

Conflict in the Operating Room

Learned helplessness theory is used to explore the barriers to collegiality existing in the operating room.

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The term helplessness frequently is referred to in discussions of power and powerlessness. Learned helplessness theory expands on helplessness and is associated with a perceived lack of control. The theory has been applied to a number of life conditions including gender role socialization, unexplained sudden death, a potential cancer cause, depression, learning disabilities and impaired autoimmune responses. In this paper, learned helplessness is applied to nursing, a predominantly female profession. The focus is on a high-stress department within a hospital—surgery. Our purpose is to explore, via the theory of learned helplessness, a potential barrier to collegiality between physicians and nurses and to provide strategies that promote egalitarian relationships.

Learned helplessness theory was proposed initially by Martin E. Seligman, expanding on the research of Engberg, Hansen, Walker and Thomas who had produced “learned laziness” in pigeons.¹ They defined voluntary responses as those which can be modified by reward or punishment. A response to stimuli which once produced an outcome (behavior) and now produces nothing is called extinction. Thus, after continuous positive reinforcement to random negative stimuli, the animals were less able to respond to future negative reinforcers and became passive, submissive and non-responsive.

Seligman found that dogs, monkeys, worms, mice and rats, subjected to repeated, random electrical shocks (negative reinforcement), eventually ceased to avoid the stimuli. Passive, helpless behavioral responses were evidenced in all species by increased social withdrawal, reduced interest in exploration, decreased social status, increased depression and passive-aggressive behaviors.

His studies revealed that if there was a lack of contingency (uncertainty) in early life between a stimulus, the subsequent behavioral response, and an anticipated outcome there was increased vulnerability to learned helplessness later in life. He hypothesized that it was not the trauma

of the stimuli that produced helpless behavior, but rather the perceived lack of control.

Defining learned helplessness the psychological state that results when events in life are uncontrollable, Seligman identified three factors that influence perception of control: motivation, cognition and emotion. Based on the animal studies, he hypothesized that learned helplessness also can be applied to humans and could have implications for child-rearing practices.

Hirato replicated Seligman's experiments with three groups of college students, using random noise as the stimulus.² His findings revealed that the group not having an opportunity to discontinue the noise perceived that they had no control over the situation and responded passively by withdrawing. His finding supported and enhanced Seligman's studies in that the helpless phenomenon can also be produced in humans. Recently, Seligman's theory has caught the imagination of psychologists who have adapted it creatively to a variety of life events and gender role socialization.¹

Learned helplessness is associated with a perceived lack of control.

Gender role socialization and learned helplessness

The literature on role socialization makes reference to helpless feminine behaviors.³ Some authors attribute this to gender role socialization of children in American culture. Role socialization includes numerous rituals and rites of passage that define appropriate behaviors for males and females.

A more frequently employed ritual is the separation of males from females, i.e., segregation and secrecy. Closely interrelated with separation is having access to specific knowledge and information, i.e., esoteric vocabulary evidenced by clearly defined appropriate feminine/masculine activities. Anthropologists maintain the rituals associated with the separation of females from males promote an image of sacredness, integrity and worth for males and decrease personal esteem for females. Consequently, females are socialized to develop excessive affiliative needs in relationships, while males are encouraged to be self-reliant and not display emotion.

As a result, independence is the expected norm for males while this trait generally is not condoned in females and independence becomes more difficult to attain. Consequently, the excessive dependence continues in adult women and promotes a need for continuous support from others, particularly from males.^{4,5}

Independence is learned through life experiences that demonstrate one has the ability to accomplish tasks via trial and error. Through exercising judgment and dealing with the resulting consequences, confidence, and self-esteem are encouraged. Increased esteem enhances independent thinking and acting, resulting in a sense of personal power and control over life situations. These experiences also reassure persons that they are competent, worthy, and adequate.³

The propensity for men to assume dominant roles appears to be universal. Masculine dominance is observed in a variety of cross-cultural settings, as men occupy the roles that are highly valued both in public or private settings. Rituals, therefore, are one of several mechanisms through which domination is maintained. Rituals serve also as a powerful means of creating and manipulating social reality, as well as of defining socially acceptable and deviant behaviors.⁷

Learned helplessness in battered women

In keeping with Seligman's theory, Walker perceived that abused females often respond in a helpless manner to their abuser.⁸ In *The Battered Women Syndrome*, she compared repeated abuse (physical and verbal) to the uncontrolled electrical shocks and noise. Consequently, helplessness theory proposed an explanation as to why women remain in battering situations even when escape appears possible. Also, American culture tends to perpetuate female dependence, passivity and powerlessness, particularly in married women. Walker defines a battered woman as "a woman who is repeatedly subjected to any forceful or psychological behavior by a man in order to coerce her to do something he wants her to do without any concern for her rights." Battered women include wives and women in intimate relationships with men. Furthermore, in order to be classified as a battered woman, the couple must go through the battering cycle at least twice, as any woman may find herself in an abusive relationship with a man once.⁸

Another dimension of helplessness is addressed by Baucom and Weiss who studied granting of peer control by women.⁹ They compared behaviors of mascu-

line-type women with feminine-type women. When the threat of loss of control was present, 17 percent of masculine-type females chose to regain control. Feminine-type females relinquished control and ended to respond with helplessness behaviors.

LeShan expands on self-perceived powerlessness, indicating that this is associated with use of manipulative behaviors.¹⁰ Through use of covert activities, a dependent person can wield a great deal of power over someone perceived as more powerful. Covert, passive-aggressive behaviors are exhibited by crying, pouting, sulking, name-calling and withholding of sex or affection. These behavior patterns can be interpreted unconsciously to mean: I can't be like you and that makes me jealous and scared; but I can force you to take care of me.^{3, 11, 12}

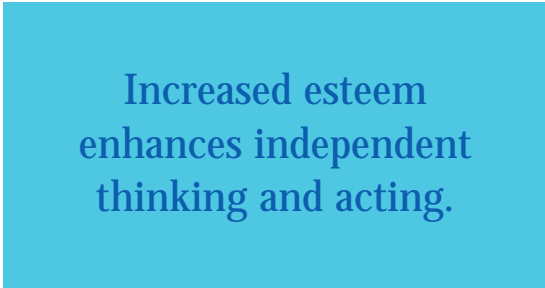
Learned helplessness in the OR

Among nurses there is a pervasive perception of lack of control or powerlessness. Historically, they have been in subordinate positions both to administrators and physicians. Moreover, being in a predominately female profession, nurses are acutely aware of the significance of sex stereotyping in the maintenance of their subordinate role.¹³ The theory of learned helplessness seems to be an appropriate model for nurses' perceived powerlessness. Consequently, the feelings of lack of control impact interdisciplinary interactions—particularly with physicians.

- *Separation* – Ritual and secret knowledge always have been prevalent in the health care field. Moreover, in Anglo-American culture the word medicine or doctor conjures up an almost mystical image, that of the "captain of the ship." Nurses are seen in a passive, maternal, wife-like, self-sacrificing role. Hospital administrators have helped to foster and reinforce these stereotypes

by their expectations of rigid adherence to hospital protocols. Particularly significant are protocols related to defining boundaries clearly: e.g., locker rooms versus doctors' lounge, doctors' coffee area versus nurses' chart room. Likewise, written and unwritten protocols reinforce impressions of dominance in physicians.^{7, 14}

Surgery departments lend themselves to learned helplessness as they often are isolated from other parts of a hospital. Operating Room (OR) personnel are isolated further by requiring special types/styles of apparel, specialized knowledge and extensive orientation. Finally, clearly differentiated skills separate the anes-



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thesiologist from the CRNA, the surgeon from the nurse, and the nurse from surgical support staff. Powerlessness is perpetuated further when physicians bring “my scrub-tech” on the surgical scene and bestow “overt favoritism” to the individual who “anticipates the doctor’s every need.”⁷

Preoperative scrubbing establishes the turf, for the relationships between the disciplines. The activities associated with scrubbing have strong ritualistic themes of separating surgeon from nurse. For instance, freshly scrubbed surgeons cannot touch anything until “dressed” in sterile garments. During the interim between scrubbing and when the nurse assists in “gowning” the surgeon is virtually helpless, somewhat like the husband who is dependent on his wife to care for his domestic needs. Thus, surgical routines as well as the physical arrangements of surgical departments promote separation of *doctor* from *nurse*.^{7, 13}

Rituals serve to define appropriate behaviors for unpredictable events or for activities which are prohibited in everyday life. For example, surgery, which often is described as a major unplanned life event, has clearly defined protocols both for the caregivers and the patient. To help cope with the stress, rituals are employed by the team. For example, specific types of social interactions accompany the stages of surgery: silence during the incision, joking during routine procedures, abrupt cessation of light conversation during the excision and repair, and resumption of talking during the counting of the instruments.⁷

During the excision stage, unanticipated emotional responses, including abusive, aggressive behaviors, may become an accepted norm for the primary actor and leader of the team. These behaviors, in turn, are accepted passively by team members who have been delegated a dependent role. Generally, there is no expected recompense by the abuser for the recurrent abusive actions.

- *Dominance* – Though both the medical and nursing professions have advocated team approaches to patient care, barriers to collegiality result from cultural presuppositions. These structural impediments are not matters of knowledge level or skills that either discipline possesses, but rather how gender role behaviors are implemented in physician-nurse interactions. Campbell-Heider and Pollock studied this relationship from an anthropologic perspective and proposed that a team approach is hampered by sex stereotyping of the two.¹⁴

Collegiality also has been hampered by the advent of Diagnosis Related Groups (DRGs). As a result of this legislation, cost containment and accountability have become a reality for all personnel in health care institutions. Since nursing service is generally one of the largest budget items in an institution, it is under great scrutiny and the frequent target for reductions in personnel hours. Consequently, nurses express feelings that their lives are at the mercy of the “whims of businessmen.”^{5, 13}

Feelings of helplessness are expressed both in overt and in covert ways. An overt activity might be organizing collective bargaining units and sick-outs (organized “call-ins” for illness). Subtle, passive-aggressive behaviors are evidenced by padding time cards, performing low-quality work, extending lunch breaks, frequent personal telephone use, wasting and petty theft.

Due to the hierarchical specialization in surgery departments, OR nurses may perceive themselves as victims of the specialists. For example, anesthesiologists oversee CRNAs, who, in turn, perceive themselves as superior to RNs. Overall, surgeons control the department’s daily activities

and assure financial viability through their admission practices. Thus, physicians’ admitting practices reinforce the perception of lack of control among nurses and this mindset becomes a factor in fostering behavior patterns of learned helplessness in those who perceive themselves as powerless.⁷

Noncontingency occurs when nurses perform routine OR activities and these elicit unpredictable responses from doctors and administrators in the department. In some instances, responses to the nurses’ activity are positive and encouraging, while at other times the same activity will elicit hostility and abuse from the same individual. This results in nurses’ responding in a helpless manner and promotes passive-aggressive behaviors specific to OR: not knowing how to use medical equipment, failing to assist in an efficient and appropriate manner or “hiding out.” These helpless behaviors frustrate all team members, and productively and quality are impaired, not only for the physician, but for the OR department and the institution as a whole.⁷

- *Control* – The issue of control becomes one of medical/nursing turf in the surgery department. Consequently, OR rituals serve also to exaggerate boundaries, prescribe appropriate behaviors for various roles and facilitate the transitions from one state to

Rituals are one way in which male dominance is maintained.

another. Katz speculates that the rituals of medicine may provide increased perceptions of power because these esoteric activities exaggerate and often permit behaviors prohibited in everyday life: e.g., surgery, vaginal examinations, delivering a pregnant woman.⁷

Despite their lower status in the hierarchical system, nurses are present in the theater of medical practice, which makes them aware of the foibles and failures of doctors. In turn, this may create animosity of physicians toward nurses in light of the fact that a subordinate is aware of a doctor's powerlessness to overcome death and disease. Powerlessness in the battle over disease and death often is in direct conflict with physicians' professional socialization. Thus, the issue of power and control between the two disciplines often results in doctor-nurse games.

Surprisingly, powerlessness, rather than power, corrupts and breeds dictatorial, rules-minded punitive styles of relating. The powerless control rather than encourage independent actions and their ultimate weapon is to hold everyone else back by anticipating resistance from all sides. The powerless direct their coerciveness downward, since those who fell anxious, helpless, insignificant or inferior have a neurotic need to dominate. They cannot tolerate disagreement and their guard their domain jealously, narrowing their interest to focus exclusively on it.^{15, 16}

Empowering: intervention strategies

To deal with helpless/powerless behaviors appropriate strategies and interventions that empower are indicated. Frequently, managers are first to become aware of complaints about low morale, increased physician-nurse incidents, decreased productivity, impaired quality of work, increased turnover rate of more assertive staff members, increased tardiness and absentee rates. The manager may notice that assignments have been completed in a haphazard manner, or that an individual "forgets" to do a task. It is not unusual for the staff on these units to voice vague complaints regarding peers' performance, along with numerous personality conflicts, "nit-picking," apathy and/or despondence.

The research suggests that specific types of helper responses seem to encourage victims to continue to seek help. For example, it is helpful and encouraging if the facilitator validates the seriousness of the abuse with comments such as, "Did someone do this to you?"

or "It sounds like she is being abusive to you." This demonstrates support but also allows the abused an opportunity to express feelings. By identifying the described behavior as an abusive situation, the manager is acknowledging both its seriousness and the belief that no human being, much less a professional person, deserves that type of abuse/misuse. Hence, the helper is encouraging full consideration of the situation.^{8, 11}

A direct interactive approach is necessary in assisting victims to identify the abuse cycle, as well as to find options to end the abuse. While making decisions for the abused person may perpetuate the feelings of powerlessness, the facilitator may stimulate the nurse to consider broader, practical alternatives beyond putting up with the abuse just because the abuser is a doctor. When nurses ask what they can do, the manager might educate a person to the theory of concerning the cycle of violence and explore ways to improve relationships.

There needs to be an initial awareness of the cycle of abuse and the helpless responses. Later, exploration of the reasons for these types of responses can be discussed. This can be facilitated by group sessions on the theory of learned helplessness.

Managers may find it helpful to provide reading materials for the OR staff on this theory. The authors' experience has been that most staff nurses seldom have time to seek out the reading materials, so it is best to provide it. If the information is available, most individuals quickly become engrossed in the topic.

The group sessions should include content on gender role socialization, as well as information about culturally defined male and female behaviors. The classes also should include content on communication skills and conflict management. Finally, assertive, aggressive and passive-aggressive behaviors should be differentiated. This information can be discussed in relation to incidents that have occurred within the department.

Through the discussions, group members may identify peers who have experienced comparable patterns of abuse and have similar feelings. Facilitators may find that staff openly verbalizes personal experiences of prior abuse and/or domestic violence. Based on these experiences, alternative coping strategies can be discussed and practiced. Managers can be most supportive to the group by assuming an active listening role. In extreme cases, professional counseling may be recommended for individuals with a history of abusive relationships.

Through facilitating the group's activities man-

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agers can assist the staff in identifying the cycle of events in abusive situations. Nurses should be encouraged to verbalize their perception as to the potential cause of the problem and their responses should be discussed. After identifying situations of helpless, passive-aggressive responses, potential interventions can be discussed. This can be facilitated with strategies such as "talking through" and role playing by the participants. Managers may find it helpful for individuals to rotate roles; i.e., have the abused (victim) assume the role of the abuser. Through this strategy, feelings can be expressed and alternative responses can be practiced. This assists individuals to identify and express feelings instead of continuing to display helpless passive-aggressive behaviors.

Once individuals are aware of personal feelings, they are in a position to consider alternative options to deal with the situation. The manager should facilitate the assessment of powerless persons' internal and external resources to deal with assaults (e.g., verbal insults, throwing instruments, slamming doors, making sexual innuendos). Assertiveness training is one strategy that can empower nurses. Examples of assertiveness include, standing when speaking to someone who is standing and removing surgical masks when speaking or being spoken to (masking is representative to the ritual of placing a veil over a woman's face to demonstrate subservience).⁷ Another strategy is to walk away rather than allow someone to continue verbal or physical threats. At another time when the victim feels in control, the conflicts can be addressed using principles of conflict management.

The following sequence of activities is suggested to facilitate change in patterned helpless responses. The goal is to develop a sense of personal power and autonomy, though there may be alternating progression and regression of the activities, depending upon recent abusive incidents that may have occurred in the department. The most effective change process is through group interaction, but these strategies are useful also for individual counseling programs:

1. Promote awareness of learned helplessness theory.
2. Identify the perceptions regarding power/control issues.
3. Explore feelings regarding the source of the problem.
4. Promote awareness of "powerless" verbal and behavioral responses.
5. Utilize interventions that interrupt the abuse-response cycle.
6. Evaluate the effectiveness of the change responses.

Learned helplessness theory has many applications

and appears to fit nicely into the OR context. As nursing establishes itself as a profession, individuals' responses should change toward those perceived as more powerful, with passive-aggressive behaviors giving way to mature assertive responses. Finally, managers have an important role in empowering an organization's members through using a participative management style.

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