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The Psychological Development of Horizontal (Lateral) Violence in Health Services

Bernice Roberts Kennedy, PhD, APRN, PMN-CNS, BC

Correspondences Address: Bernice Roberts Kennedy, PhD, PMNCNS,

Research Consultant

BRK Global Healthcare Consulting Firm, LLC

P.O 90899Columbia, South Carolina, 29209e-mail brkhealthcare@gmail.com

Abstract

Workplace violence has a major impact on productivity, morale, increase absenteeism, turnover, patient outcome, and cost. The hierarchy of the hospital structure is based on a patriarchal system dominated by male physicians and administrators with nurses in the lower position. However, because of nurses being in a lower position of hierarchy, their frustrations are acted out laterally (horizontally) toward other nurses. This paper is an analysis of the literature in addressing the psychological process of lateral (horizontal) violence among health healthcare employees in health services organizations. A model was developed describing this psychological process with the proposed impact of preventive strategies. Horizontal hostility or lateral violence (LV) has been defined as unkind, discourteous, antagonistic interactions between employees in the workplace. Also, nurses experienced numerous physical and psychologic stress and even death. In many health services organizations, this horizontal/ lateral violence behavior is accepted and considered the norm and often overlooked and not reported. Health services organizations need to promote better working relationships among healthcare professionals to have better patient outcomes. In the hospital environment, physicians and nurses need to work more collaboratively. Therefore, nurses need to be empowered to report and advocate against violence.

Key Words: Lateral violence; horizontal violence; nurses; physicians; workplace violence

Introduction

Workplace violence has a major impact on productivity, morale, increase absenteeism, and turnover (Martin, Gray & Adams, 2007). Nurses experience approximately (3 times) as many violent incidents in the workplace in comparison to other professionals (Martin, Gray & Adams, 2007). Although nurses experience violence from patients, clients, and customers, it has been reported that nurses' experiences as much as 36% of violence from colleagues in private hospitals (Hegney, Plank & Parker, 2003). Workplace violence experienced by peers of equal power is called lateral (horizontal) violence.

Numerous literature reviews and studies have reported that in health services organizations especially in hospitals, physicians are frequently a source of verbal abuse toward nurses (Bruder, 2001; Buback 2004; Cook et al., 2001; Farrell, 1997; Simms, 2000; Sofield & Salmond, 2003; Vogelpohl, Rice, Edwards, & Bork, 2013). The hierarchy of the hospital structure is based on a patriarchal system dominated by male physicians and administrators with nurses in the lower position (Chu & Evan, 2016; Woelfle & McCaffrey, 2007). However, because of nurses being in a lower position of hierarchy their frustrations are acting out laterally (horizontally) toward other nurses. As a result, nurses reported experiencing lateral violence daily in practice (Park, Cho, & Hong, 2015). If lateral violence is not addressed in the workplace, there can be negative outcomes to include poor quality of patient care, increased turnover rate, and cost increase to the organization (Bloom , 2018; Chu & Evans, 2016). Also,

nurses experienced numerous physical and psychological stress and even death (Kennedy, 2020). In many health services organizations, this behavior is accepted and considered the norm and often overlooked and not reported (Bambi et al., 2014)

Definition

Alspach (2008) defines specific forms of lateral hostility as belittling and condescending behaviors, sabotage, gossip, exclusion from activities or conversations, elitist attitudes, intimidation, threats, humiliation and embarrassment, sarcasm, and unfair judgment of completed work. Also, Alspach provided examples of lateral violence to include “eye-rolling”, constant criticism, impatience, patronizing attitudes, threats, excessive demands, and unfair work evaluations.

Horizontal hostility or lateral violence (LV) has been defined as unkind, discourteous, antagonistic interactions between employees in the workplace (Alspach, 2008). The behaviors displayed by nurses in the workplace are as follows: (a) confrontation, (b) sabotage, (c) intimidation, (e) information withholding, and (d) mockery, (e) abuse of power, (f) humiliation (g) bullying, and (i) backbiting (Center for American Nurses, 2008; Stanley, Martin, Michel & Nemeth, 2007; Moye, 2010).

Incidence and Prevalence

Lateral (horizontal) violence is very prevalent in health services organizations especially in hospital settings (Gaudine, Patrick, & Busby, 2019.

Also, lateral (horizontal) violence has been studied for over four decades. Lateral violence has been reported by nurses as occurring daily in the work environment (Park, Cho, & Hong, 2015).

Research studies reported that about 44% to 85% of nurses are victims of lateral violence (Bambi, 2014; Jacobs & Kyzer, 2010; Quine, 2002) Also, about 93% of nurses reported witnessing violence in the workplace. In most cases, the experienced nurse is a perpetrator of violence while the novice nurse is more likely to be a victim (Jacobs & Kyzer, 2010). When lateral violence occurs at least once a day for a period of 6 months , it becomes *bullying* (Bambi, 2014).

This paper is an analysis of the literature in addressing the psychological process of lateral (horizontal) violence in health services organizations. These sections will be addressed (a) an overview of the healthcare environment; (b) the psychological process of lateral (horizontal) violence; (c) characteristics of persons involved in horizontal violence; (d) overall impact of lateral violence; (e) strategies used in prevention; and (f) future Strategies.

Overview of the Healthcare Environment

Naturally, the culture of hospitals which was the center of the healthcare system has been entrenched in a patriarchal hierarchical structure dominated by the discipline of physicians (Chu & Evans, 2016; Martin, Gray & Adams, 2007). The expert and legitimate power in the healthcare system have been contributed to physicians. Historically, most persons entering the medical profession have been males, whereas most of the persons in the nursing profession have been females (Martin, Gray, & Adams, 2007). So, the culture of

the healthcare system has been based on the patriarchal structure with gender inequalities that operates to subordinates of women in the nursing profession (Martin, Gray & Adams, 2007). Bruder (2001) argued that verbal abuse was a method of men asserting themselves and maintaining their dominate. Nurses have experienced the phenomenon of lateral (horizontal) violence, bullying, or workplace hostility.

Healthcare managers struggle to comply with regulations of a zerotolerance policy aimed at preventing violence in the workplace (JCAHO,2016a,b). American Nurses Association supported JCAHO in no longer tolerating violence of any kind and source in the workplace.

New graduates have been considered a vulnerable group (Alspach, 2008; Christi & Jones, 2013; Gaudine, Patrick, & Busby, 2019; Griffin, 2004; Stokowski, 2010a; Stokowski, 2010 b). Approximately, 60 % of new nurses who leave their job after only 6 months are due to some form of horizontal hostility (Griffin, 2004). Also, 20% of these new graduate nurses leave the profession involving as much as $30.000 to $50.000 loss when resigning (Thobaben, 2007). Alspach (2008) suggested the overwhelming majority of females were nurses, the matriarchal origins of nursing, and organizational hierarchy are in part responsible for the retaliatory response to peers in the form of lateral violence.

The culture of an organization dictates the norms of a workplace environment (Kennedy & Wider, 2020). An unhealthy organization will promote an unsafe work environment. Also, an organization that core values promote an

abusive environment may socialize ineffective managers and employees to be fearful, distrustful, dissatisfied, and unproductive.

In healthcare, medical practitioners such as physicians are characterized as the dominant culture (Chu & Evans, 2016; Manojlovich & Laschinger, 2006; Martin, Gray & Adams, 2007). Often, the nursing profession as a group lacks autonomy, accountability, and control over their profession. When nurses are oppressed, they internalize the values of the dominant medical practitioner culture as being right, they lose their cultural identity as nurses, and self-hatred may be the result. Nurses need the power to be able to influence patients, physicians, and other health care professionals, as well as each other (Manojlovich & Laschinger, 2007). Powerless nurses are less satisfied with their jobs (Manojlovich & Laschinger, 2007), and more susceptible to stress, burnout, and depersonalization (Gaudine. Patrick, & Busby, 2019; Christi & Jones, 2013; Leiter & Laschinger, 2006). Lack of nursing power may also contribute to poorer patient outcomes (Chu & Evans, 2016; Manojlovich & DeCicco, 2007).

Healthcare managers struggle to comply with regulations of a zerotolerance policy aimed at preventing violence in the workplace (JCAHO, 2016a,b). Nurses have experienced the phenomenon of horizontal violence, bullying, lateral violence, or workplace hostility.

The Psychological Process of Horizontal (lateral) Violence

The origin of the term, *horizontal violence* was originated by Paulo Freire (1970), a champion of the poor and disenfranchised in South America. He

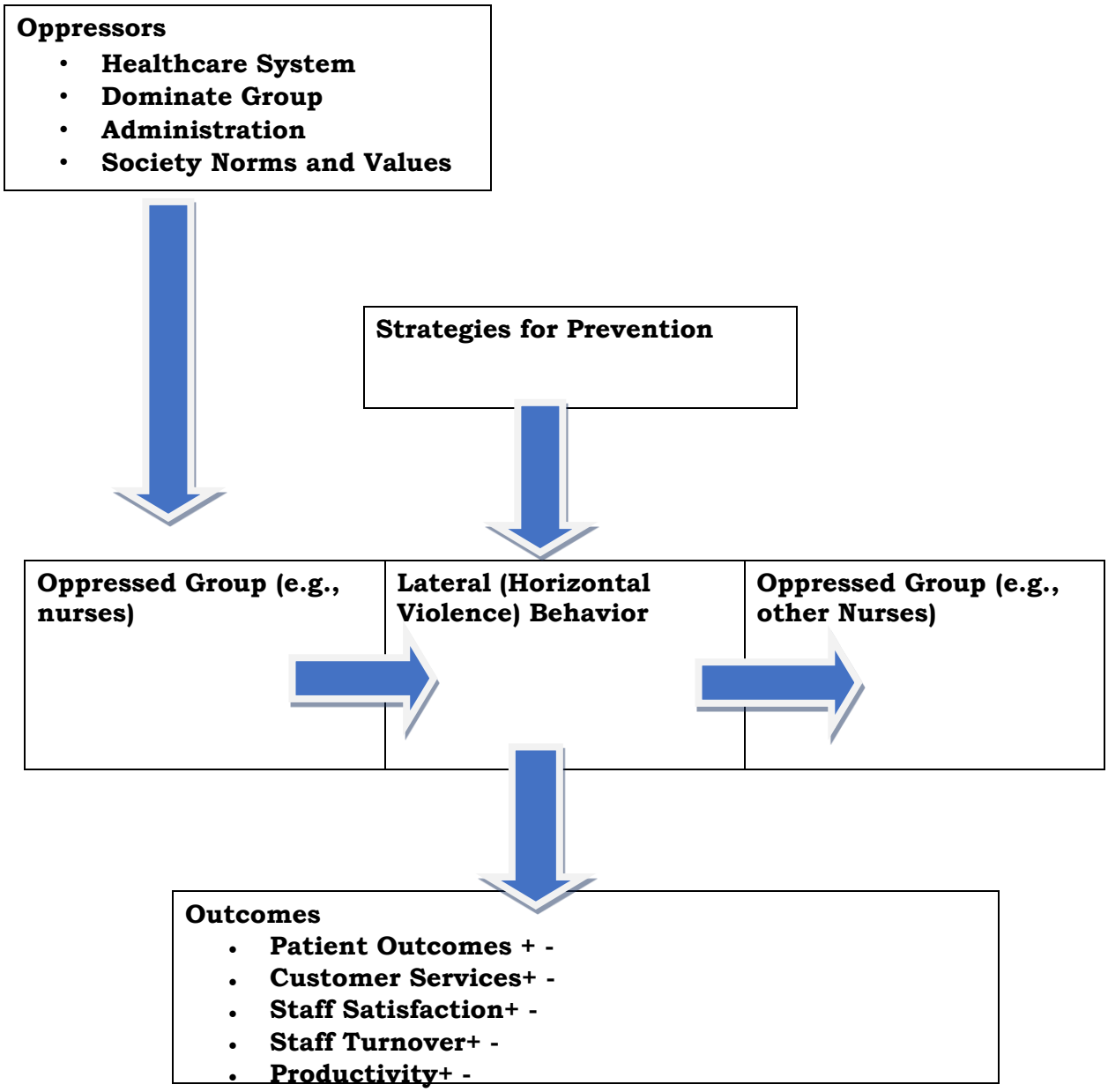
explored the effects of oppression on minorities in his book, *Pedagogy of the Oppressed***.** Freire proposed the use of *horizontal violence* as a term to indicate the curious behavior of members of oppressed groups who lash out at their peers in response to oppression instead of attacking their oppressors.

Freire defined the concept of *horizontal violence* as when minorities and other oppressed groups (e.g., women who live in male-dominated society) rage internally because of their lack of power but take out their anger and violence on their oppressed peers (e.g., other women). He proposed the causal factor for this behavior is the powerlessness and impotence of the oppressed that would be severely punished if they attacked the powerful individuals who control their lives. Freire (1970) proposed that people who are oppressed punish others like themselves. The oppressed groups may use sabotage as dysfunctional or unhealthy method of dealing with their frustration and anger. However, when sabotage is directed at coworkers who are on the same level within an organization's hierarchy, it is called *horizontal violence***.** Disruptive behavior is common in healthcare settings and has an adverse effect on nursing and physicians which translates to patient safety issues and patient outcomes.

Freire's theory of oppression is applicable to nurses in the workplace because the nursing profession is a predominantly female profession and the power and authority in healthcare is held by physicians and other specialists. Historically, nurses were subordinate, poorly paid, and lack decision-making in healthcare. Nurses as an oppressed group display backstabbing and sabotage among nurses which Freire defines this behavior as a concept of *horizontal*

violence. Figure1: The Psychological Process of Horizontal (lateral) Violence depicts the process of horizontal (lateral) violence in the workplace. Also, as indicated in this figure below, outcomes can be positive or negative based on effective strategies.

Figure 1: The Psychological Process of Horizontal (lateral Violence)



Horizontal violence requires an understanding of oppression theory. (Matheson & Bobay, 2007). The phenomena of horizontal violence and oppression have been recognized in nursing literature for more than 20 years (Matheson & Bobay, 2007). Managers must recognize and assess these behaviors and provide strategies for prevention to eliminate horizontal violence in the workplace. The presence of sabotage is an indicator that horizontal violence and oppression exist in the workplace.

Oppression

Oppression exists when a powerful and prestigious group controls and exploits a less powerful group (Dunn, 2003; Freire,1970; Kennedy, 2020; Woelfle & McCaffrey, 2007). The oppressor which is a person in power may control others out of self-interest thereby dictating how their goals or secondary gain will be achieved at the expense of the oppressed person (s) (Dunn, 2003; Freire, 1970; Kennedy, 2020; Woelfle & McCaffrey, 2007). The oppressed group internalizes the oppressor's values as right, the social norm, and standard in society (Dunn, 2003; Fanon, 1963). As a result of this oppression, members of oppressed groups may lack identification within their own culture resulting in behavioral characteristics (e.g., low self-esteem, self-hatred)(Dunn, 2003; Fanon, 1963). For example, the characteristics of nurses are caring and nurturing when compared with those of medical practitioners, however, this process of oppression may increase divisiveness and fragmentation resulting in horizontal violence (Dunn, 2003).

Characteristics such as divisiveness and fear of confrontation with powerful groups are common among members of oppressed groups (Dunn, 2003; Fanon, 1963; Kennedy, 2020). The nursing profession has evolved to embody these dysfunctional attributes. However, when feelings of aggression against a powerful group arise, members of the oppressed group often are unable to confront the dominant group for fear of reprisal. This fear represents the basis of the submission to authority. Also, as the oppression continues, the fear of change manifests.

Oppressed Group

According to Dunn (2003,) there are three characteristics of the oppressed groups. They are as follows:

1. The oppressed group often exhibit self-hatred, dislike for members of their own group display a desire to be a part of the dominant group, lack of pride in their group and, desire not to be associated with their group because of powerlessness.
2. The oppressed groups are the member's own fear of change when success may be the result, lacking self-confidence in their ability, and choose the path of resistance when given the opportunity to effect change.

Oppressed groups are fearful because they do not believe that alternatives to the status quo exist (Dunn, 2003). This group may complain about others in the organizations but rarely confront the person directly. The oppressed person, who has aggressive feelings such as bitterness and anger toward the oppressor, is unable to confront these emotional hostilities. The behavior results in

displaced and self-destructive aggression within the oppressed group with subsequent infighting and self-criticism. *Horizontal violence* is the outcome of this process.

People who are oppressed have specific characteristics that lead them to punish others like themselves (Freire, 1970). These characteristics are as follows: (a). Reluctant or unwilling to resist the oppressor; (b) having the characteristic of low self-esteem; and (c) fear autonomy and responsibilities because of the possibility of retaliation or sanctions from their oppressors (Freire, 1970). The oppressed person will attack their peers to reduce the feeling of powerlessness and in also to devalue them. This attack is usually lateral instead of directing hostile feeling to the real source or identifying the source of violence (Freire, 1970).

Characteristics of Persons involved in Horizontal Violence

Women often are considered to be a subordinate group within society, in addition to the healthcare environment (Kennedy, 2020). Also, women comprise at least 90% of the nursing profession (Kilborn, 1999). Acts of anger, such as sabotage, are common among members of oppressed groups. These horizontal violence behaviors are described as follows: (a) devaluing, (b) discourage, (c) scapegoating, (d) backstabbing, (e) complaining, (f) non-therapeutic, and (e) destructive communication.

This *horizontal violence* has become the standard in health care (Kennedy, 2020; Crhisti & Jones, 2013). Studies show physicians don't recognize the problem in their own profession and their behavior of a position in power is a

norm in most organizations (Bartholomew, 2007; Craig, 2008; Porto, 2007: Rosenstein, 2005). Nursing as the oppressed pass the same behaviors horizontally (Bartholomew, 2007; Craig, 2008; Porto, 2007: Rosenstein, 2005). Also, this behavior and ways of coping is passed from generation to generation in this discipline.

Nurses often experience bullying as a form of lateral violence. (Alspach, 2008; Gaudine. Patrick, & Busby, 2019; Griffin, 2004; Christi & Jones, 2013; Stokowski, 2010a; Stokowski, 2010 b) .Bullying behaviors in *lateral or horizontal violence* involve: (a) nurse to nurse hostility; (b) workplace intimidation; and (d) professional incivility or negative behaviors often targeting the most vulnerable groups of new graduate nurses (Alspach, 2008; Gaudine, Patrick, & Busby, 2019; Griffin, 2004; Christi & Jones, 2013; Stokowski, 2010a; Stokowski, 2010 b). The new nurse may experience bullying in the organization by the following profile of nurses: (a) super nurse with the superior attitude, (b) resentful nurse, (c) overly critical and gossip nurse, (d) backstabbing nurse, and (e) cliquish nurse (Stokowski, 2010a; Stokowski, 2010b).

Overall Impact of Lateral Violence

The lateral violence is more than $4 billion every year related to lost time, decreased productivity, and training new staff due to turnover (Rainford, Wood, McMullen, & Phillpsen, 2015). This cost has a negative impact on patient safety, patient outcomes, recruitment, and retention (Kennedy, 2020). Some negative impacts of lateral violence are as follows: (a) employee will leave a job; (b) increase cost to hire, recruit, and orient employees; (c) increase the turnover rates in the

workplace because of the poor reputation of an organization in supporting lateral violence; (d) Increase cost due to the emotional and physical impact on employees (e.g., increase sick time; increase staffing); (e) increase cost due to the legal and lawsuits may be involved, and (f) decrease patient safety and outcomes in the workplace (e.g., lack of communication causing medical errors; reports of PTSD in patients that witness lateral violence).

Strategies Used in Prevention

Workplace violence will increase employee's grievances, resignations, or requests for transfer (Kennedy, 2020; Kennedy & Wider, 2020). These organizations will have increase absenteeism and sickness. Also, increase disciplinary action will be evidence in a workplace with more violence. Employees in a more violent work environment will experience more stress, inadequate coping, and conflict (United States Department of Labor Industrial, 2020). The mission and goals of an organization may not be accomplished if workplace violence is not managed .

The healthcare system needs to become aware of the process of violence (Kennedy, 2020; Kennedy & Wider, 2020). This issue has been accepted as the standard in some healthcare organizations. Studies reported that physicians don't recognize this as a problem in their own profession but just a way of interacting in most organizations (Craig, 2008). Nursing as the oppressed pass the same behaviors horizontally to other nurses in the workplace (Bartholomew, 2007; Craig, 2008; Rosenstein, 2005).

Figure 1: indicates that strategies for prevention impact the outcomes in the organization. Outcomes can be positive or negative based on effective strategies. The healthcare environment has used numerous strategies for decreasing horizontal and lateral violence in the workplace. Strategies for improving the work environment are (a) awareness and education of lateral environment in the healthcare environment to change these behaviors; (b) training to develop competencies in staff; (c) conflict resolution to develop insight regarding lateral violence behavior in the workplace; and (d) a positive culture by leadership commitment (Bartholomew, 2007; Craig, 2008; Rosenstein, 2005).

Violence in the workplace occurs in an organization with poor management lacking conflict resolution skills and awareness of workplace violence behavior (Cowie et al., 2002; Einarsen, 2000; Tutar, 2004). For example, management may utilize mobbing or bullying to eliminate staff despite the damaging effects of individuals (Cowie, et al., 2002; Einarsen & Mickkelsen, 2003; Tutar, 2004). The lack of assessment of the organization by a manager for common symptoms of, violence, poor morale of staff, and poor customer services contributes to negative organizational effectiveness (Kennedy, 2020a,b). It is important for top management to promote ongoing improvement in the competencies of staff. Also, these same outcomes will occur if upper management does not hire competent managers or assess the competencies of managers.

Change efforts need to focus on the fundamental unit of an organization, team, or workgroups, as a means for improving the organization's effectiveness (Brown, 2011; Kennedy, 2020; Kennedy & Wider, 2020). For example, lateral

violence must move away from just targeting nurse-nurse relationships but must address the entire relationship levels of the organization from top-down. The culture such as norms, values, artifacts, rituals, etc. of the organization needs to be addressed. Also, the relationships of the different layers of the organization and staff relations must be diagnosed such as physicians-physicians, physicians-nurses, nurses-nurses, physician-patients, and nurses-patients, etc. These relationships do not need to be dealt with in isolation. Often, nurse-nurse relationships are target more in organizations because of symptoms of violent behavioral patterns are more visible in the workplace. The nurse-on-nurse violence behavior is often used as a scapegoat instead of examining the real problem or diagnosis in a health services organization.

Historically the health services organizations have been physician-driven and the acting out behaviors of this group have often been overlooked by the health care systems (Chu & Evans, 2016). In some cases, physicians have viewed talking down to others or use of profanity as business as usual and may not perceive this as inappropriate behavior or offensive to staff and patients. Some health services organizations may be a culture that condones this type of interaction in the workplace. However, in some cases, nurses may leave the job because of this behavior and feeling helpless with no support from the organization (Rittenmeyer, Huffman, Hopp, & Block, 2013). Also, patients or clients may leave this organization and seek care or treatment elsewhere. Team activities need to focus on improving problem-solving, working through conflict (Brown, 2011; Kennedy, 2020; Kennedy & Wider, 2020. These activities are

designed to improve work teams. For example, violence and conflict can destroy the nurse-patient relationship which is essential for a therapeutic relationship (McCabe & Priebe, 2004). Nurses serve as a patient advocate, a supporter, a teacher, and a protector (Dziopa & Ahern, 2009). This incidence of violence must be assessed to identify possible causes, strategies for prevention, and improving patient outcomes.

Building relationships between nurses and physicians are important through collaboration as teamwork (Pullon, 2009). A positive relationship will improve patient outcomes and quality of work-life for nurses who often experience a greater level of job dissatisfaction (Gaudine, Patrick, & Busby, 2019; Linkeke & Sieckert, 2005). In health services organizations, nurses are typically more positive about working as a team than physicians (Mattsson & Bobay, 2007).

However, changing a corporate culture is not easy (Brown, 2011; Kennedy, 2020; Kennedy & Wider, 2020). Culture emerges out of the shared behavior and the working relationships of organization members that have developed over time. Organizational change strategies are more likely to succeed if the factors that shape the culture can be identified and managed. For example, healthcare workers must build effective collaboration instilling core values such as respect, trust, and professionalism in the work environment. The lack of collaborative relationships between physicians and nurses or administration and staff are barriers to providing quality patient care. The key competence of collaborations is a need for respect, trust, and dismissing inaccurate professional stereotyping,

status inequalities, limited open communication, and lack of education related to teamwork (Pullon, 2009).

The culture of the healthcare organization has contributed to inequalities of professional status (Kennedy, 2020; Kennedy & Wider, 2020). Often, physicians are placed at higher status because of the legal and financial responsibilities for patient care. The physicians are placed as a higher status because of the money generated in the organization (Lindeke & Sieckert, 2005; Longo, 2010). Historically, when physicians display disruptive behavior, the organization, does not intervene but ignore and accept his/her behavior as part of the system (Longo & Sherman, 2007). This behavior is accepted as the norm in some health services organizations by the administration which does not intervene regarding changing the workplace environment. This behavior impacts cost and productivity in the workplace.

Administrators need to be aware that not addressing these issues are costing the organization due to recruitment and retention, poor patient care (e.g., medication errors, accidents, etc.). As indicated in *Figure 1:* Longo (2010) addressed other strategies for prevention. Longo (1010) suggested these strategies are helpful when addressing horizontal/lateral violence (a) establish policies to address lateral and horizontal violence; (b) develop a code of conduct for all employees; (c) Provide orientation and continuing education classes to introduce and remind the individual of these policies; (c) develop an infrastructural to implement and reinforce these policies on horizontal/ lateral violence such as an ethics committee to review cases; and (d) offer victims and

abuser of violence education, rehabilitation, and counseling as needed. As indicated in *Figure 1*: outcomes can be positive or negative based on effective strategies for prevention.

Healthcare professionals need more education on contributing and barriers to collaboration in the workplace (Kennedy, 2020). These healthcare professionals bring norms, values, and professionalism of their disciplines when they enter the workforce. Often, disciplines are socialized according to their profession, not recognizing the strengths of other disciplines as team members. However, the healthcare system is now a business, and the collaboration of workers as teams will be vital for future success.

Manojlovich proposed that "nurses' power may arise from three components: (a) a workplace that has the requisite structures that promote empowerment ; (b) a psychological belief in one's ability to be empowered; (c) and acknowledgment that there is power in the relationships and caring that nurses provide. A more thorough understanding of these three components may help nurses to become empowered and use their power for their practice and better patient care (Manojlovich & DeCicco, 2007).

Future Strategies

Future strategies are needed to improve interprofessional collaboration among healthcare professionals for the 21st century (Kennedy, 2020; Kennedy & Wider, 2020). Often, nurses experienced abuse from other nurses and physicians in addition to patients (Vogelpohl, Rice, Edwards, & Bork, 2013). The result of

this abuse is lateral nurses eating their own in health services resulting in generational abuse.

Health services administrators must create a healthy work environment (Kennedy, 2020; Kennedy & Wider, 2020). Strategies need to be developed to eliminate violence in the workplace. Administrators must do their part by instituting zero-tolerance policies addressing violence and educating along with making staff aware of violence in the workplace and promoting a healthy work environment. Healthcare managers can do their part by enforcing established policies and creating a safe place for reporting any abuse. Nurses need to be empowered to report and advocate against violence. However, health services managers may not be aware of the violence permeating their organization focusing on the symptoms such as decreased cost, chronic absenteeism, decrease productivity, etc. An external consultant would be useful in improving organizational effectiveness.

Conclusion

Health services organizations need to promote better working relationships among healthcare professionals to have better patient outcomes. In the hospital environment, physicians and nurses need to work more collaboratively. Nurses are the largest health care profession, and the national nursing shortage is expected to increase in the United States. Violence has been an issue in nursing for decades. Recruitment and retention of nurses are very vital in health services organizations. The healthcare system needs to be aware of violence among employees in the workplace. Often, violent behavior may become business as

usual resulting in negative implications for patient outcomes, productivity, and quality of work-life. When implementing a policy to stop disruptive behavior, all parties must comply with the policy. Health services organizations need to establish a standard behavior for professional practice, so individuals are not afraid to intervene when a situation occurs. The expected outcomes of this policy are to promote a healthy work environment enhancing retention of staff and promoting patient safety.

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Bernice Roberts Kennedy, PhD, APRN, PMH-CNS, BC, *is a research consultant at BRK Global Healthcare Consulting Firm, LLC, P.O. 90899, Columbia, South Carolina, 29290. Dr. Kennedy may be reached at: brkhealthcare@gmail.com*