for an ideal and balanced work environment.

Textual descriptions for Theme 7. The following are direct statements made by participants applicable to Theme 7.

- "Not have nurses feel that they are only good for shift work" (P3).
- "Staff want to be cared about on a personal human level" (P7).
- "Ideation around Magnet principles need to be consistently applied, measured, and felt at the front line" (P3).
- "Engage nurses in expectations and decision making" (P3).
- "Nurses need to be at the table to influence policy" (P4).
- "True shared governance with shared principles and values, staff decision-making" (P1).

Summary

In this chapter, the findings of the current study were presented. The data collection process was outlined and described in detail. The data analysis process was

then explained, and the findings were provided, including seven themes that emerged from the process. For the first research question, “What are nurses’ experiences with civilized oppression in the hospital setting?”, two themes emerged: (a) nonphysical violence and harm, and (b) feelings of powerlessness. For the second research question, “What are nurses’ experiences with power dynamics and equity in the hospital setting?”, four themes emerged: (a) feelings of marginalization and submissiveness, (b) fear of backlash and negative reactions, (c) social acceptance and rationalization, and (d) intentional and unintentional systems failures. For the final research question, “What are nurses’ perceptions of an ideal, safe, and empowered work environment?”, one theme emerged: call for structural empowerment and civility. The trustworthiness of the data was defended in terms of credibility, transferability, dependability, and confirmability. In Chapter 5, the findings, social change implications, and opportunities and recommendations for further action or future studies are presented. The final chapter will also include a reflection of my experience as a researcher, the process of this research, and any changes in my approach and assumptions as a result of this study.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

The Institute of Medicine (IOM), the Joint Commission, American Nurses Association, and the American Organization of Nurse Executives' have all published reports, standards, and expectations regarding issues related to disruptive and inappropriate behavior and have accelerated the need for hospital administrators to understand and mitigate root causes, prevalence, and extent of negative and disruptive in healthcare. The American Nurses Association (2015) published a position statement on incivility, bullying and workplace violence citing the professional responsibility of nurses to display ethical and civil behavior as addressed in the Nurses' Code of Ethics as a primary driver for the development of this position.

It is important to understand the predictors and correlative factors for nurses' job satisfaction that may support the development of effective strategies to address the nursing shortage and improve patient care quality (Lu, Zhao, & While, 2019). Al-Hamdan, Banerjee, and Manojlovich (2018) revealed that communication is a significant factor for nurses' job satisfaction, the nursing work environment, outcomes, and intent to stay. Al-Hamdan et al. also illustrated that improving communication between nurses and physicians is a key factor in job satisfaction and retention.

A heuristic approach was appropriate for this phenomenological study to understand nurses' perceptions of civilized oppression and power dynamics in the hospital setting. This method allowed me to unveil participants' interpretations,

meanings, and life experiences using self-dialogue, self-discovery, tacit knowledge, and intuition (see Salmon, 2012).

In this chapter, I will provide conclusions from the data analysis and findings. I attempted to explore (a) nurses' experiences with civilized oppression in the hospital setting; (b) nurses' experiences with power dynamics and equity in the hospital setting; and (c) nurses' perceptions of an ideal, safe, and empowered work environment.

Key Findings

The research questions addressed in this study were

1. What are nurses' experiences of oppression in the hospital setting?
2. What are nurses' experiences with power dynamics and power balance in the hospital setting?
3. What are nurses' perceptions of an ideal, safe and empowered work environment?

The approach to these research questions illuminated seven themes based upon coding and analysis of responses obtained from participants' interviews:

Theme 1: Nonphysical violence and harm

Theme 2: Feelings of powerlessness

Theme 3: Marginalization and submissiveness

Theme 4: Fear of backlash and negative reactions

Theme 5: Social acceptance and rationalization

Theme 6: Intentional and unintentional systems failures

Theme 7: Need for structural empowerment and civility

These findings align with the research questions and conceptual framework to explore civilized oppression in the hospital setting. The participants signaled the presence of civilized oppression in the hospital setting between nurses and nurse leaders, nurses and physicians, and nurses and administration. The participants also revealed the importance of civility and true shared governance in nurses' work setting.

The seven themes of nonphysical violence and harm, powerlessness, submissiveness and marginalization, fear of backlash, social acceptance and rationalization, and system failures and management were all derived from codes and from the data collected from participants in this study. The high frequency of codes with the themes of nonphysical violence (52) and powerlessness (53) compared to the five other themes confirmed a presence and nurses' perception of civilized oppression in the hospital setting.

The generalized perception of powerlessness is at the center of the nurses' perceptions in the hospital setting that is being fueled or worsened by the dynamics in the hospital setting. The other themes all showed a negative work environment that is further compounded by the inaction and failures of systems to manage and mitigate these issues, which also leads to normalization and acceptance of these dynamics as "nature of the beast" norms. The internal environmental issues identified by nurse participants that occur within the hospital setting are connected and contribute to the instability and unrest within the profession overall. The themes extracted from this study link with the concepts of civilized oppression, which has concepts that are germane to an unhealthy work environment for any individual.

Interpretation of the Findings

The participants included in this study provided their perceptions and impressions to interview questions on power, harm, relationships, and the work environment in the hospital setting that were translated to codes and then themes. The participants confirmed the presence of civilized oppression with their perceptions of power and influence with nurses, physicians, and administration. Participants shared their own experiences and witnessed accounts of incivility between and within groups of nurses, physicians, and leadership who interact within the hospital setting. These conflicts reflect the moral relations concept of civilized oppression that occur between victims, agents, and bystanders (Harvey, 2015). The agents are civilized oppression within all three groups –nurses, physicians and administration- and from individuals from one group towards individuals in other groups that tend to be targets. Behaviors range from subtle to overt to persistent to outlandish outbursts that were evident in all the codes extracted from the data. In many of the examples of incivility, targets were not aware that they were possibly oppressors or agents leading to continued behaviors unless they were made aware of their behavior and the impact it was having on others.

Table 3

Research Questions Aligned with Interview Questions

	Aligned Interview questions
RQ1	Questions 1, 2, 3, 4, 5, 7
RQ2	Questions 2, 5, 7
RQ3	Questions 6, 6b, 7

Research Question 1

In RQ 1, I aimed to understand nurses' perceptions of civilized oppression in the hospital setting. Five interview questions (Questions 1, 2, 3, 4, and 5) provided four themes for RQ1. Themes that emerged from RQ 1 were fear of backlash and negative reactions, marginalization and submissiveness, subtle and pervasive interactional nonviolence and harm, social acceptance and rationalization, and intentional and unintentional system failures. Most participants identified that these perceptions were present and prevalent in the hospital setting with nurse to nurse, nurse to nurse leader, and nurse leader to nurse leader. Perceptions of nurses' lack of competency among patients, family members, managers, and physicians may create conditions that are conducive to violence and may also stoke harassment and discriminatory behavior by nursing colleagues (Najafi, Fallahi-Khoshknab, Ahmadi, Dalvandi, & Rahgozar, 2018). Nonphysical harm between nurses and between nurses and physicians were of particular concern from the data analysis. There is direct victimization in oppression through

violence and a constant fear that violent or negative acts may occur or recur towards the oppressed (Ayon, Messing, Gurrola, & Valencia-Garcia, 2018).

Health care organizations inadvertently propagate oppressive work conditions, which may be organizational antecedents to horizontal violence (Blackstock, Salami, & Cummings, 2018). The theme of powerlessness from the data analysis indicted the normalizing of these behaviors not just within the participants' current work settings but in other organizations as well. Sundean, Polifroni, Libal, and McGrath (2017) explored perceptions of marginalization that impacted nurses and nurse leaders' participation on governance boards given the low participation and appointment of nurses to boards and general impression that nurses lack leadership characteristics, capacity, and decision-making power.

Submissiveness was reflected in the data in terms of yielding or apologizing during conflict even when the participants had a real concern or concern but heeded to prevent further conflict or harm. There was an example of one of the participants apologizing after suffering a written backlash for questioning a physician regarding a policy. Submissiveness and Marginalization were themes identified from the data analysis with nurses not feeling they are not being heard and submitting to pressure when participants voiced a concern and were met with conflict. Submissiveness occurs as a series of occupational conditions that result from dissatisfaction, discrimination between nurses, and favoring physicians over nurses and since nurses were not able to control such conditions, they felt compelled to accept them (Rooddehghan, ParsaYekta, & Nasrabadi, 2015). Nurses tend to fluctuate between states of oppression and

submissiveness in the provision of equal care and their submissiveness was a root cause of their oppression (Rooddehghan et al., 2015).

Cheung, Lee, and Yip (2018) indicated that the most common forms of violence and incivility was verbal abuse or bullying came from nurses themselves and from physicians towards nurses. The results from this study aligned with previous research on nonphysical harm being conducted by nurses towards other nurses and from physicians toward nurses. McFarland and Doucette (2018) suggested that system failures to respond, follow up and act has an impact on nurse reporting of adverse events and nurses would be more willing to escalate adverse events when there is trust between hospital staff and leaders and if nurse leaders model the characteristics of transformational leadership. System failures to respond and manage incidents and raised concerns also arose from data analysis where further harm was inflicted towards nurses practicing in oppressive environments. It is important for hospital administrators to keenly focus on and improve nurses' work environments to achieve civility in work environments where nurses can focus squarely on patient care (Smith, Morin, & Lake, 2018).

Research Question 2

RQ2 was to understand nurses' perceptions of power dynamics and equity in the hospital work setting. Two questions (Questions 2 and 5) were directed towards nurses' perceptions of power and equity that provided a theme of generalized powerlessness from nurses included in the study. Roberts (2015) identified power and powerlessness as key drivers in oppressive environments that are anchored in fear, anger and aggression. The highest frequency of coding from data collection was related to powerlessness. The data

analysis also revealed that nurses who participated in the study did not feel they had power or influence in their environment. One of the most painful aspects of being oppressed is recognizing that one is part of an oppressed group and the feeling of powerlessness to manage or do anything to resolve or remove oneself or others from the situation (Harvey, 2015).

Finchilescu, Bernstein and Chihambakwe (2019) revealed that oppression leaves nurses with feelings of powerlessness, anger, aggression and frustration which tends to turn inward within those groups and are directed and people that are less powerful. This phenomenon aligns with the incivility that was extracted from the data analysis of nurses bullying nurses. An example of that was from a participant stating that "it is hard to break in as a newbie as the behavior I am experiencing is bullying and I experienced this with my previous employer".

Rainer (2015) performed an integrated review of literature that identified power struggles between nurses and physicians and organizational leadership as a predictor of ethical dilemmas along with nurses' lack of authority over physicians and hospital leaders as a broader problem that needs to be addressed. The results of the study indicated that hospital leaders have failed the participants who also felt that hospital administrators have the power to impact the work environment in a positive manner if they were more involved and in a negative manner if matters are left unaddressed. Hospital leaders were identified from the analysis as a group that should focus on improving collaboration and relationships between nurses and physicians to foster a better work environment. There is a correlation between work stressors and nurse physician collaboration and could

maximize opportunities to improve quality patient care and a satisfying work environment equally for nurses and physicians (Alabd, Elsayed, & Elattar, 2018).

Findings in this study revealed feelings of powerlessness at numerous levels (a) the inability to self-manage as victims, (b) the inability to manage incivility that was noted locally managers oversee thus becoming bystanders, and (c) the inability to manage or control systemic issues of incivility that were more disperse organizationally. The imbalance of power between administration and physicians presents a crisis of incivility for nurses who have not historically had the power to impact the environments they practice within (Phillips, Stalter, Winegardner, Wiggs, & Jauch, 2018). Another dynamic that was revealed in this study was intractable conflict with a single well-known bully that some participants yielded and cowered to for acceptance and avoidance of conflict. Most of the participants were in leadership roles and interestingly, they also had feelings of powerlessness and felt that physicians and administration had the most power and influence in their respective organizations. The World Health Organization and International Council for Nurses have identified incivility and feelings of powerlessness have been identified as a global nursing crisis (Phillips, Stalter, Winegardner, Wiggs, & Jauch, 2018).

Nurse managers tend to be large and impactful groups in health care systems and should have the capability to be able to make decisions concerning patient safety, quality of care and nurses' working conditions (Trus, Doran, Martinkenas, Asikainen, & Suominen, 2018). The study emphasized that chief nurses must to find ways to promote innovative and supportive behaviors in nurse managers that will help them achieve their

goals (Trus et al., 2018). However, two of the participants in this study were also chief nursing officers who expressed feelings of powerlessness and lack of control when they were victims of incivility.

Smith et al. (2018) further emphasized the role that nursing leadership, abilities and support of nurses are critical with shaping work environments which ultimately drive decreased coworker incivility. The study findings and analysis indicate an overwhelming perception that power rests heavily on administration to improve work culture and that administration has not leveraged their power to address incivility and in some cases ignored nurses when these issues were escalated. Systemically, research indicated that managers must employ strategies to mitigate the civility climate by strengthening and focusing on fundamental ideologies, mission and core values to address deep "under the iceberg" organizational cultures of incivility that also negatively impacts interactions with patients (Oppel & Mohr, 2019).

Research Question 3

RQ3 was designed to understand participants' perceptions of an ideal and positively balanced work environment and there were two interview questions (Questions 6 and 6b) related to this RQ (Table 10). The theme of shared governance and systemic civility emerged from the data analysis. All participants stated that a system of shared governance and global or systemic civility are key to creating a healthy work environment where nurses would feel as if they have a voice; however, they were specific regarding elements that should be considered with creating structures of empowerment. The themes from the data analysis intersects with perceptions on how to address these

work environment dynamics and creating a systemic structural fix to address these issues. The power dynamics model provides contrasting views of how nurses' work environment can be influenced by dynamics of civilized oppression and true shared governance. True shared governance was coined by one of the participants but expressed strongly by all participants and includes codes (open communication, equity, inter and intra-departmental civility, and shared accountability) which will lead to empowerment but will need to be sustained. Shared governance structures are typically created by nursing leaders for empowerment and shared decision-making (Dechairo-Marino, Raggi, Mendelson, Highfield ,& Hess, 2018). What was clear from the data analysis is that shared governance and civility is not only important for frontline nurses but also pertinent for nurse leaders at all levels.

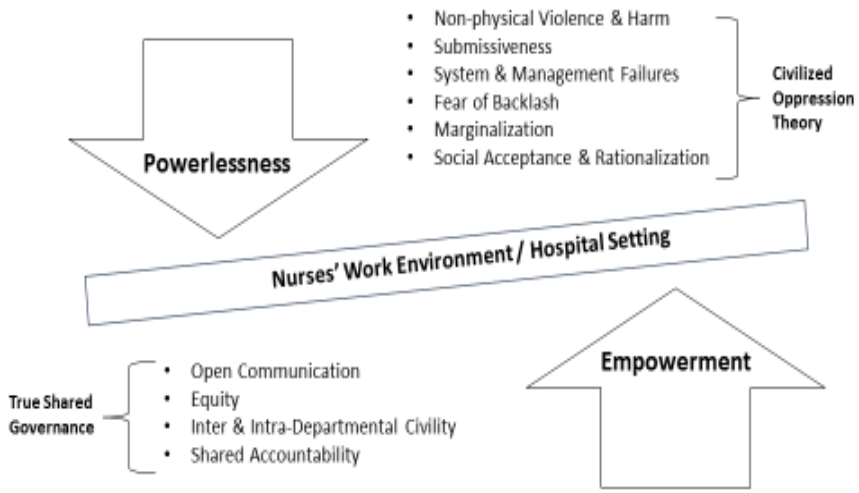


Figure 1. Power Dynamics Model in the hospital setting.

Low levels of organizational support and high moral distress indicates a need for a more supportive environment to reduce this type of stress that impacts nurses' ability to

perform tasks due to psychological barriers (Robaee, Atashzadeh-Shoorideh, Ashktorab, Baghestani, & Barkhordari-Sharifabad, 2018). The results of this study showed that the level of perceived organizational support was low in nurses and moral distress was high. It is necessary to provide a supportive environment in hospitals and to consider strategies for diminishing moral distress.

Oppel and Mohr (2019) offered a model integrating civility between clinical providers and civility toward patients and outcomes which tie into organizational priorities of improving patient satisfaction. Organizations should not rest on the fact that they have shared governance structures but should also measure and understand effectiveness of these structures and whether it empowers nurses and nurse leaders to be able to address incivility in the work setting regardless of whom, when and where it comes (Pattani et al., 2018). The ability for all voices to be heard is critical not only for the initial actions to create structures of empowerment but is more important to build sustained processes for high quality and staff well-being to move the organization forward (Owen et al., 2018).

Characteristics of civilized oppression are indicated in all themes and dynamics from the data collection and analysis from the study by Rogge, Greenwald, and Golden (2004) with key elements and characteristics of "(1) non-peer, power laden relationships; (2) interactions that diminish and control the recipient that has little recourse; (3) cumulative acts of omission and commission that distorts relationships; (5) may or may not with malicious intent and; (6) are insidious and obscured in routine or daily encounters" (p. 306). The conceptual framework aligns strongly with the themes from

this study as the concepts of civilized oppression–workplace dynamic, nonphysical harm, power of one or more groups over another, pervasiveness and insidiousness align with the themes of nonphysical harm, powerlessness, work setting presence, and perceptions of power of other groups (administration and physicians) over nursing. The textual descriptions from the participants reflect the insidiousness and prevalence of incivility in the hospital setting confirming the presence of civilized oppression.

Limitation of the Findings

There are a few limitations of this study. First, the initial intent of this study was to include more frontline nurses and given the methodology for recruitment on LinkedIn, most participants in the study are nurse leaders. More frontline nurses would have provided more direct insight on current workplace environments and dynamics between nurses, nurse leaders, administration and physicians. Secondly, the study was limited to participants that practiced in the United States. Another factor is that all participants were female and it would be interesting to understand gender dynamics as it relates to perceived power and influence in their work environment. A larger sample size would also support general applicability. Lastly, the researcher was the primary investigator in this study and is a registered nurse by profession.

Recommendations

Exploring the presence and impact of civilized oppression on nursing turnover is important to support structures to stabilize the nursing workforce. There is no current research on civilized oppression in nursing work environments specifically, but there are innumerous literature and studies on lateral violence, incivility and bullying in nursing

work cultures. Additional research related to frontline nursing staff and the influence on patient outcomes from a quantitative approach is also warranted as well as the impact that incivility and civilized oppression may have on nurse leaders that are responsible and charged with efforts to mitigate frontline peer to peer and clinician to clinician incivility. Furthermore, exploring this concept outside of the United States for learning and comparison along with understanding whether gender or age impacts levels of incivility would be indicated for further research.

Implications for Positive Social Change

Healthcare workers are four times more likely to suffer from serious workplace violence, with two million reported incidents but many more go unreported (AHA, 2019). It is unclear whether these incidents include the nonphysical harm that is occurring within organizations from caregivers aiming their anger and frustration at each other on a recurring basis. Civilized oppression is considered to be modern day's oppression that is mostly found in workplace settings (Harvey, 2015). Workplace violence studies need to be inclusive of nonphysical harm created from within as it has a psychological impact on health care workers and the costs of this stress account for approximately 0.5% to 3.5% of the gross domestic product (Schwartz & Bjorklund, 2019). Workplace incivility is considered to be the first level of workplace violence (Leiter, 2013). Nursing is the most vulnerable professions to workplace incivility which creates poor working conditions, poor outcomes and increases in medical errors (Arslan Yürümezoğlu & Kocaman, 2019).

Hospitals need to mend and heal from the inside out. Nursing has an ulcerative culture with switching places between being the oppressed and the oppressor. The impact

of this pervasive perverse culture impacts an already unstable workforce, patient outcomes, patient safety, community health, and global wellness. The ability to understand the sources of unhealthy work environments in hospital settings that are endured mostly by the largest workforce in the healthcare sector is pertinent to strike at the root causes of workplace violence for resilience and challenges that nurses face given increasing demand, complexity and challenges from external sources.

Conclusion

Based on the findings from this study, civilized oppression is present in hospitals and needs to be researched more extensively. With all the extensive research on nurse bullying, incivility and lateral violence, nursing turnover and the nursing shortage persists. There was little indication of intent to leave the profession by the participants, but there is constant turnover of nurses and nursing leaders in search for healthier environments to practice within. It is dangerous that nurses are becoming more apathetic and accepting of these behaviors from their peers, supervisors and physicians. This will only lead to a continued vicious cycle that leads to more and more instability with the largest workforce in the health care sector that is being heavily relied on to manage a much-needed transformation of health care from a sick care system to a true health care system. A strong health care system starts with a workforce of healthy nurses that are empowered, engaged and energized to face the challenges of today.

There needs to be awareness of oppression and civilized oppression principles and concepts that are applicable to the hospital setting which will then allow leaders to properly leverage to appropriate professional and external resources to manage these

environments. The exclusive reliance and dependence on nurse leaders who are victims themselves, to mitigate and manage the forces of marginalization, submissiveness, fear of backlash and negative reactions, feelings of powerlessness, nonphysical harm, social acceptance, and systemic inaction is a fallacy with continued efforts in futility.

References

Abdollahzadeh, F., Asghari, E., Ebrahimi, H., Rahmani, A., & Vahidi, M. (2017). How to prevent workplace incivility: Nurses' perspective. *Iranian Journal of Nursing and Midwifery Research*, *22*(2), 157.

Ackerman-Barger, K., & Hummel, F. (2015). Critical race theory as a lens for exploring inclusion and equity in nursing education. *Journal of Theory Construction & Testing, 19*(2), 39-46. Retrieved from http://ezp.waldenulibrary.org/login?url=https://search-proquest.com.ezp.waldenulibrary.org/docview/1801608790?accountid=14872

Alabd, A. M. A., Elsayed, W. A., & Elattar, N. F. M. (2018). Effect of work stressors coping strategies program on nurse physician collaboration. *American Journal of Nursing*, *6*(4), 183-190.

Al-Hamdan, Z., Manojlovich, M., & Tanima, B. (2017). Jordanian nursing work environments, intent to stay, and job satisfaction. *Journal of Nursing Scholarship, 49*(1), 103-110.

AllNurses. (2017). 30% of nurses leaving the workforce - 2017 salary survey results Part 2. Retrieved from http://allnurses.com/general-nursing-discussion/30-of-nurses-1108961.html.

American Nurses Association. (2015). ANA position statement: Incivility, bullying, and workplace violence. Retrieved from https://www.nursingworld.org/practice-policy/nursing-excellence/official-position-statements/id/incivility-bullying-and-workplace-violence/

American Nurses Association. (2018). Workforce. Retrieved from http://nursingworld.org/MainMenuCategories/ThePracticeofProfessionalNursing/workforce

Andersson, L. M., & Pearson, C. M. (1999). Tit for tat? the spiraling effect of incivility in the workplace. *Academy of Management Review, 24*(3), 452-471. Retrieved from http://ezp.waldenulibrary.org/login?url=https://search-proquest.com.ezp.waldenulibrary.org/docview/210962800?accountid=14872

Arslan Yürümezoğlu, H., & Kocaman, G. (2019). Structural empowerment, workplace incivility, nurses' intentions to leave their organisation and profession: A path analysis. *Journal of Nursing Management*.

Aul, K. (2017). Original research: Who's uncivil to who? Perceptions of incivility in pre-licensure nursing programs. *Nurse Education in Practice, 27*, 36-44. doi:10.1016/j.nepr.2017.08.01

Ayón, C., Messing, J. T., Gurrola, M., & Valencia-Garcia, D. (2018). The oppression of Latina mothers: Experiences of exploitation, violence, marginalization, cultural imperialism, and powerlessness in their everyday lives. *Violence Against Women, 24*(8), 879–900. https://doi.org/10.1177/1077801217724451

Barasa, E. W., Cleary, S., English, M., & Molyneux, S. (2016). The influence of power and actor relations on priority setting and resource allocation practices at the hospital level in Kenya: A case study. *BMC Health Services research*, *16*(1), 536.

Basit, T. (2003). Manual or electronic? The role of coding in qualitative data analysis. *Educational Research, 45*(2), 143-154.

Blackstock, S., Salami, B., & Cummings, G. G. (2018). Organisational antecedents, policy and horizontal violence among nurses: An integrative review. *Journal of Nursing Management, 26*(8), 972-991.

Blegen, M. A., Spector, N., Lynn, M. R., Barnsteiner, J., & Ulrich, B. T. (2017). Newly licensed RN retention: Hospital and nurse characteristics. *Journal of Nursing Administration*, *47*(10), 508- 514.

Boateng, G. O., & Adams, T. L. (2016). "Drop dead… I need your job": An exploratory study of intraprofessional conflict amongst nurses in two Ontario cities. *Social Science & Medicine*, *155*, 35-42.

Boyd, N. M. (2010). Forum: Oppression in the mundane of management. *Administrative Theory & Praxis (M.E. Sharpe)*, *32*(3), 445-449. doi:10.2753/ATP1084-1806320311

Bradbury-Jones, C., Irvine, F., & Sambrook, S. (2010). Phenomenology and participant feedback: Convention or contention? *Nurse Researcher, 17*(2), 25-33. Retrieved from http://ezp.waldenulibrary.org/login?url=https://search-proquest.com.ezp.waldenulibrary.org/docview/200849137?accountid=14872

Breault, R. A. (2003). Dewey, freire, and a pedagogy for the oppressor. *Multicultural Education, 10*(3), 26. Retrieved from https://search proquestcom.ezp.waldenulibrary.org/docview/216474461?accountid=14872

Burton, L. J., & Mazerolle, S. M. (2011). Survey instrument validity part I: Principles of survey instrument development and validation in athletic training education research. *Athletic Training Education Journal*, *6*(1), 27-35.

Callahan, J. L. (2011). Incivility as an instrument of oppression: Exploring the role of power in constructions of civility. *Advances in Developing Human Resources*, *13*(1), 10-21.

Carling, A. (1987). Exploitation, extortion and oppression. *Political Studies*, *35*(2), 173-188.

Chachula, K. M., Myrick, F., & Yonge, O. (2015). Letting go: How newly graduated registered nurses in Western Canada decide to exit the nursing profession. *Nurse Education Today*, *35*(7), 912-918

Cheung, T., Lee, P. H., & Yip, P. S. (2018). The association between workplace violence and physicians' and nurses' job satisfaction in Macau. *PloS one*, *13*(12), e0207577.

Cohen, M. Z., Kahn, D. L., & Steeves, R. H. (2000). *Hermeneutic phenomenological research: A practical guide for nurse researchers*. Sage Publications.

Collins, C. S., & Cooper, J. E. (2014). Emotional intelligence and the qualitative researcher. *International Journal of Qualitative Methods*, *13*(1), 88-103.

Cooke, A. L. (1999, Fall). Oppression and the workplace: A framework for understanding. *Diversity Factor*, *8*, 6-11. Retrieved from https://search-proquest-com.ezp.waldenulibrary.org/docview/213077523?accountid=14872

Cortina, L. M. (2008). Unseen injustice: Incivility as modern discrimination in organizations. *Academy of Management Review*, *33*(1), 55-75. doi:10.5465/AMR.2008.27745097

Creel, E., & Tillman, K. (2011). Stigmatization of overweight patients by nurses. *The*

Qualitative Report, 16(5), 1330-1351. Retrieved from http://ezp.waldenulibrary.org/login?url=https://search proquest-com.ezp.waldenulibrary.org/docview/902571541?accountid=14872

Creswell, J. (2013). *Research design: Qualitative, quantitative, and mixed methods approaches,* 4thEdition. SAGE Publications, Inc.

D'ambra, A. M., & Andrews, D. R. (2014). Incivility, retention and new graduate nurses: an integrated review of the literature. *Journal of Nursing Management*, *22*(6), 735-742.

Dawson, A. J., Stasa, H., Roche, M. A., Homer, C. S., & Duffield, C. (2014). Nursing churn and turnover in Australian hospitals: nurses' perceptions and suggestions for supportive strategies. *BMC nursing*, *13*(1), 11.

Dechairo-Marino, A. E., Raggi, M. E. C., Mendelson, S. G., Highfield, M. E., & Hess Jr, R. G. (2018). Enhancing and advancing shared governance through a targeted decision-making redesign. *Journal of Nursing Administration*, *48*(9), 445-451.

Deutsch, M. (2006). A framework for thinking about oppression and its change. *Social Justice Research*, *19*(1), 7-41. doi:10.1007/s11211-006-9998-3

Diekelmann, N. L. (2002). *First, do no harm: Power, oppression, and violence in healthcare* (Vol. 1). Univ of Wisconsin Press.

Duckham, B. C., & Schreiber, J. C. (2016). Bridging worldviews through phenomenology. *Social Work & Christianity*, *43*(4), 55-67

Ebrahimi, H., Hassankhani, H., Negarandeh, R., Jeffrey, C., & Azizi, A. (2016). Violence

against new graduated nurses in clinical settings: A qualitative study. *Nursing Ethics*.

Embree, J. L., Bruner, D. A., & White, A. (2013). Raising the level of awareness of nurse-to-nurse lateral violence in a critical access hospital. *Nursing Research and Practice*.

Emerson, R. W. (2015). Convenience sampling, random sampling, and snowball sampling: How does sampling affect the validity of research?. *Journal of Visual Impairment & Blindness*, *109*(2), 164-168.

Fackler, C. A., Chambers, A. N., & Bourbonniere, M. (2015). Hospital nurses' lived experience of power. *Journal of Nursing Scholarship*, *47*(3), 267-274.

Fernández-Aballí Altamirano, A. (2016). Where is Paulo Freire? *International Communication Gazette, 78*(7), 677-683. doi:10.1177/1748048516655722

Finchilescu, G., Bernstein, C., & Chihambakwe, D. (2019). The impact of workplace bullying in the Zimbabwean nursing environment: is social support a beneficial resource in the bullying–well-being relationship? *South African Journal of Psychology*, *49*(1), 83-96.

Flood, A. (2010). Understanding phenomenology. *Nurse Researcher*, *17*(2), 7-15.

Fraher, E. P. (2017). The value of workforce data in shaping nursing workforce policy: A case study from North Carolina. *Nursing Outlook*, *65*(2), 154-161.

Fornäs, J. (2014). Introducing capitalism: Current crisis and cultural critique. *Culture Unbound: JournaloOf Current Cultural Research*, 615-38.

Freire, P. (1970). Pedagogy of the oppressed. *Herder & Herder, New York*.

Fusch, P. I., & Ness, L. R. (2015). Are we there yet? data saturation in qualitative research. *Qualitative Report, 20*(9), 1408-1416. Retrieved from http://ezp.waldenulibrary.org/login?url=https://search-proquestcom.ezp.waldenulibrary.org/docview/1721368991?accountid=1487

Gentles, S. J., Charles, C., Ploeg, J., & McKibbon, K. A. (2015). Sampling in qualitative research: Insights from an overview of the methods literature. *Qualitative Report, 20*(11), 1772-1789. Retrieved from http://ezp.waldenulibrary.org/login?url=https://search-proquest.com.ezp.waldenulibrary.org/docview/1750038029?accountid=14872

Georgiou, E., Papathanassoglou, E. D., & Pavlakis, A. (2017). Nurse-physician collaboration and associations with perceived autonomy in Cypriot critical care nurses. *Nursing in Critical Care, 22*(1), 29-39.

Gibbons, M. (2015). Teamwork, communication and safety climate: A systematic review of interventions to improve surgical culture. *BMJ Quality & Safety, 24*(7), 458.

Gina Marie, A. H. (2004). Sampling issues in qualitative research. *Nurse Researcher, 12*(1), 7-19. Retrieved from http://ezp.waldenulibrary.org/login?url=https://search-proquestcom.ezp.waldenulibrary.org/docview/200776754?accountid=14

Gulzar, S., Karmaliani, R., Vertejee, S., Khan, K. S., Amarsi, Y., & Macfarlane, J. (2015). A qualitative study of nursing leader's perceptions of professional empowerment amongst Pakistani nurses. *International Journal of Nursing Education, 7*(3), 247-251. doi:10.5958/09749357.2015.00174.9

Haertl, K. (2014). Writing and the development of the self-heuristic inquiry: A unique way of exploring the power of the written word. *Journal of Poetry Therapy*, *27*(2), 55-68.

Hagbaghery, M. A., Salsali, M., & Ahmadi, F. (2004). A qualitative study of Iranian nurses' understanding and experiences of professional power. *Human Resources for Health*, *2*(1), 9.

Hall, J. M. (1999). Marginalization revisited: Critical, postmodern, and liberation perspectives. *Advances in Nursing Science*, *22*(2), 88-102.

Harvey, J. (1999). *Civilized oppression*. Lanham: Rowman & Littlefield Publishers.

Harvey, J. (2010). Victims, resistance, and civilized oppression. *Journal of Social Philosophy*, *41*(1), 1327. doi:10.1111/j.1467-9833.2009.01475.x

Harvey, J. (2015). Civilized oppression and moral relations: Victims, fallibility, and the moral community. Springer.

Heinonen, K. (2015). Van manen's method and reduction in a phenomenological Hermeneutic study. *Nurse Researcher*, *22*(4), 35 http://dx.doi.org.ezp.waldenulibrary.org/10.7748/nr.22.4.35.e132

Ibrahim, S. A. E. A., & Qalawa, S. A. (2016). Factors affecting nursing students' incivility: As perceived by students and faculty staff. *Nurse Education Today*, *36*, 118-123.

Kantek, F., Kaya, A., & Gezer, N. (2017). The effects of nursing education on professional values: A longitudinal study. *Nurse Education Today*, *58*, 43-46.

Koch, T. (1999). An interpretive research process: Revisiting phenomenological and Hermeneutical approaches. *Nurse Researcher, 6*(3), 20. Retrieved from http://ezp.waldenulibrary.org/login?url=https://search-proquest.com.ezp.waldenulibrary.org/docview/200806755?accountid=14872

Kuokkanen, L., Leino-Kilpi, H., Numminen, O., Isoaho, H., Flinkman, M., & Meretoja, R. (2016). Newly graduated nurses' empowerment regarding professional competence and other work-related factors. *BMC Nursing*, *15*(1), 22.

Lancaster, G., Kolakowsky-Hayner, S., Kovacich, J., & Greer-Williams, N. (2015). Interdisciplinary communication and collaboration among physicians, nurses, and unlicensed assistive personnel. *Journal of Nursing Scholarship*, *47*(3), 275-284.

Laschinger, H. K. S., & Read, E. A. (2016). The effect of authentic leadership, person-job fit, and civility norms on new graduate nurses' experiences of coworker incivility and burnout. *Journal of Nursing Administration*, *46*(11), 574-580.

Leonard, P., & McLaren, P. (Eds.). (2002). *Paulo Freire: A critical encounter*. Routledge.

Li, J., Matouschek, N., & Powell, M. (2017). Power dynamics in organizations. *American Economic Journal: Microeconomics*, *9*(1), 217-41.

Lu, H., Zhao, Y., & While, A. (2019). Job satisfaction among hospital nurses: a literature review. *International journal of nursing studies*.

Luparell, S. (2011). Incivility in nursing: The connection between academia and clinical settings. *Critical Care Nurse*, *31*(2), 92-95.

MacKusick, C., & Minick, P. (2010). Why are nurses leaving? Findings from an initial

qualitative study on nursing attrition. *MEDSURG Nursing*, *19*(6), 335-340.

Malterud, K., Siersma, V. D., & Guassora, A. D. (2016). Sample size in qualitative interview studies: guided by information power. *Qualitative Health Research*, *26*(13), 1753-1760.

Maner, J. K., Miller, S. L., Schmidt, N. B., & Eckel, L. A. (2008). Submitting to defeat: Social anxiety, dominance threat, and decrements in testosterone. *Psychological Science*, *19*(8), 764-768.

Mason, M. (2010, August). Sample size and saturation in PhD studies using qualitative interviews. *Forum Qualitative Sozialforschung/Forum: Qualitative Aocial Research*, *11*(3).

Mazurenko, O., Gupte, G., & Shan, G. (2015). Analyzing US nurse turnover: Are nurses leaving their jobs or the profession itself? *Journal of Hospital Administration*, *4*(4), 48.

McFarland, D. M., & Doucette, J. N. (2018). Impact of high-reliability education on adverse event reporting by registered nurses. *Journal of Nursing Care Quality*, *33*(3), 285-290.

McLaren, P., & Farahmandpur, R. (2002). The theoretical: Friere, Marx, and the new imperialism: Toward a revolutionary praxis. *Freirean Legacy: Educating for Social Justice* (pp. 36-56).

Merriam, S. B., & Tisdell, E. J. (2016). *Qualitative research: A guide to design and implementation*. John Wiley & Sons.

Merriam Webster. (2018). Definition of oppression. https://www.merriamwebster.com/dictionary/oppression.

Moustakas, C. (1994). *Phenomenological research methods*. Sage.

Najafi, F., Fallahi-Khoshknab, M., Ahmadi, F., Dalvandi, A., & Rahgozar, M. (2018). Antecedents and consequences of workplace violence against nurses: A qualitative study. *Journal of Clinical Nursing, 27*(1-2), e116-e128.

Nantsupawat, A., Kunaviktikul, W., Nantsupawat, R., Wichaikhum, O. A., Thienthong, H., & Poghosyan, (2017). Effects of nurse work environment on job dissatisfaction, burnout, intention to leave. *International Nursing Review, 64*(1), 91-98.

Nemetz, P. L., & Christensen, S. L. (1996). The challenge of cultural diversity: Harnessing a diversity of views to understand multiculturalism. *Academy of Management. The Academy of Management Review, 21*(2), 434-462. Retrieved from http://ezp.waldenulibrary.org/login?url=https://searchproquest-com.ezp.waldenulibrary.org/docview/210974120?accountid=14872

Ness, L. R. (2015). Are we there yet? Data saturation in qualitative research. Occupational Safety and Health Administration (2001). Retrieved from https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=9636

Oppel, E. M., & Mohr, D. C. (2019). “Paying it forward”: The link between providers’ civility climate, civility toward patients and patient experience outcomes. *Health Care Management Review.*

Owen, D. C., Boswell, C., Opton, L., Franco, L., & Meriwether, C. (2018). Engagement, empowerment, and job satisfaction before implementing an academic model of shared governance. Applied Nursing Research, 41, 29-35.

Oxford Dictionary (2019). Definition of Powerlessness. https://en.oxforddictionaries.com/definition/powerlessness.

Ozertugrul, E. (2017). A comparative analysis: Heuristic self-search inquiry as self-knowledge and knowledge of society. *Journal of Humanistic Psychology*, *57*(3), 237-251.

Pattani, R., Ginsburg, S., Johnson, A. M., Moore, J. E., Jassemi, S., & Straus, S. E. (2018). Organizational factors contributing to incivility at an academic medical center and systems-based solutions: a qualitative study. *Academic Medicine*, *93*(10), 1569.

Patton, M. Q. (2014). *Qualitative research & evaluation methods: Integrating theory and practice*, 4th Edition. SAGE Publications, Inc.

Phillips, J. M., Stalter, A. M., Winegardner, S., Wiggs, C., & Jauch, A. (2018). Systems thinking and incivility in nursing practice: An integrative review. *Nursing Forum*, *53*(3), 286-298.

Plager, K. (1994). Hermeneutic phenomenology. *Interpretive Phenomenology: Embodiment, Caring, and Ethics in hHealth and Illness*, 65-83**.**

Prestia, A. S., Sherman, R. O., & Demezier, C. (2017). Chief nursing officers' experiences with moral distress. *Journal of Nursing Administration*, *47*(2), 101-107.

Priest, H. (2002). An approach to the phenomenological analysis of data. *Nurse Researcher, 10*(2), 50-63. Retrieved from http://ezp.waldenulibrary.org/login?url=https://searchproquest-com.ezp.waldenulibrary.org/docview/200822749?accountid=1487

Rainer, J. (2015). Speaking up: factors and issues in nurses advocating for patients when patients are in jeopardy. *Journal of Nursing Care Quality*, *30*(1), 53-62.

Ravitch, S. M., & Carl, N. M. (2015). *Qualitative research: Bridging the conceptual, theoretical, and methodological*. Sage Publications.

Read, E., & Laschinger, H. K. (2017). Transition experiences, intrapersonal resources, and job retention of new graduate nurses from accelerated and traditional nursing programs: A cross-sectional comparative study. *Nurse Education Today*, *59*, 53-58.

Rippon, T. J. (2000). Aggression and violence in health care professions. *Journal of Advanced Nursing*, *31*(2), 452-460.

Robaee, N., Atashzadeh-Shoorideh, F., Ashktorab, T., Baghestani, A., & Barkhordari-Sharifabad, M. (2018). Perceived organizational support and moral distress among nurses. BMC Nursing, 17, 1–N.PAG. https://doi-org.ezp.waldenulibrary.org/10.1186/s12912-017-0270-y

Roberts, S. J. (2015). Lateral violence in nursing: A review of the past three decades. *Nursing Science Quarterly*, *28*(1), 36. doi:10.1177/0894318414558614

Robinson, O. C. (2014). Sampling in interview-based qualitative research: A

theoretical and practical guide. *Qualitative Research in Psychology*, *11*(1), 25-41. doi:10.1080/14780887.2013.801543

Rodwell, J., Demir, D., & Flower, R. L. (2013). The oppressive nature of work in healthcare: predictors of aggression against nurses and administrative staff. *Journal of Nursing Management*, *21*(6), 888-897.

Rogge, M. M., Greenwald, M., & Golden, A. (2004). Obesity, stigma, and civilized oppression. *Advances in Nursing Science*, *27*(4), 301-315.

Rooddehghan, Z., ParsaYekta, Z., & Nasrabadi, A. N. (2015). Nurses, the oppressed oppressors: A qualitative study. *Global Journal of Health Science*, *7*(5), 239-245. doi:10.5539/gjhs.v7n5p239

Rubin, H. J., & Rubin, I. S. (2011). *Qualitative interviewing: The art of hearing data*. Sage.

Rudestam, K. E. (2015). *Surviving Your Dissertation: A Comprehensive Guide to Content and Process, 4th Edition*. [Bookshelf Online]. Retrieved from https://bookshelf.vitalsource.com/#/books/9781483312576/

Russell, M. (2001). Disablement, oppression, and the political economy. *Journal of Disability Policy Studies, 12*(2), 87. Retrieved from https://search-proquestcom.ezp.waldenulibrary.org/docview/211249311?accountid=14872

Sacks, G. D., Shannon, E. M., Dawes, A. J., Rollo, J. C., Nguyen, D. K., Russell, M. M., . Maggard. http://dx.doi.org.ezp.waldenulibrary.org/10.1136/bmjqs-2014-003764

Salmon, J. (2012). The use of phenomenology in nursing research. *Nurse Researcher,*

19(3), 4–5. Retrieved from https://search-ebscohost-com.ezp.waldenulibrary.org/login.aspx?direct=true&db=rzh&AN=104560058&site=ehost-live&scope=site

Samson-Mojares, R. A., Chin, C. R., Colvin, M. K., & Umadhay, T. (2019). Where do you think you are? A grounded theory study of the critical factors triggering the existence and fueling the persistence of incivility in nursing. *Nursing Education Perspectives, 40*(3), 133-138.

Sauer, P. A., Hannon, A. E., & Beyer, K. B. (2017). Peer incivility among prelicensurenursing students: A call to action for nursing faculty. *Nurse Educator, 42*(6), 281-285.

Schwartz, F., & Bjorklund, P. (2019). Quality improvement project to manage workplace violence in hospitals: lessons learned. *Journal of Nursing Care Quality, 34*(2), 114-120.

Smith, J. G., Morin, K. H., & Lake, E. T. (2018). Association of the nurse work environment with nurse incivility in hospitals. *Journal of Nursing Management, 26*(2), 219-226.

Snavely, T. M. (2016). Data watch. A brief economic analysis of the looming nursing shortage in the United States. *Nursing Economic$*, *34*(2), 98-100.

Spence Laschinger, H. K., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: Impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management, 17*(3), 302-311.

Spencer, B. (2001). Changing questions of workplace learning researchers. *New*

Directions For Adult & Continuing Education, *2001*(92), 31.

Stahl, T. (2017). Collective responsibility for oppression. *Social Theory & Practice, 43*(3), 473-501. doi:10.5840/soctheorpract201773110

Sundean, L. J., Polifroni, E. C., Libal, K., & McGrath, J. M. (2017). Nurses on health care governing boards: An integrative review. *Nursing Outlook*, 65(4), 361-371.

Swartz, M. K. (2014). Critical theory as a framework for academic nursing practice. *Journal of Nursing Education, 53*(5), 271-276. http://dx.doi.org.ezp.waldenulibrary.org/10.3928/01484834-20140408-01

Thomas, D. R. (2006). A general inductive approach for analyzing qualitative evaluation data. *American Journal of Evaluation*, *27*(2), 237-246.

Tinsley, C., & France, N. (2004). The trajectory of the registered nurse's exodus from the profession: a phenomenological study of the lived experience of oppression. *International Journal for Human Caring*, *8*(1), 8-12.

Trus, M., Doran, D., Martinkenas, A., Asikainen, P., & Suominen, T. (2018). Perception of work-related empowerment of nurse managers. *Journal of Research in Nursing*, *23*(4), 317-330.

Tuckett, A., Winters-Chang, P., Bogossian, F., & Wood, M. (2015). 'Why nurses are leaving the profession… lack of support from managers': What nurses from an e-cohort study said. *International Journal of Nursing Practice*, *21*(4), 359-366.

United States Department of Health and Human Services (2014). The future of the nursing workforce: National- and state-level projections, 2012-2025. Retrieved from

https://bhw.hrsa.gov/sites/default/files/bhw/nchwa/projections/nursingprojections.pdf

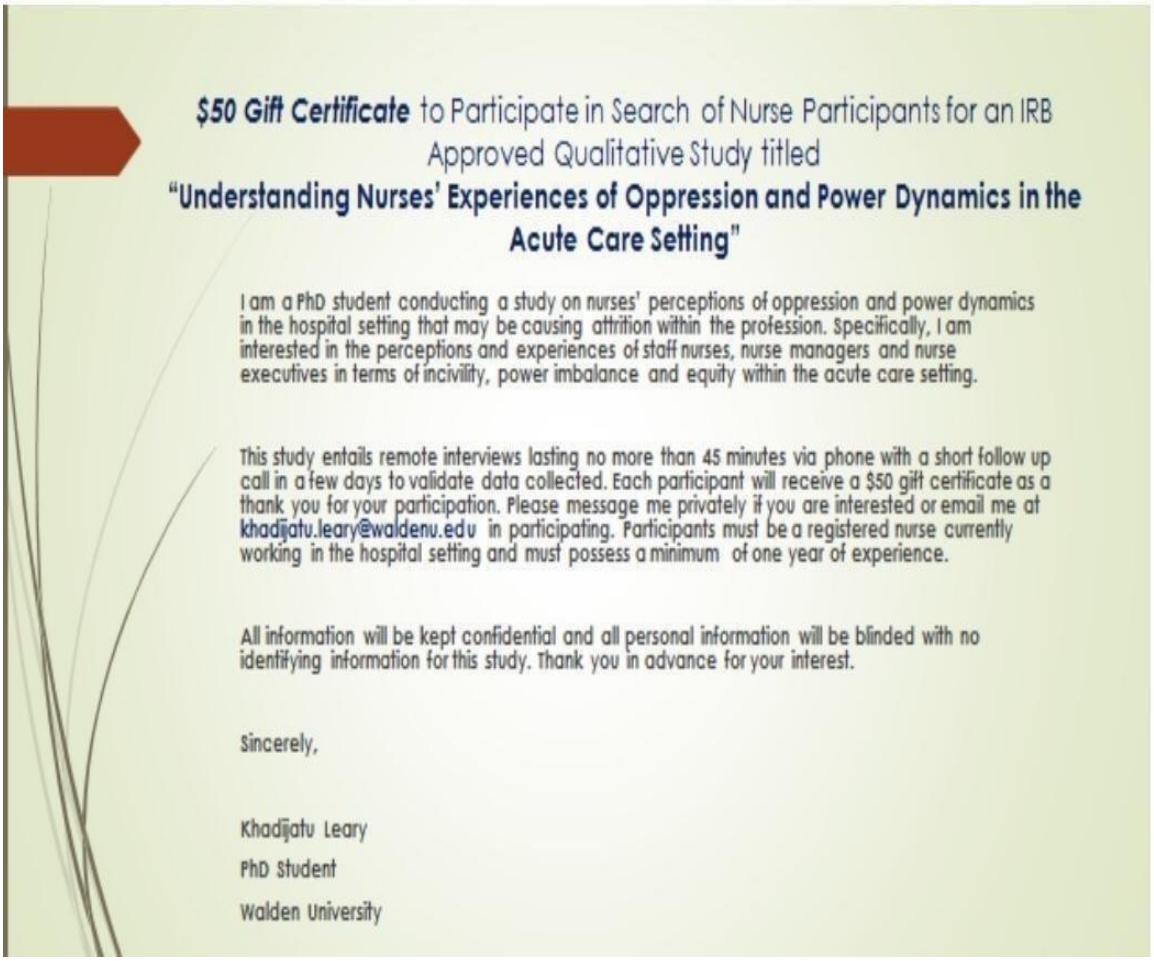
Vila, L. L. (2016). Physician perceptions of magnet nurses and magnet Designation. *Journal of Nursing Care Quality*, *31*(4), 380-386.

Ward, D., & Mullender, A. (1991). Empowerment and oppression: an indissoluble pairing for contemporary social work. *Critical Social Policy*, *11*(32), 21-30.

Woodward, B., Smart, D., & Benavides-Vaello, S. (2016). Modifiable factors that support political participation by nurses. *Journal of Professional Nursing*, *32*(1), 54-61.

Wright, M., & Hill, L. H. (2015). Academic incivility among health sciences faculty. *Adult Learning*, *26*(1), 14-20. doi:10.1177/1045159514558410

Appendix A: LinkedIn Advertisement



Appendix B: Interview Guide

Introduction: Thank you for your interest in participating in my study on nurses' experiences with oppression and power dynamics in the hospital setting. I appreciate the contribution that you will be making to my study and I am excited about your involvement in it. I am, Katie Boston-Leary, the researcher and please know that it is my goal to make sure that you are comfortable and you can ask any questions or stop at any time. I will be recording this session which was addressed as an expectation in this process.

Validate and test functionality of equipment/application: Y/N
Discuss recording of interview and validate consent: Y/N
Review of participants' rights and confidentiality completed: Y/N
Do you have a tool to keep notes during the interview? Y/N

Icebreaker question:

Tell me how you became a nurse and how long have you been practicing nursing in the hospital setting?

Interview questions:

1. Describe your current work environment and culture in the acute care setting.
2. Can you describe your current relationships with:
your manager?
physicians?
other nurses?
How do you rank those relationships starting with the most positive? Are any of these relationships mostly positive?
3. Can you describe a recent experience with one of those relationships that was related to power dynamics or being heard in the workplace?
4. What is your understanding of who holds power and influence in the hospital setting with governing practice and impacting the work culture?
5. What does an ideal and balanced work culture and environment look like to you?

5b. Have you experienced any of the elements of a balanced work culture now or in the past in the acute setting?

6. Did you or have you considered a change in employment while employed in the acute care setting?

6b. What type of change are you considering?

7. Is there anything else you would like to share that I may have overlooked or missed?

Thanks for participating in this interview. Please remember that there will be confidentiality and your rights will be protected. I will be in touch to validate data collected prior to analysis. You can contact me as the researcher at any time. I sincerely appreciate your time.

Appendix C: Consent Form

You are invited to take part in a research study about. "Lived Experiences of Oppression and Power Dynamics in the Hospital Setting". The researcher is inviting registered nurses that have practiced in the hospital setting for more than one year to be in the study. I obtained your name/contact info via Facebook of Linkedin. This form is part of a process called "informed consent" to allow you to understand this study before deciding whether to take part.

This study is being conducted by a researcher named Khadijatu Leary, who is a doctoral student at Walden University.

Background Information:

The purpose of this study is to is to explore nurses' experiences of oppression and power dynamics within the hospital setting. These issues will help with understanding how these dynamics may be impacting the ability to sustain and build up the nursing workforce which has suffered shortages across the globe creating implications for population health and wellness in our communities

Procedures: If you agree to be in this study, you will be asked to:

- Commit to a maximum of 45 minutes for a telephone interview or conferencing applications – Whatsapp or webex
- Agree to sign an informed consent to agree to audio recording of the interview
- Review of interview notes during a follow up call

Here are some sample questions:

- What is your understanding of who holds power and influence in the hospital setting with governing practice and impacting the work culture?
- What does an ideal and balanced work culture and environment look like to you?

Voluntary Nature of the Study:

This study is voluntary. You are free to accept or turn down the invitation. No one at Walden University will treat you differently if you decide not to be in the study. If you decide to be in the study now, you can still change your mind later. You may stop at any time.

Risks and Benefits of Being in the Study:

Being in this type of study involves some risk of the minor discomforts that can be encountered in daily life, such as nervousness, stress or becoming upset. Being in this study would not pose risk to your safety or wellbeing.

This study will benefit nurses and nurse leaders with understanding the impact that this is having on nursing retention and nurses leaving the profession. It will help nurses explore their feelings about the work environment and provide nurses avenues to have these discussions to improve the work environment that would in turn improve patient outcomes and foster innovation.

Incentive: $50 gift card will be provided at the start of the initial interview.

Privacy: Reports coming out of this study will not share the identities of individual participants. Details that might identify participants, such as the location of the study, also will not be shared. The researcher will not use your personal information for any purpose outside of this research project. Data will be kept secure by maintaining

computer information in a password protected computer and recordings will be maintained in a locked drawer in the researcher's home office that the researcher will maintain. Data will be kept for a period of at least 5 years, as required by the University.

Contacts and Questions:

You may ask any questions you have now. Or if you have questions later, you may contact the researcher via 3022993348 or Khadijatu.leary@waldenu.edu. If you want to talk privately about your rights as a participant, you can call the Research Participant Advocate at Walden University at 612-312-1210. Walden University's approval number for this study is IRB will enter approval number here and it expires on IRB will enter expiration date.

Please print or save this consent form for your records.

Obtaining Your Consent

If you feel you understand the study well enough to make a decision about it, please indicate your consent by replying to this email with the words, "I consent."

Appendix D: Interview Protocol

Date: Time: Medium utilized:	Interviewee Name:	Interviewer Name:	Follow up questions and response
	Responses	Notes	
Validate and test functionality of equipment/application: Y/N			
Discuss recording of interview and validate consent; Y/N			
Review of participants' rights and confidentiality completed: Y/N			
Do you have a tool to keep notes during the interview? Y/N			
Icebreaker:			
Tell me how you got into nursing.			
How long have you been practicing nursing in the hospital setting?			
Survey questions:			
1. Describe your current work environment and			

culture in the acute care setting.
2. Would you please share any experiences within the work environment that indicated a power struggle between nurses and any other group?
3. How did that impact your ability to make decisions and provide care?
4. Would you please describe any situations that made you feel as if your voice wasn't important to provide high quality care to your patients?
5. Can you describe a recent experience that was uncivil that continues to give you concerns?
6. What is your understanding of who holds power and influence in the hospital setting with governing practice and impacting the work culture?
7. What does an ideal and balanced work culture and environment look like to you?
8. Is there anything else you would like to share that I may have overlooked or missed?

Thank participant for their time and remind them about confidentiality, right to decline participation and follow up call within one week.

End call and recording

Appendix E: Screening Questions

1. Are you currently a Registered Nurse?
2. Have you been a nurse for more than one year?
3. Have you worked for me or have had a working relationship with me in the past?
4. Are you currently employed or have worked in the hospital setting within the past 5 years?