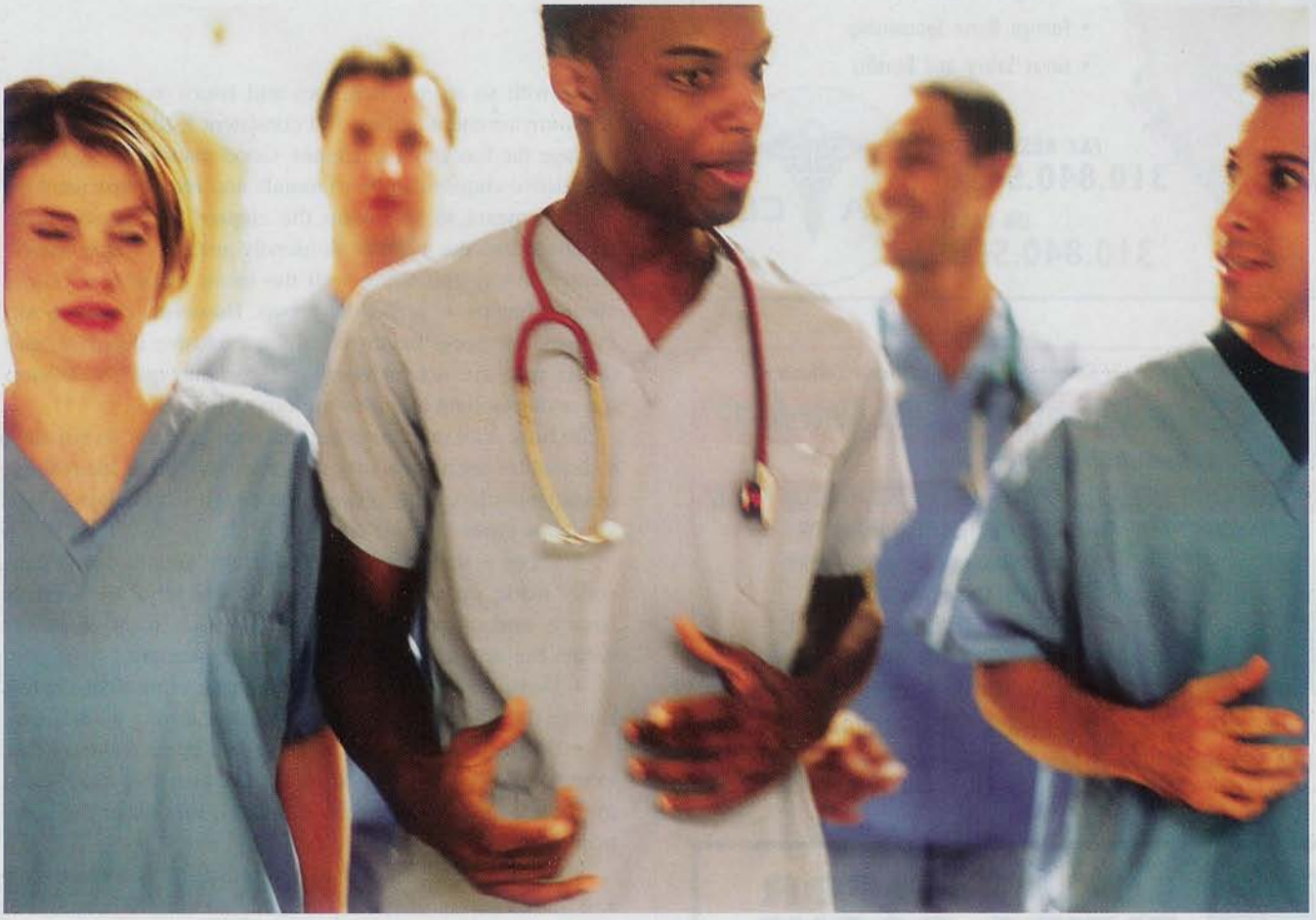
Cliques, and Why This is *not* a Good Thing.

BY GENEVIÈVE M. CLAVREUL, RN, PH.D.

MANY YEARS AGO I WAS WORKING IN THE NICU and providing care for two of seven children who were on ventilators (vents). It was my first time working in that particular hospital. Not long into my shift, the charge nurse approached me and, while making small talk, inquired how things were going. At the end of the conversation, she politely informed me that "they"—the other nurses on the unit—were going across the hall to the break room to have dinner. She wished me a good evening, and I acknowledged her statement, though I was sure she couldn't have meant *all* of them were leaving for dinner.

A few minutes passed and I realized that I had indeed been left alone to provide care for all seven infants on vents. Later when I shared my concerns about having been left alone, the charge nurse cheerfully reminded me that they were after all just across the hall.

I mention this vignette for three reasons. One, this illustrates clique behavior that can have negative consequences for patients. Two, regardless of whether or not the other nurses were "just across the hall," I was a nurse they had never worked with before and they had no knowledge of my actual skill level or competence. And, three, this hospital is one of the famed



On the nursing floor, cliques can quickly turn a happy workplace into an environment of **"Us and Them"**

three percent that the ANCL awards their "Magnet Hospital" designation to. (So much for setting a "gold" standard, but this will have to wait for discussion in another article.)

Though this may seem like an absurd example, I want to remind my readers that I always use real-life experiences as illustrations. The only literary license I take is to protect the identities of the innocent or guilty parties, and to comply with privacy issues (many of them required by HIPPA). So, please, no irate calls or angry e-mails admonishing me because, as they say, truth is often stranger than fiction.

This experience with clique behavior came to mind when I was reading an article in another nursing magazine. The article attempted to paint clique (not group) behavior in a positive light, and even going so far as to place the onus of "breaking into/breaking up" the clique on the non-clique member. Without a doubt it is safe to say that people tend to congregate; after all, we are "herd" animals. This, however, does not mean we should accept or condone cliques.

Some may wonder why take issue with cliques, aren't cliques just a fancy word for groups? There is an example used in biology: all doves are pigeons, but not all pigeons are doves. The same holds true for cliques, all cliques are groups, but not all groups are cliques. A clique, which is French in origin, is most commonly defined as a group of friends, associates, colleagues, having similar interests, goals, and whom outsiders view as excluding them. It is this final sentence that differentiates a simple group from its less pleasant cousin, the clique.

Cliques by their very nature discourage esprit de corps and usually contribute to a negative work environment. Cliques rarely respond to "political correctness" or even to polite societal rules. Being exclusive, rather than being inclusive, is what defines the clique, and it can quickly turn a happy workplace into an environment of "Us and Them."

As with so many challenges and issues in today's nurse work environment, strong and consistent leadership can discourage the formation of cliques. Good managers know how destructive cliques can be to morale and often implement in-services meant to "break-up the cliques" by helping them transform into the more work-friendly group. A clique doesn't always spring into being with the intent of being a clique; often it begins as a friendly group. However, as the group evolves, members begin to exhibit exclusive behavior, and others who are not members of the clique quickly develop the understanding that they are not welcomed.

So how does one recognize that their group is, in actuality, a clique? It's not always easy to self-identify, since many think of cliques only as they relate to their high school days. There are many types of overt cliques:

- There is the "old guard," or tenure clique, that is generally made up of long-term employees who are seen as having, and often do have, seniority and a lot of power within the unit and even within the department.
- There are cliques where a language other than English is used during break and, upon occasion, during work hours.
- We have cliques that are regulars at meal breaks (for example the same five people always take the exact same meal break and fail to invite others who may share the same meal time).
- There are cliques that reserve much of their discussion and humor for "inside jokes" or "you had to have been there" comments.
- And, of course, there is the clique that is filled with clones (you know, where all the members have an uncanny resemblance to one another, down to the accessories). Some may believe that the group that shares a common addiction, such as smoking, coffee, or that evening nightcap is a clique as well, but they are in reality just a group unless they begin to exclude others deliberately.

AN ASTUTE HEAD NURSE, nurse manager, director of nursing (DON) or Chief Nursing Officer (CNO) will usually recognize that cliques do not benefit the organization. Some of the warning signs of clique behavior on the floor are:

1. Equipment or information being shared freely only within the group, excluding those that are not perceived as members of the clique.
2. Clique members getting noticeably different treatment such as better or lighter assignments, receiving promotions that are not based on performance but on perceived status of how well liked they are by the person in power, getting to take longer breaks than those who are not members of the clique.
3. Members of the clique receiving a different ratio of disciplinary actions, complaints, or write-ups than those who are not members.

When clique behavior dominates a unit, floor, or even an entire department, such as nursing, the immediate impact of the behavior might not be noticeable. However, over time, signs can be observed by studying the following indicators: staffing turnover, ie: the inability to maintain competent, new staffing or registry personnel; feedback from nursing staff that their immediate superiors ignore input or opinions; complaints from others that assignments and punishments are doled out unfairly; comments that they feel excluded from discussions or conversations on the floor; to name a few.

It should never fall upon an individual nurse to change the clique behavior, as this is the responsibility of those in the chain of command. The charge nurse is the first agent for change. They make the assignments and can be instrumental in using new assignments to help create an atmosphere more conducive to positive group dynamics.

Unfortunately, due to the way many hospitals structure the charge nurse position, she may become the leader of the clique itself. This scenario is the most destructive one since the charge nurse is often oblivious to the clique's impact on the non-clique members and may dismiss the complaints as being "sour grapes."

When the charge nurse is part of the clique, it may become necessary for the DON and/or CNO to intervene and disassemble the clique. The DON and CNO should have both the experience and tools at their disposal to address clique behavior. Some of these tools can include, but are not limited to, holding in-services, bringing in outside consultants, and even changing assignments of nurses, if necessary.

In many cases, clique behavior is easy to deal with; it may simply take a gentle reminder of simple and common courtesy. For instance, when organizing a unit/floor event be sure to extend an open invitation to all. Individual flyers in each person's message box, or notices placed in areas common to all such as break rooms, nurse's stations, etc. should do the trick. Promote more self awareness of individual actions that may be sending a "you're not part of the group" message—

such as conversing in another language other than English when there are others that do not speak that "other language" present. (Of course, you could always form a group that helps teach conversational use of your language to interested parties.)

If you are in a position of authority, such as the head nurse or charge nurse, try to make nursing assignments based on skills and experience versus likability (unless of course you need a very "likable" nurse to deal with that very difficult patient). Cultivate conversations at break time based on topics of broader interest than personal gossip or complaints about the hospital or fellow workers. A few safe topics for break time

that are guaranteed to be inclusive are interesting articles from the news or magazines, a book you read and liked, interesting personalities you know about, delicious recipes, spot removers that work (or any other solution to a common problem), your last trip to the beach, updates on a sick friend everyone knows, and on and on. Not only will the break be more relaxing, it will be fun and productive.

In cases where the clique behavior is too entrenched, rely on the experts, but be sure to play your part in the solution. Remember, when there is clique behavior, morale suffers, turnover increases, and work-related stress escalates. Not only does this make for an unpleasant work environment and a healthcare setting where the patient may not receive the optimum attention and care from their nursing team, it can lead to negative and lethal consequences for all involved. WN

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