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Covert violence in nursing

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(Occupational Health and Safety)**

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

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Abstract

There is no official avenue in nursing for the reporting of incidences of covert violence to staff and so they remain unrecorded and often stressful. This study sought to collect data from currently employed nurses concerning covert violence in their workplace, and to collate the information to obtain a valid assessment of this hidden problem. A qualitative methodology was used to report on the experiences of nurses in relation to covert violence directed at them by their peers, other health professionals, patients and patients' families. The participants were all registered nurses employed by a suburban health service. Each was given an open-ended questionnaire to:

1. establish the participant's position and professional experience within the Health Service,
2. request for incidences regarding the various forms of covert violence encountered by them in the workplace,
3. describe how they dealt with such episodes

It is anticipated that this study will lead to an acknowledgement of, and interventions to prevent, such forms of violence. It is also anticipated that minimising the occurrence of covert violence will improve nursing productivity, provide greater job satisfaction for nurses, and promote savings in terms of less staff absenteeism, Workers' Compensation Insurance claims and staff turnover.

DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

1. Incorporate without acknowledgement any material previously submitted for a degree or diploma in any institute of higher learning.
2. Contain any material previously published or written by another person except where due reference is made in the text, or
2. Contain any defamatory material.

Signed

Date *March 17, 2003*

CHAPTER ONE –THE PROBLEM

Introduction

'Research shows that nurses experience high rates of verbal and emotional abuse, physical violence and sexual harassment in the course of their work from a variety of sources including patients, families of patients and co-workers' (Canadian Nurses Association, 1993, p3). Historically, the philosophy of nursing focused on care of the patients and their families, and co-operating with other health professionals regardless of their words, actions and manner. A nurse was expected to rise above harassment or abuse, put her patients first, colleagues second, and themselves a long way last. There was an inference that if one could not cope with this stress, which was an integral part of professional life, then one was not strong enough to be in the profession.

Whilst physical violence is unacceptable, and therefore monitored carefully, covert violence is not recorded and remains, as the name suggests, hidden. This is often more stressful than overt violence because of its apparent non-importance. There is no true recognition of the events nor of the consequences to staff members. In most workplaces there are few avenues of senior support, no counselling offered, and it may be the final straw that decides if a nurse resigns from the position or leaves nursing altogether. At a time in Western Australia when the government has launched an expensive campaign to attract qualified people back to nursing. It is appropriate to explore at least one of the reasons why they might have left the profession in the first place.

In 1997, in a Western Australian suburban hospital of 200 beds, 48 staff members were physically assaulted by patients whilst on duty. The figures collected do not indicate the severity of the injuries nor how much time was taken in sick leave, nor any workers' compensation claims arising from these assaults on employees. However, each was documented and, when necessary, staff were counselled and given recovery time off. What is not recorded is the covert violence that was directed to staff from other staff, patients and their relatives. Because they were not recorded such incidences have gone unrecognized or unacknowledged and untreated as far as staff were concerned.

The purpose of this study was to document Western Australian nurses' experiences of covert violence within their workplace, identify the effects on the nurses, and establish whether there were any support measures in place to resolve the specific issues as they arose.

Organisation of Thesis

This thesis on covert violence in nursing describes the relevant background to the topic, the theoretical framework used in the research, and the results that emerged. Chapter one gives a definition of the term 'covert violence' which was employed for this study. It also includes the list of questions that was used for collecting data from the nurses. The chapter concludes with an outline of the significance and purpose of the research and a discussion of the research objectives. Chapter Two explores the qualitative method used in this research

and contains the historical context of various forms of violence experienced in nursing in Australia and other countries. Chapter Three outlines the research process used and the ethical decisions that had to be made as well as the limitations that were found to be of importance to both the collection of data and the understanding of it. Chapter Four discusses the four themes of covert violence that emerged from the data. These included incidences from patients, their families, other nursing staff, and the medical officers, with details of each nurse's experiences. This also included the responses given to the nurse from his/her senior. Chapter five concludes with a collation of findings and their implications for wider research.

Definition of Covert Violence

In general, there is no one definition of covert violence. There is not even one central term. Where British articles refer to 'covert violence' (Alderman, 1997, p23), American and Canadian articles refer to 'horizontal violence' (Nurse Advocate, 1998b, p2). There are six types of covert violence directed towards nurses in a hospital setting (Nurse Advocate, 1998b,p1):

1. Bullying, intimidation, belittling;
2. Inappropriate or unwelcome physical contact;
3. Sexual harassment;
4. Elitist behaviour based on education or area of practice;
5. Unacceptable language, e.g. swearing; and
6. Management practices such as understaffing, disregard for staff safety or mental or physical health

There are articles from each country such as those written by Spring and Stern (1998) from Canada, the Queensland Nurses' Union (1998) from Australia and Lybecker (1998) from the United States of America which highlight the identified problem, albeit under different titles. In brief, they all refer to unrecorded, non-physical abuse.

The Australian Concise Oxford Dictionary (Fowler & Fowler, 1987, p237) defines 'covert' as being 'secret ... hidden ... disguised ... threat or glance' and 'violence' as being 'violent conduct or treatment, outrage, injury...unlawful exercise of physical force, intimidation or exhibition of this.' This word, then, can be used as part of this research because the violence indicated is 'secret, hidden, disguised ...' in that there is no official recognized method of reporting such incidences except verbally. More specifically, 'horizontal violence', discussed by Freire (1972) and expanded by Skillings (1992), is defined as 'a form of internal fragmentation of oppressed groups' (p180). Covert violence results in an attitude of acceptance on behalf of nursing staff. It is a form of 'culture of silence' (Freire, 1972, p167) which tends to just perpetuate the problem, with nurses feeling unable to voice their concerns due to fear of belittlement or even job loss. Their self-deprecation and perceived helplessness within the greater whole leads to violence from within the group and is believed to be a self-perpetuated cycle. *Nurse Advocate Forum* (1998a) states that horizontal violence is 'harmful behaviour, via attitudes, actions, words, and other behaviours that are directed towards us by another colleague ... (It) controls, humiliates, denigrates or injures the dignity of another ... (It) indicates a lack of mutual respect and value for the worth of the individual and denies another's fundamental human rights.' (p1). It is, then, a special form of

covert violence, one which is rarely reported, lest the harmed staff member is judged as being petty-minded or having a low tolerance level or of being a poor team member.

Spring and Stern (1998) define horizontal violence as 'behaviour that we direct toward each other that would be totally inappropriate if we directed that same behaviour, action, word, tone, attitude, judgement, towards a patient!' (p1). In this research, then, 'covert violence' is defined as 'any behaviour that is directed towards a person in order to belittle, humiliate or to cause that person to feel professionally, personally or emotionally inadequate. It does not involve physical violence.' *The National Health News* (1994, p4) defines horizontal violence as 'persistent attempts to belittle staff, unjustified criticism and putting people under pressure to produce work ... shifting goalposts and withholding information.'

Significance of the Study

The aim of this research was to explore and analyze the experiences of covert violence of nurses within a health care system. Their feelings, attitudes and perceptions associated with these experiences will be discussed using a qualitative approach.

Nurses are leaving the profession in numbers greater than ever before. Young nurses are not staying much beyond their post-graduate year. Older nurses are leaving for jobs often unrelated to nursing. Retention rates continue to fall. Given this and the fact that patient throughput is expected to increase across the metropolitan health campuses, there is a need to assess honestly why

nurses are leaving. In this study there were several respondents who stated that they were becoming tired of being abused and that management did not appear to support their right to a safe working environment because of the negative reactions given to the report of such abuse. These people were prepared to look for other work if the situation did not change.

It is believed that once issues of covert violence have been identified and strategies put into place to assist staff to report and seek assistance in coping with these situations, there will be improved productivity, greater employee satisfaction and improved communication between staff members. There will also be a saving to the establishment financially in terms of less staff absenteeism, Worker's Compensation insurance claims and staff turnover.

Objectives of the Study

The specific objectives of this research were:

- to describe incidences of covert violence to nurses;
- to gain an understanding of the issues behind some of the violent episodes;
- to consider the experiences described against the current social, economic and political background of nursing; and
- to consider the implications of their experiences in relation to nursing, self-esteem and interpersonal relationships.

Summary

This study seeks to determine issues of covert violence that have been experienced by nurses in a specific workplace, and their reactions to it. It is planned that the information gained from the study will be used to improve the working conditions of nurses in the public sector. These will be used, conceptually, to form a plan by which this health service and its nurses can work towards an environment where such stressors can be acknowledged then minimized, thereby providing a safer workplace and a more settled workforce.

CHAPTER TWO – LITERATURE REVIEW

Introduction

This chapter outlines the history of nursing. There was a time when nursing was considered an occupation only for men, but gradually this turned full circle and became the domain of women. Today there is more equality between the sexes and nursing has become a dual-gender occupation. It is of historical importance that nurses through the ages have been subject to various forms of covert violence such as poor wages, long hours, and medical and management staff who were both physically and verbally violent toward staff, but patient-perpetuated violence was rare. Writers such as William Shakespeare painted nurses in a poor light, as untidy, drunken women who had as much difficulty taking care of their patients as they did of themselves. Gradually, though, as nursing became an honorable profession, women (and later men) were seen as vital to the smooth running of hospitals and clinics and now Nursing is a university-based course. Yet it seems, from this study, covert violence continues.

History of Nursing

'The untrained nurse is as old as the human race; the trained nurse is a recent discovery. The distinction between the two is a sharp commentary on the follies and prejudices of mankind.' Victor Robinson, 1956, p21

'Modern' nursing as we know it, began in the early Eighteenth century with Elizabeth Fry and Florence Nightingale as the main protagonists. Prior to this, medicine had been a predominantly male bastion and women were ascribed only the most menial of tasks. The advent of Christianity may have been the catalyst for the recognition of nursing as a separate vocation, later a profession. Caring for the sick, delivering babies and, when necessary, finding for them a wet nurse ('Shall I go and call you a nurse from the Hebrew women to nurse the child for you?' Exodus 2:7 – New International Version of the Holy Bible, 1998) were considered all part of a normal domestic situation for females. Historically, in the Anglo-Saxon tradition, the wife of the lord of the manor was responsible for the nursing of guests and visitors, and oversaw the care of villagers. She 'applied first aid, faced surgical emergencies and had an extensive knowledge of some remedies for all types of illnesses' (Donahue, 1985, p85). With the expansion of Christianity through Europe, there was a greater emphasis on social reform and with it the establishment of institutions for the sick, aged, orphaned, insane, leprous and for foundlings; 'Usually it seemed more economical to gather all classes of unfortunates into one institution known as a Xenodcheion, which was the ancestor of the modern institutions as well as if most other kinds of charitable institutions' (Shrylock, 1959, p79). Religion, along with elements of chivalry, militarism and charity, saw also the building of hospitals in the late middle ages. Men became nurses and the discipline and order of military life was carried through. Nursing orders called Hospitallers

were established, the most noted being the Knights Hospitallers of St John of Jerusalem (St John the Almoner, not St John of the Gospel) which was established in 1050 AD in Amalfi, Italy. 'As the knights were rich, they could equip and conduct their hospitals far better than any other community of that period' (Seymer, 1932, p38). The Teutonic Knights of Germany allowed women (called Consores) to work in some areas of their hospitals 'because services to cattle and to sick persons in hospital are better performed by the female sex' (Seymer, 1932, p40).

In England, church-aligned hospitals came into being in 1120 with St Thomas' opening in London and St Bartholemew's at Smithfield in 1123. Most of the staff were men (part of the Order of St John) but there were some females (the Order of St Alix [Agnes] of Jerusalem). In 1544 St Bartholemew's was reorganized with the mayor and corporation responsible for its finances and its running. They employed five 'sisters' with an overseer (Matron) for 'making the beds and keeping clean their wards, also washing and purging their unclean clothes and other things' (Masson, 1985, p260).

St Vincent de Paul, in 1632, founded the Daughters of Charity – a group of women who devoted their lives to caring for the sick and needy. In 1654 he allowed them to nurse French soldiers. Prior to this only men cared for military personnel. In 1726 Guy's Hospital (named after its benefactor, Thomas Guy, a wealthy Bible printer) was built with accommodation for 435 patients. Female nurses and a matron were hired but it was not until 150 years later that a dedicated nursing school was established within its campus. Interestingly, though, a nursing school was established in New York as early as 1798, by a Dr

Valentine Seaman. He offered classes in Anatomy and Physiology and in Childcare.

The first English training school was set up by the social reformer Elizabeth Fry in the early 1800s. She had visited the Newgate Prison and had found the sick bay particularly lacking. There were only beds for men, women were nursed on the floor, and no medical care was offered by site staff. The first nursing students were called the Protestant Sisters of Charity and later the Fry Sisters. They were granted a uniform and 20 pounds per annum with a rise to 23 pounds after three years' work as 'compensation for their hard work and piety'. Later, during the Crimean War, forty Fry Sisters accompanied Florence Nightingale and her nurses to Scutari and Sebastapol.

The problem around this time was that female nurses were not always women of good character. Charles Dickens' character, Sairey Gamp, was a parody on the type. She was a nurse and midwife, 'fond of a tippie which she kept in the teapot' (Dickens, n.d., p411). Her personality was shaped by shrewdness, personal strength, callousness, vulgarity and base experiences. 'A nurse was ...a coarse old woman, always ignorant, usually dirty, often brutal, a Mrs Gamp in bunched-up soiled garments, tippling at the brandy bottle or indulging in worse irregularities' (Stachey, 1918, p134).

With the declaration of war on Russia from Turkey in 1853, there was an immediate need for nursing staff. Impressed with this need, Florence Nightingale offered herself and a group of nurses who were trained only in the basics of nursing care. The price of victory for the Turks and their allies

(including Britain) was expensive. The war wounds were overshadowed by scurvy, dysentery, typhus and cholera. There was little equipment, few bandages and even less Morphine. Doctors and (male) nurses were also in short supply. The arrival of the nurses at Scutari did not fill the doctors with joy. They were concerned lest the ladies would hamper the 'real' nursing such as dressings, which was done by the male orderlies. So originally the nurses concentrated on cleaning, cooking, making tea and writing letters for the servicemen who were unable to do so for themselves. Eventually, with the ever-increasing casualty list, the nurses were allowed to work alongside their male colleagues.

After the war, Florence Nightingale returned to England and established a training school at St Thomas' Hospital. She wanted women she believed best, namely 'daughters of small farmers who have been used to household work – and well-educated domestic servants' (Masson, 1985, p63). Again, there was dissension from the medical staff. Up until this time, hospital nurses were classed as 'skilled servants operating in strict obedience to the physician's power' (Morrow 1986, p217). They came to be seen as a threat to the medical profession. Gamarnsk, (1991, p122) suggests the concerns were on three fronts. Firstly, they were afraid that control of the wards would pass from themselves to the nurses. Secondly, they feared that the nurses' new-found knowledge would challenge their own, and thirdly, they were concerned that the nurses would take over the entire management of the patient. Regardless of the nursing training, the doctors still regarded women as naturally subordinate to men, as most nurses were female, so they were 'naturally' subordinate to medical men.

The nurses (aged 25 – 35) were to provide a reference from their local doctor, live in, fill in a daily workbook, and keep a discipline register. They were also to be unencumbered by children or a husband, and they were not to be 'abandoned' women. Florence Nightingale believed that 'the most important practical lesson that can be given to nurses is to teach them what to observe – how to observe, what symptoms indicate improvement, what evidence of neglect, and what ought to make part, and an essential part, of the training of every nurse' (Nightingale, 1969, p105). Grounds for dismissal were strict. They could be dismissed for having a 'determined manner', for not wearing a hat, for not acquiescing to a head nurse (Reverby, 1987, p121) and for talking to another nurse in their room after duty. Attitude was also challenged, because they could also be dismissed for complaining about not having enough to eat (Kalisch & Kalisch, 1975, p231), for questioning hospital rules, and for questioning a doctor's orders (Ashley, 1976, p27).

These apparent hard conditions became part of a nurse's lot. Even the *Nursing Record* of 1892 (p350-351) considered them to be 'the white slaves of hospitals – overworked, underpaid, often more than half-starved inside their walls, or sweated as private outside nurses to produce larger profits for the hospitals, and then, when their health was broken down under the strain, discharged – tossed aside like old worn-out things'. Even as late as 1930, English nurses were still working a 57hour week. However, by the end of World War 1, there was the total acceptance of females in nursing, including the former male-dominated military nursing.

Moves towards the State Registration of nurses began around the turn of the twentieth century, and not without a great deal of opposition, even from other nurses. Sarah Swift, a retired matron from Guy's Hospital, wanted to establish a College of Nursing modelled somewhat on the College of Surgeons. She wanted registration of 'bone fide nurses of good character irrespective of social origins' (Masson, 1985, p117). By March 1916 hospitals of more than 250 beds and with a resident Medical Officer could register their nurses. These nurses were to have had at least one course of lectures per year and sit for, and pass, a State-set final examination. By May 1916 there were 70 such schools registered (Masson, 1985, p118), and by 1917 over 7000 nurses were registered. This type of registration is now world-wide, and nurses cannot work as such if not registered with the national or state registration council in their country.

The British General Nursing Council was established in 1920, with the task of setting wages scales and working conditions. It also, for the first time, acknowledged the registration of male nurses, mental health nurses and those who cared for sick children. Male nurses were considered most suitable for areas such as mental health, and to care for male patients with venereal disease. They were not necessarily accepted at general hospitals. It was felt unsuitable to have male nurses because it was felt that the female (senior) nurses would have difficulty ordering the men around, that the men would make sexual advances to female nurses, and there was a fear that males would bring with them the issue of homosexuality. It was not until 1949 that men could register as General Nurses with the Registration Board.

The Second World War saw, yet again, the need for more nurses, both on the home front and in the front lines. Nurses were employed in every theatre of war, and in every situation. The war was also responsible for great advances in both medicine and nursing. Antibiotics (such as penicillin) were manufactured, and there were remarkable advances in both medical care for specific injuries such as burns and resultant plastic surgery and for the way these cases were nursed. The war also resulted in women wanting a more equitable life-style with men.

Since the war there have also been some remarkable changes. There has been the introduction of a central health service (National Health Service in Britain, Medicare in Australia) meaning that there are now two types of medical care – private and public. There have also been changes in nursing itself. Now it is possible for nurses to attain degrees in Nursing and higher tertiary qualifications to the level of Doctor of Philosophy, and the old system of hospital-based training is now obsolete. Nevertheless, there is still a remnant of mostly medical practitioners who still view nurses as a form of second-class practitioner. To quote from Johnstone, (1994, p3), 'A nurse still lacks legitimated authority as a nurse, and is legally bound to 'obey' the lawful and reasonable orders of his or her superiors – the medical practitioners.' Further, 'Doctors are generally regarded as having superior knowledge and experience to nurses, and therefore as being in a better position to decide what is the 'right' course of action in clinical, administrative, ethical and other matters.'

(Johnstone, 1994, p5)

Hospital conditions, at least financial and aesthetically, have improved, but, in some, nurses are still expected to continue to work under conditions that, although certainly better than in the past, are difficult. Johnstone (1994, p5) opines that 'It is not uncommon for nurses to be instructed by a nursing supervisory authority to 'cope' and to 'do the best you can'. Thus, although nurse superiors can and do have authority over subordinate nurses, and subordinate nurses are obliged to follow the directions of a nurse superior, in the final analysis, nurse superiors and nurse subordinates alike show the commonality of legitimized powerlessness – neither has ultimate control in the realm of nursing, and neither has any real influence over the legitimated power and authority of doctors.

To sum up this historical overview of nursing, it has to be said that although there have been great leaps forward in the actual nursing situation there is still some work to be done on the relationship side. Nurses trained in a hospital-based system were often seen as servants of both the senior nursing staff and of the medical fraternity and they were often bullied by both. Interestingly, patients were sympathetic to the student nurses and tried to encourage them to continue their studies. Today, nurses are given the opportunity to study and to achieve in their field as never before. It is also true that nursing is now a much more respectable occupation and career than in the days of Charles Dickens. However, the hierarchical process of career improvement based on academic ability now rather than on an experience level still leaves the nurse open to being undervalued by nursing and medical staff as well as by the general public. Many are now regarding a university degree as being more important than actual hands-on experience, and conversely, the patients are now

complaining about the lack of skills that nurses attain prior to graduating. It would seem that the nurse's actual working situation has not changed too dramatically over the centuries. Yet, many nurses are no longer prepared to accept bullying from colleagues, medical staff or patients. The problem has been that they are not sure about the processes of complaint or if their immediate seniors will support their claims of covert violence. It still is a situation where many nurses are just told to accept the violence or leave the profession.

Covert Violence in Nursing

The history of nursing is littered with examples of covert violence, from bad working conditions and abuse from senior staff, to unfulfilling career structures and inadequate personal recognition, but it is only now being recognized as a major force in the discontent experienced by nurses in the workplace. It is only in the last two decades of the twentieth century that such behaviour has been highlighted and brought to the notice of both professionals and public alike.

Specific research into covert violence in nursing comes mainly from Canada (Spring and Stern, 1998), the United States (Lybecker, 1998), and Australia (Queensland Nursing Union, 1998). Because of a lack of reporting systems, most data available has been taken from anecdotal collections. Canadians Spring and Stern (1998) discuss intrapersonal violence in nursing considering it to be 'too often unidentified and tolerated' (p1) the results being all the more serious because the 'wounds are harder to see' (p2). Intrapersonal violence is described as that behaviour which is perpetrated upon a colleague in order to

make them feel frightened, anxious, intimidated or belittled either in front of others, or by more subtle actions which may affect rostering, partnering with difficult staff, longer or shorter shifts, the non-acceptance of roster requests, or by giving the colleague a task which is either beneath their qualifications or too senior for them to be able to achieve it. It is their belief that nurses have been socialized into accepting abuse, have become desensitized to its effect, and are at risk primarily because most are female, having to 'fight to establish their identity, value and worth' (p2). Covert violence, they write, robs nurses of their time, energy and devotion to their profession. Spring and Stern (1998) do not go into any detail regarding covert violence from other sources such as patients, their families and visitors as this study seeks to do, but concentrate on staff-to-staff incidences only.

The Registered Nurses Association of Nova Scotia (RNANS) (1998) asserts that covert violence in nursing is now rampant, and so has a Resource Guide for nurses. In it is a list of contributing factors that they consider to be possible triggers to workplace violence. They include such elements as environmental factors, staffing issues, client and staff characteristics, and organisational policies and management systems. This Guide reviewed many aspects of covert violence in a hospital setting, and some of the issues, both internal and external, which contribute towards a violent workplace setting.

Lybecker (1998) refers to workplace violence in the United States of America as an epidemic due to the under-reporting of incidences for 'fear of reprisals, the belief that reports will not be taken seriously, and that the effort itself is not worthwhile' (p2). She quotes the American National Institute of Occupational

Safety and Health figures that show that nurses and other health care workers are assaulted in the workplace more often than any other American workers' groups and yet less than 20 percent of all events are recorded (p1). Lybecker (1998) believes that the public and the media are apparently unaware of either the incidence or violence towards nurses or the effects it has on them. This study, however, looks more at overt violence. She cites very few figures regarding covert violence.

Another American study was tabled at the International Labour Organization's (ILO) seminar on 'Violence on the Job – Global Problem' seminar at Geneva in July 1998. In this paper three specific forms of covert violence were discussed. These were bullying, ganging-up or mobbing, and being forced to work alone (p3). These add to the psychological stress of the incident and leave staff edgy and nervous, humiliated, tired and depressed, resulting in 'long term disruption to interpersonal relationships ... reduced efficiency and productivity, and loss of image, both personal and corporate' (p5). This work on bullying is excellent but again it is only one form of covert violence experienced by nurses in their workplace.

Australian studies come mostly from the Queensland Nurses Union (1998) and concur that nurses in Australia are just as much at risk of workplace violence as in other countries. Workplace bullying ('less favourable treatment of a person by another in the workplace, beyond which may be considered reasonable and appropriate workplace practice') is on the increase, is illegal, but goes largely unreported and is destructive to both the nurse being bullied and to the smooth,

efficient running of a health service. It results in 'forced resignation, ill health, exclusion from productive duties and low morale' (p1).

It appears then that a similar picture of violence, overt and covert, in the workplace is emerging from all three countries. Nurses are keeping silent on this issue to their detriment, and seem unable to break their silence and have the situations dealt with appropriately.

There have been five studies of a specific form of covert violence, namely bullying: The *Nursing Times* (1995) found that nurses were bullied throughout all health systems, private and public and at all nursing levels. A survey questionnaire asking about bullying was distributed through the journal and the completed forms were sent to the publisher, McMillan. So many complaints were received that it was impossible to publish all the findings and only two hundred were considered. The results showed that over 60 percent of managers were bullies, criticizing, humiliating and denying staff access to promotions and other employment opportunities. Two and three years later the same trend was occurring with most of the complaints being made against senior doctors, managers, and senior nurses (*Nursing Times*, Feb. 1998, p18). A similar study by Alderman (1997) confirmed this from a survey conducted by the Royal College of Nursing (UK). Bullying persisted, it seems, because staff felt unable to report such behaviour for fear of job loss, demotion or victimization (*Nursing Times* 1998, p10). There is no other form of covert violence in these studies and so it was solely horizontal violence which was studied.

Skillings (1992) interviewed nursing staff and concluded that oppression in nursing is the norm, is 'multidimensional and socially constructed' (p173). Lack of support from peers and management resulted in a type of class/power situation between staff members where senior staff were not encouraging more junior staff to become more proficient in tasks, and in some cases even hindering their actual learning opportunities. Skillings (p177) reported that staff unknowingly perpetuated oppression, resulting in a continuous cycle of bullying leading to further oppression.

Farrell (1997) using both questionnaires and interviews, found that nurses who remained in a clinical area were more tolerant of staff-to-staff aggression, but concluded that those nurses involved in an academic stream were not so, and were thus reluctant to return to clinical areas. Also noted was that nurses were remaining subservient to doctors, and that there are within the health systems, inherent rules related to intimacy, task orientation and support. There still remains within nursing the idea that doctors are the task setters and nurses obey, verbal intimacy is discouraged, and there is still an expectation from some doctors that nurses support their actions whether they be unprofessional or just outside the hospital's guidelines of service delivery. When any of these mores are broken the way is open to colleague bullying and abuse.

The Workplace Bullying Project (nd) instituted in South Australia by the Working Women's Centre interviewed nurses from across the health systems. It concluded that bullying was neither discussed nor adequately dealt with, and that it was a response from staff members who could not manage their own stress levels and work tasks. Their constant pressure led to intolerance of

others often resulting in bullying and abuse of power. National guidelines of Occupational Safety and Health (OSH) do not clearly address the concept of workplace violence but this is changing and increasingly there is a greater emphasis on OSH input into the nursing workplace.

The overall impression of all the studies cited is that staff-to-staff relationships are at the base of all the reported covert violence incidences. Granted this is of concern to all staff, but it is not the only form of covert violence which nurses experience. Other forms of covert violence include abusive language, offensive language and bullying. Little is mentioned about these. However, regardless of nationality, each researcher cited has acknowledged that covert violence is a significant aspect of the nursing experience, that it is under-reported and that its effects on staff can have far reaching results, not only for the nurses themselves, but for patient care and health services accountability as well as to their own family interactions.

The current literature indicates that violence in nursing is on the increase. Blick, (2002, p1) has found that there is an average of thirteen incidents of violence or threat of violence each month in British National Health Service institutions. Clay (1995) states an American increased figure of around 200 percent, mostly in the form of threats of physical or sexual abuse. The International Labour Organisation, meeting in Geneva in 1998, stated that women health care workers were at greatest risk for experiencing verbal and physical abuse and sexual harassment at the workplace. There is, however, no information given on the incidence of covert violence as outlined in this research. The group, Nurse Advocate, has an ongoing internet forum for anecdotal recording of

forms of covert violence experienced by nurses, and is being updated and expanded on a regular basis. Spring and Stern (1998) were concerned that, despite evidence of covert violence being on the increase, there is 'denial, minimization and rationalization' (p2) by other staff and management in an effort to maintain the status quo rather than looking at the incidences, the victims and the resultant effects.

Legal Issues

In the U.S.A. there is a bill (still in 2003) making its way through the courts system concerning the issue of harassment by supervisors ('Enforcement Guidance: Vicarious Employer Liability for Unlawful Harassment by Supervisors' 6/18/99 – Ida L.Castro, Chairwoman). There is the underlying assumption that employees are often subject to harassment by supervisors based on race, colour, sex, religion, national origin, age and debility. Although this is not directly related to nursing *per se* its enactment will have a profound effect on the nursing profession. In this paper by Castro (1999), supervisors are described as anyone 'with immediate or successively higher authority over the employee ... or anyone who has authority to direct employees' daily work activities ... or who can recommend employment decisions affecting the employee' (p4). These include decisions such as hiring and firing, promotion or failure to promote, demotion, undesirable reassignment, compensation decisions and work assignments. The paper also lists a 'second prong' issue where the employer is liable if the employee fails to complain because of a perceived risk of retaliation, obstacles are deliberately placed before the complaint, or if there is a perception that the complaint was ineffective. It offers

an outline for the formation of a central policy of complaint by an employee.

This includes:

- A prohibition against harassment;
- Protection against retaliation;
- An effective complaint process;
- Confidentiality; and
- Effective investigative process.

Working in a health care facility in the United States is considered the third most dangerous job. To this end, The Commonwealth of Massachusetts has actually passed a bill requiring health care employers to develop and implement programmes to prevent workplace violence. An employee is defined as 'any individual employed by a health care facility...' (2002, p1). The Act requires the service to complete an annual risk assessment of the problem and to develop and implement a programme to minimize the danger of workplace violence to employees. This includes all violence, whether covert or overt. Failure to provide a safe working environment will result in a large fine to both the health service, and where deemed personally liable, to the staff member/s involved (p7).

In the United Kingdom, bullying is still the main complaint from nurses. Bullying and harassment are at epidemic levels (*NHS News*, September 1999:4). It is reported that one in three health staff have been victims of workplace bullying in 1998, and the figure continues to rise (p1). This ranged from persistent attempts to belittle staff, unjustified criticism and putting people under pressure

to produce work. Other concerns were shifting goalposts and withholding information. Up to two thirds of the staff involved tried to take action against the bullying, but were dissatisfied with the outcome. The bullying had resulted in significantly lower levels of job satisfaction, higher levels of job-induced stress and anxiety, with an increased intention to leave the job. To this end the UK government health ministers were to have set specific targets to be achieved by April 2000 dealing with issues of racial discrimination. These as yet are not in place.

The Nuffield Trust (1998) have found that between 29% and 48% of UK nurses are suffering symptoms of psychological disturbance ranging from depression to suicide. The main causes were reported to be overwork, staff shortages, unsupportive managers, insufficient time to get through the workload, and constant harassment by other staff.

The United Kingdom has, from July 23, 2001, made a ruling of zero tolerance for violence against nursing staff. This is in response to research that has shown that one in every three nurses is abused by members of the public whilst in the workplace. The National Health Service has now decreed that it is an offence to make any offensive sexual gesture or use threatening or abusive language against any hospital staff. Consistent offenders may actually be banned from NHS facilities.

Australian studies through the Queensland Nurses' Union confirm that bullying is a major problem among hospital staff. They are suggesting that in some instances the situation is so acute that it may be in breach of the Workplace

Health and Safety Act or the Anti-Discrimination Act. They call for all workplaces to have a clear statement indicating that bullying is unacceptable, and they should provide access to counselling as needed. Interestingly, there is no specific information as to the actual challenging of bullying itself.

Hastie (2001) cites an extreme example of workplace bullying in New South Wales. Jodie was a new midwife, twenty-five years old who was considered 'enthusiastic, passionate about her work, talented and committed to learning as much as she could about her chosen profession.' Instead of support she received 'hostility, criticism and intimidation' from her colleagues. Gradually her confidence was shattered and the constant disparagement led her to doubt her own abilities and value. Eventually she gassed herself in her car. Her suicide note stated her disillusionment and profound sense of hopelessness.

Summary

This chapter has attempted to set the background for this research. It has outlined the history of nursing and also the history of study into covert violence in nursing. It has also shown how such incidences in the workplace have moulded and influenced nurses for generations and continues to do so. There is more emphasis on Occupational Safety and Health on most worksites now than ever before, and yet covert violence goes unrecorded and thereby dismissed.

The literature survey shows that there have been studies on specific types of covert violence, mostly intrapersonal, but very little research has been done on other forms of covert violence. The significance of this research, then, is to tell of nurses' experiences of covert violence right across the workplace. These include interaction between the nurse and his/her patients, their relatives and direct staff-to-staff issues. This research has evaluated these experiences and considered some of the hidden stresses that arise in a health care system.

Nursing has come a long way since the days of the Knights of St John of Jerusalem, far further than either Elizabeth Fry or Florence Nightingale could ever have foreseen. It is in the light of this study on covert violence that one can say that nursing still has a long way to go before it and its practitioners are accepted and respected.

CHAPTER 3

METHODOLOGY

Introduction

This chapter outlines an interpretist paradigm of inquiry, as contextual meaning was sought from the participants' points of view. A discussion of qualitative research follows with a description of the steps inherent in the research procedure. Issues such as reliability and validity, along with procedures of coding and storage of the collected data are discussed. Finally, ethical issues are considered, which are particularly important in a study that covers sensitive issues such as bullying and workplace concerns.

Paradigm for Inquiry

The research seeks to describe and interpret the meaning nurses have in relation to covert violence in their workplace. It is concerned with their world as they have experienced it. The researcher does not have any control over variables or the data. This, then, is an interpretist method of inquiry. Patton, (1990, p55) outlines that:

The interpretist researcher's commitment is to understand the world as it is, to be true to complexities and multiple perspectives as they emerge, and to be balanced in reporting both confirming and disconfirming evidence.

The opposite – a positivist approach – is more suitable when statements can be measured and situations observed. However, not all phenomena can be measured or controlled, and so an interpretist approach has been deemed the most suitable for use in the project. Field and Morse (1985, p11) confirm that an

interpretist approach is best used when 'the research question pertains to understanding or describing a particular phenomenon or event about which little is known.'

In this study the meaning of the data has been interpreted through the thoughts, feelings and behaviours of the nurses. There is a shift from concrete to abstract ideas as the experiences are expressed. It follows a 'naturalistic generalisation' which Stake (1978, p6) explains:

...develop within a person as a result of experience. They derive from tacit knowledge of how things are, why they are, how people feel about them, how these things are likely to be later or in other places with which this person is familiar... These generalisations may become verbalised, passing from tacit knowledge to proposition...but are...never formal.

This study, then, is of an interpretist model using qualitative research methods, and relying on naturalistic generalisations to collate the data into specific categories.

Features of Qualitative Research

Many writers such as Bendoliel (1984), Munhall and Oiler (1986), Patton(1990) and Leininger (1985) have identified characteristics of naturalistic research.

The following list represents an ideal type which encapsulates the essence of this methodology:

- qualitative research uses the natural setting as a source of data. The researcher maintains an 'empathetic neutrality' (Patton, 1990, p55) while observing and interpreting the settings;
- the researcher acts as a human instrument of data collection;

- qualitative researchers predominantly use inductive data analysis;
- qualitative research reports are descriptive, incorporating expressive language and the 'presence of voice in the text' (Eisner,1991,p36);
- qualitative research has an interpretive character, seeking to discover the meaning events have for the individuals who experience them;
- qualitative researchers pay attention to the uniqueness of each case;
- qualitative research has an emergent (not predetermined) design and outcome.

According to Patton (1990, p40) these characteristics are interconnected and 'mutually reinforcing' (Lincoln and Guba, 1985,p39). There are no strict criteria for sample size because 'Qualitative studies typically employ multiple forms of evidence ... there is no statistical test of significance to determine if results "count"' (Eisner,1991, p39). Strauss and Corbin (1990) contend that what is most needed is what they refer to as the 'theoretical sensitivity' of the researcher. This is:

.a personal quality (that) indicates an awareness of the subtleties of meaning of data ...the attribute of having insight, the ability to give meaning to data, the capacity to understand, and capability to separate the pertinent from which isn't. p42.

Credibility and usefulness decisions are at the mercy of the reader and of the researcher.

Validity

These issues have been dealt with by many authors including Lincoln and Guba (1985), Leininger (1985) and Whyte (1984). According to Leininger (1985, p68) validity

refers to gaining knowledge and understanding of the true nature ... of a particular phenomenon ... and reliability focuses on identifying and documenting recurrent, accurate and consistent or inconsistent features ... confirmed in similar or different contexts.

Validity is the degree to which an instrument measures what it is intended to measure. In this case, the questionnaire was used to collect information on the forms of covert violence experienced in a particular work situation. It was not intended to actually measure the violence *per se*. The open-ended questions were deliberately constructed so as to enable the identification of any or all forms of covert violence experienced with freedom for the participant to include any comments or reasons for the violence as they saw appropriate. The aim was to amass information about covert violence in the workplace – the types and the perpetrators.

Validity in scientific research is very important. It is a check that the research data accurately represents the phenomenon that is being studied. The concept of validity can be gauged by four criteria:

1. Credibility

This is achieved when the people who experience the phenomenon recognize descriptions and interpretations of it. In this case, the fact that the participants wrote of their own experiences made the data collected credible within the framework of the questionnaire. The findings of the data analysis were

checked against other participants' documentation and also with published literature in the area of covert violence in nursing. This was done to establish whether there were commonalities between experiences and interpretation with regard to the data.

2. Aptness

This refers to how well the research 'fits' other comparable situations. The emerging themes were scrutinized for other seemingly unrelated elements, though none were found.

3. Auditability

This occurs when an outside researcher can follow the decision trail of the original researcher. In order to make this possible, the researcher needs to provide information about the decisions made in the research. These include the actual purpose for study, the method used and all details about data collection and analysis.

For auditing purposes the researcher has left a trail of decisions made. These include:

- the purpose of the study;
- the rationale for participation;
- chosen methodology; and
- how the data was collected.
- how long the data collection lasted
- the transformation of data into analysis

4. Confirmability

Confirmability is said to be attained when all of the above three criteria have been met. In this study credibility has been achieved because all the respondents understood and recognized the phenomenon of covert violence. Their responses were checked against published literature on the topic and direct commonalities of the experiences were found. The data collected was apt because it corresponded to other data that has been collected from other countries. Auditability is possible through the trail of decisions.

Reliability

One person collected and analyzed the data. This provided study reliability through having a consistent method of data collection and analysis.

As each staff member was asked to document incidences of covert violence that they had experienced, then the information written must be taken as being reliable. With this, too, there were several examples of specific issues that were raised too coincidental to consider accidental or unreliable.

A Review of Qualitative Research in Nursing

There is some literature regarding the workplace experiences of nurses, but very few from Western Australia, and certainly not with the broad heading of covert violence. Rather some research has been done on specific areas such as bullying, but none of a more wider base. Serghis (1998), Giles (1998) and Witham (1998) have collected data from nurses regarding their work experiences using a qualitative, phenomenological approach. They were

concerned with how their participants saw their role as nurses and working women, this study, though is one of 'what' they experienced.

Although there can be some comparisons between the actual episodes experienced, there is no one way of dealing with them and the response by the nurses vary enormously. This study looked at, not only what happened, but also the response each had to the various episodes. Respondents describing their roles as nurses were challenged to think through their experiences.

The Research Process

This study aimed to provide data about nurses' experiences of covert violence in a particular work situation. It did not attempt to infer a like finding for similar work places. The three research questions concerned:

1. What forms of covert violence were experienced whilst working in the health service?
2. What contributed to the episodes?
3. What was done about the covert violence experienced?

The aim of this section was to outline the steps and decisions used in obtaining reliable data. There was a discussion of the selection process for participants, the open-ended questions used to obtain information, the analysis of the data using phenomenological guidelines, as well as a discussion of ethical and research limitations.

Inspiration for the Research

A pilot study, as such, was not originally carried out. The researcher is a member of the health service's Peer Support Group. Over a year, so many staff members voiced their concerns and distress at some episodes of covert violence that they had experienced that the whole issue of covert violence was considered of importance, not only to the health service, but to the betterment of nursing in general.

Staff were unhappy with their experiences and felt isolated in that there was no-one, other than a Peer Supporter, who would listen to them. Management were either too busy or too stressed themselves to take notice, or disregarded the nurses' concerns as being 'immature, time-wasting or just plain foolish'. 'Why make a big deal out of it? It happens all the time' (Respondent 8). So this research was commenced.

Sampling

The aim of the present study was to obtain information about nurses' experiences of covert violence within a public hospital. To do this it was necessary to find willing participants who would be prepared to write of their experiences and of the reaction of senior staff to the incidents reported to them. The sample, then, was based on the descriptive information given by an acceptable number of participants.

It must be acknowledged that the number of participants was limited by the very fact that they had to actually document incidents often involving other staff

For some, signing the consent form was equally difficult. Although it was written on the questionnaire that no names were to be mentioned on the actual document, and verbally reinforced by the researcher, it was still a concern. To develop contact with potential participants, the researcher spoke to various ward and unit groups regarding covert violence and encouraged participation.

The study targetted registered nurses in a suburban health service, covering working areas of maternity, mental health, theatres, geriatrics, infant health and community nurses from local schools. There were 225 in this population. This was deemed a small enough group to be manageable yet large enough to be representative of other, larger health campuses. The larger the sample size the more accurate will be the data, but the more unwieldy the results. Hawe (1994,p136) suggests that when the reason for the survey is merely to investigate the dynamics of problems in a community in order to formulate policies and strategies, then the sample size need not be excessively large as it would be if data was being collected for specific measuring purposes. This study sought to investigate the types of covert violence experienced by nurses rather than the actual amount of violence experienced, so the 225 participants would be a useful, manageable and acceptable number. The actual number in the sample, that is, the number who responded was 40.

Data Collection

Using a qualitative research approach the collection of data was carried out using an open-ended questionnaire. The first page of the questionnaire sought

to establish the participant's age, gender and length of time in the profession.

The second was concerned with the three questions:

- What forms of covert violence have you experienced whilst at this health service?
- What factors may have contributed to these situations?
- What was done about the incidences?

Confidentiality and anonymity were assured and a signed consent form for release of information was obtained. To address the issue of anonymity, it was documented on the questionnaire that no names or dates were to be given which may have been able to identify the nurse or the perpetrator. In the original covering letter it was stated that if a participant did not want to actually write the answers to the questionnaire, then they could have a taped interview with the researcher. No-one asked for an interview.

Ethical Consideration

Originally, ethical approval was given to commence the research from Edith Cowan University. It took over a year, though, for the health service ethics committee to approve it. The committee members had concerns that information may be distributed outside the service, and also were anxious that participants may be distressed at remembering and reliving their experiences.

It was agreed that if the participants became distressed the researcher would either discuss and counsel the person immediately or else refer them to a staff counsellor either at the health service itself or through the Australian Nurses

Federation. Data collected from the participants would be kept in a locked filing cupboard as per university guidelines.

Sieber, (1982, p21) outlines specific ethical values necessary for the protection of human subjects in research projects. They are 'justice, beneficence and respect'. This means that all participants need to be treated equally as far as their written data is concerned, and what they write is treated confidentially and carefully, and that their concerns are recorded without any bias or levity by the researcher. Aligned with these are norms related to the research in particular, and they include investigator competence, validity of design, identification of outcomes, voluntary consent, subject selection and injury compensation.

In order to minimize ethical issues, then, all participants were given written information as to the aim of the study and understood that they could withdraw from the study at any time. They were assured of anonymity and confidentiality. All participants signed a consent form (Appendix D) outlining

- the reason for the research project;
- the anticipated benefits of the research;
- the actual data collection method;
- the assurance of anonymity and confidentiality;
- the assurance that all data would be stored securely;
- that participation in the study was voluntary and consent could be withdrawn at any time without any form of personal, professional or emotional penalty.

All returned questionnaires were given a number and the consent forms were removed to a secure location.

Role of the Researcher

The researcher was responsible for the distribution of the questionnaires, but her own personal values, judgments and biases did not influence the interpretation of the data collected. Having worked in the health service for many years, though, there was an inherent insight into some of the issues raised.

Research Limitations

Time was the limitation in the final analysis. Staff spoke about the research with each other and with the researcher but took time to formulate their answers and actually write them down. This was due in part to the busy workload that each encountered leaving little work time to fill in the questionnaire. Several folded up their questionnaire and simply forgot to fill it out. The main problem for the participants, though, was that they were concerned that the researcher may have been able to identify the perpetrator/s of the violence incidents because she worked at the same site. Also, given the current climate of nursing where hospitals are so short staffed that there has been a determined effort through mail outs and media advertising to woo nurses back to the profession, and the instability of the job market it was felt by some that the identification of unrest or discontent might reflect poorly on the participant. There has been talk for several years that this specific health service was to be scaled down, and so

people were anxious about their tenure in the workplace. Several wards have been closed in the last ten years and the rooms turned into offices so the actual bed capacity of the hospital has fluctuated as have staff numbers. Successive health ministers have denied that there is a rethink on the working of the service, and yet the print media have had several articles published over the past two years indicating that the health service may be scaled down in the services that it is allowed to offer the community. This has had an unsettling effect on all staff across the site.

Summary

The data for this research was collected using a qualitative approach. Issues of reliability, validity, credibility, aptness auditability and confirmability have all been accounted for in the process. Ethical considerations were discussed, with emphasis on confidentiality and also the right of a participant to withdraw from the project whenever they wished.

The two limitations were time and the reluctance by some staff members to participate in the research. It took over a year for the ethics committee of the health service to approve the research. Their concerns were that the remembering of incidences may result in distress to the participants, and that confidentiality of the data received may be compromised. However, these concerns were addressed by the researcher and the committee allowed the project to proceed.

The staff members who replied to the questionnaire did so with a little reluctance. There had been information rumoured and in the printed media that the health service was being threatened with closure and so employees were worried that their participation and information given in the questionnaire may have a detrimental affect on their employment then and in the future. They were reassured by the researcher that the information given would be kept in confidence and the actual data collected would be stored in the university-approved manner.

CHAPTER FOUR

FINDINGS

Introduction

The purpose of this study was to document and describe nurses' perceptions and understanding of their experiences of covert violence in their workplace.

This chapter discusses the profile of participants in the study and the results of the questionnaires that were submitted.

Profile of Participants

Forty (40) Registered Nurses replied to the questionnaire. Seven and a half percent (3) respondents were male and 92.5 percent were female. 92.5 percent were Caucasian and 7.5 percent were of Asian background. The amount of time employed in the health service varied from six months to over twenty years. Each nursing 'unit' was represented – Theatres, Day Surgery, Geriatrics, General Surgery, Mental Health and Maternity. Spurgeon (1997) has identified that, depending on the culture represented, there may be different definitions of workplace violence. It was anticipated that this could actually broaden the framework of this study.

The Experience of Nursing

Most of the nurses who responded to the study had a sense of empathy and compassion for their patients and for their colleagues, and pride in their workplace. Rarely did they consider themselves to be 'special' because they deal with people's lives and bodies every day. Rather, they saw themselves as

being 'fairly ordinary' but with a genuine belief in nursing as a career, a profession and a calling. The nurses surveyed felt that they had invested time, energy and emotion into their work specifically, and into their workplace in general. It seemed, though, that most considered their nursing environment stressful, with increasing legal accountability and larger numbers of patients, yet with staffing levels they believed to be dangerously low. These stressors often accounted for the nurses' reactions to the covert violence they experienced. Several mentioned that 'on another day' the same experience would not have affected them to the same extent, and neither would they have reacted in the same way.

Themes

Following the collection of questionnaires from forty nurses, significant statements were extracted that pertained specifically to incidences of covert violence. These statements were organized into clusters resulting in four themes. These were then referred back to the original transcripts in order to validate them. See Appendix A for the responses of each nurse.

The four main themes that emerged from the data were:

- offensive language;
- verbal abuse;
- bullying; and
- unfair workloads.

Four groups of people were also identified from the data as being the 'abusers'.

They were:

- Patients;
- Patients' relatives;

- Colleagues, i.e. other nurses; and
- Medical staff

1. Offensive Language

From the data received, offensive language included swearing, the telling of rude jokes, sexual innuendoes and general rudeness as displayed by body language. The questionnaire elicited subjective replies from the nurses and so it needs to be understood that what may be deemed to be offensive language by one person may not necessarily mean the same to another. However, the nurses who recorded such incidences were offended.

The perpetrators of this form of abuse came from all four categories of people who were identified. These included patients, their relatives, colleagues and medical staff. The recipients included male and female staff, their age, experience and length of time in nursing or specialty was not a factor.

There is very little literature available about why the public and staff are so rude, but the nurses themselves have several suggestions as to why this is so. The first is the belief that people are simply ruder today than in the past. This is corroborated by the results of Marketing Focus, a market research group, as quoted by G. McNamara (2002, p3). They surveyed two thousand people Australia wide and among their conclusions was that sixty percent (60%) of the people interviewed were concerned about the use of bad and foul language in today's society.

A second suggestion is that the use of bad language is so common today that people have become desensitized to it. In the past, offensive language such as swearing was seldom used in public and rarely around women. It was considered to be acceptable only for groups of (mostly) men gathered in sports change rooms, building sites, hotels and bars. It was never used on television or in general-release movies.

Nowadays such restraint is no longer evident. Swearing is accepted as part of 'normal/street' language, occurring on television, screen and in the printed media. One example is that of an advertisement by a car manufacturer. The word 'bugger' is used several times and the overall effect is one of amusement. This word has an offensive meaning, but its use in the context of the advertisement has changed its meaning, now used to signify frustration and annoyance. It would seem that as people are desensitized to swear words, they become more comfortable using them and no longer feel guilty about doing so.

To use such language in front of a woman was once considered in poor taste and quite ungentlemanly. Now this seems to be an attitude assigned to the past. Perhaps the push for gender equality is to blame or simply that manners are no longer being taught at home or in the schools, or are no longer deemed as a standard for behaviour.

Offensive language also includes the telling of rude jokes. One of the participants reported that this was happening regularly perpetrated by one of the visiting surgeons. She considered that the jokes told were in themselves offensive, but it was more of an issue because she felt 'trapped' within an

operating theatre situation where, as one of the scrub team, she could not leave the room if the jokes became too bawdy. She also felt that the surgeon was aware that she was not happy with the jokes told and so she was considered a prude by him and this offended her more.

Perhaps one of the reasons people swear at nursing staff in a health care setting is from frustration at the time taken for staff to see to them. One participant (no. 6) was sworn at by a patient because she could not meet his needs immediately. She was seeing to another patient at the time and could not leave this patient to assist the other. Whilst frustration is understandable in such an occasion, there appeared to be no recognition by the patient involved that he understood the nurse's workload or situation. Even given the situation, it was felt by the nurse that his outburst was totally unnecessary and offensive.

Another incident involved a nurse on a usual evening medication round. The patient involved, a middle-eastern man, swore at the nurse because she had interrupted his mealtime with her round. On trying to explain to him that the medication round was necessary, he refused her explanation and continued to swear at her (participant no.18). His comment was that he would take his medication whenever he wanted and that was not during his mealtime. This shows lack of understanding by the patient that some tasks of the nurse need to be conducted to a certain timetable. Some medications need to be taken with meals or just afterwards, and so the most appropriate time for a medication round is during meals. It also shows some of the difficulties of working in the multicultural setting of a modern Australian hospital.

An incidence of swearing was also recorded by a nurse (no. 11) against a patient who was non-compliant with hospital policy regarding the leaving of the ward. He was a heavy smoker and found it hard to limit his nicotine intake whilst in hospital. The nurse involved had wanted to attend his dressings, but he wanted to smoke. His feelings of frustration was understood by the nurse but she felt that his attitude and resultant language was totally inappropriate.

Psychiatric patients have special needs whilst in hospital and in the most part this is accommodated. Swearing might be part of their everyday language, even so staff find it difficult at times to accept. Participant no.33 records that she was asked by medical staff to obtain blood from a patient with a psychiatric history. He did not want to comply and began swearing at the nurse and others who were in attendance. Although she dismissed most of it because of the situation and the patient's own stress, she felt that the almost daily recurrence of such an incident left her feeling anxious and distressed. Some incidences may be unavoidable but in these cases there should be an opportunity for support and debriefing, but this is not so. Respondent 17 stated 'no-one cares or listens, it's considered just part of nursing'.

Body language was also considered by the participants to be offensive on occasions. This included shrugs and eye rolling by patients when they were being questioned about their medical history. Although verbal language was not used as such, the participants who reported it considered the actions to be hostile and abusive towards nursing staff who were trying to complete the charts.

2. Abusive Language

Have you ever been wounded by words? I have, and most of you who are reading this probably have too. As children, you might have recited the familiar rhyme; "Sticks and stones may break my bones but names will never hurt me." Even then, you probably sensed that it wasn't true. (Shinder, 2002, p1)

Abusive language, for the purposes of this study, is differentiated from offensive language by the fact that abusive language is directed specifically at the nurse.

Examples included:

1. curses;
2. demeaning or abusive labels;
3. Insults; and
4. Sarcasm and demands.

Again, like offensive language, abusive language was found to have been perpetrated by people from across all four groups cited. There is an abundance of literature on this topic (Canadian Nurses' Association, (1993, p2) McNamara,(2002, p1), Nurse Advocate,(1998b, p3) and that suggests why abusive language is so rife and directed towards nurses. Certainly It is not a recent phenomenon. It quite possibly has always been a part of any service industry. In 1994 the Canadian Union of Public Employees found that 70% of the people they surveyed believed that verbal aggression was the leading form of violence they had to contend with (ILO,1998, p1). They reported that in the same year over 350,000 British retail staff suffered abuse (p3). Nursing, being a service industry, is similarly affected.

A study of nurses in Nova Scotia in 1995 identified that patients were the most frequent perpetrators of insulting or abusive language (56%), verbal threats (26%), family members were the offenders in 28% of cases of abusive language and 3% of verbal threats. Colleagues were the perpetrators in 25% of cases of insulting language (of these 41.6% were physicians, 16.8% were nursing staff) and this was 1% of all verbal threats. (RNANS 1998, p2).

This study has found that little has changed. The reasons for this type of covert violence can be attributed to four specific categories – the individuals themselves, the conditions at the health service, the work environment, and the interaction of people in general. One participant (no. 28) wrote that verbal abuse happens 'almost daily'. No. 26 wrote that in her experience these abusers were 'usually male, aged 20 to 30' although this may not overall be the case.

For the patients, abusive language may be the result of a feeling of powerlessness, especially in relation to male patients. It would seem that if a woman is anxious about a procedure or impending surgery, she is likely to express this fear through crying. Men, on the other hand, are conditioned by society into believing that crying is not acceptable for a male, and so their fear is expressed through abusive language. To some extent the nurses tolerate this because often, after the procedure has finished, the patients calm down and are often contrite about their pre-operative behaviour. Nevertheless the nurses who identified this type of behaviour found it stressful at the time.

Feelings of powerlessness can arise because of the whole system of hospital care. People are removed from their families, put to bed, usually in pyjamas or a surgical gown and not only their dignity is forfeited, but also their normal daily routine is upset. Their independence is lost – often if only for a short time – and in its place they find sterile surroundings, unknown staff, intimate procedures and a timetable for meals and medications that is quite alien and rigid. One patient became abusive when his medications were locked in his bedside cupboard, the key to which only the nurse on duty held. The patient did not appear to understand that hospital policy as well as the safety of other patients were the reasons for such a procedure, but he had been used to taking his own medication when he felt he needed it and so felt powerless over the System as well as feeling powerless over his own life and health management.

Added to this powerlessness may often be ignorance. People enter hospital for surgery or procedures for which they have consented but many have no real idea as to what is involved. Some are not even aware of what body parts are involved. Ignorance creates fear, fear anxiety, and anxiety, (often) abuse.

Both patients and their families are victims of their expectations of the health system. It would seem that everyone who enters a health service wants the experience to be fast, first, friendly and free. The speed by which a clinic or surgery runs depends on many things such as the number of cases booked for that session, the length of time each takes to finish, the change-around time between each procedure, whether the doctors or anaesthetists are on time to start the list and what external emergencies may arise during a list. Patients' Local Medical Officers (G.Ps) often tell their patients that the procedure they

are having is only minor, will only take a few minutes and they should be 'in and out' in less than an hour. This then is taken as correct, and when informed by nurses that, yes the procedure will only take a short time, they are tenth on the list and will probably have to wait several hours before being seen at all, both patients and their families can become abusive. The 'System' is just not understood.

Having to wait in 'line', as it were, is also quite difficult for some. The comment is often passed 'If I was a private patient I would not have to wait'. Nurses try to explain that, even in a private hospital, there is a 'list' and one can never guarantee that one will be first on it. One example cited in the research concerned a young lady who, when she found that she was seventh on the theatre list for the morning, walked out of the hospital angry and threatening to sue the doctor and the hospital for time wasted in waiting. This sort of behaviour, spurred on by wrong expectations, is hard to deal with, and even the most sympathetic nurse is often the recipient of verbal abuse and threats. The idea that someone must be last on a theatre list does not seem to be compatible with patients' and relatives' idea of health care.

Another example of timetable problems is cited by participant no.26. In this case it was the relatives of a patient who became abusive because their family member was made to wait for surgery. He had been given pre-operative medications and had fasted for the appropriate length of time and then the surgery was delayed (indeed eventually cancelled) and they were distressed. The nurse involved felt she understood the situation and was quite empathetic towards the client and his relatives, but there was nothing she could do about it,

and felt that the frustration and anxiety of the relatives should not have been taken out on her. Power failures had caused the cancellation of the procedure, something quite out of her control. It was explained that in the event of a power failure it is only permitted to finish a piece of surgery that may already be underway, but it is not permissible to commence a new operation. The relatives and the patient said they understood the situation, but were still angry, frustrated and abusive towards the nurse in particular and the hospital system in general.

One participant (no.32) wrote of a patient's relative who threatened to 'blow up' the ward if his son did not receive immediate care. The patient was a mental health client and had become too difficult for his family to manage and they thought the hospital would take over his care. Although this did happen, the interminable paperwork and history-taking and physical and mental assessments all took time and the father was too stressed to accept the situation.

An interesting contrast to this was the situation (participant no. 23) where a patient who was expected into hospital for an 11am surgery was rung to come in earlier. Several other patients had not turned up for their surgery and so the theatre schedule was running ahead. The patient was abusive because she felt inconvenienced at having to change her own time schedule. Certainly some of this verbal violence could have been attributed to her own personal concerns about the procedure and what may be found at surgery, but the nurse was upset at her response. The nurse felt she had been targeted for something over which she had no control.

One very angry mother wrote a letter complaining about the time her twelve year old son had to wait for his surgery. He was admitted to the hospital at 10.30a.m.the normal admitting time for patients booked for surgery in the afternoon. He was collected for surgery at 2p.m. The letter accused the hospital and the nursing staff of deliberately making him wait, and adding to his stress. She felt that the staff were not friendly, indeed quite officious and that they were deliberately against the boy. The staff found the letter hard to deal with, firstly because the mother had accused the Day Surgery staff of deliberately keeping him longer than she felt he should have been when he was not actually admitted to the Day Surgery Unit (DSU) at all but another ward. Secondly the Director of Nursing demanded an explanation from the DSU staff on the issue rather than him checking the facts first. The young lad had been placed last on the list because he was the oldest patient on that list. It is the surgeon's wish that the children are placed by order of age on his list. Perhaps if the mother had voiced her concern whilst in the ward, this misunderstanding could have been settled and all involved would have been less stressed. Waiting times for patients and their families are always a concern, but it is usually beyond a nurse's capacity or jurisdiction to shorten them in any way.

Another example of the misunderstanding of hospital procedure is that of a patient who became abusive when he could not understand the paperwork he was asked to sign. It related to his being admitted to the health service as a public patient. Every patient in this category signs to affirm his status and gives permission for the hospital to elicit monies from Medicare to cover the costs of

their care. There is no mention in the participant's data (no. 34) whether the person involved had a reading or cognitive problem, just that he did not understand the paperwork. Interestingly, on the wards, there is the stipulation that ward procedures and discharge advice be held in files in different languages such as Chinese, Italian, Greek, but it would appear that no such information is available at the reception desk where all patients are admitted. So if the patient was non-English speaking then, although his reaction was still not acceptable, he may have been able to understand the situation better. If this was not the case then abusive language did not make the situation any easier for the staff member trying to admit him and explain to him about the paperwork.

Sometimes, too, it is not the paperwork which causes frustration but the general information given as well. Participant no.12 cited a case where a patient became abusive because he did not understand the information given to him by staff. The instructions for his recovery activities were apparently unclear and so he had misinterpreted them and found himself out of line with the staff members on the ward. Added to this was interference from other patients who continued to tell him other information, thereby just making him more confused and distressed. The more distressed he became and the more abusive, then the more distressed the staff became and this just compounded the entire situation. Eventually it was all handled well by a second staff member and was resolved to everyone's satisfaction, but the actual stress to both patient and nurse was real and lasting.

A further problem is that people do not understand that the health service does not offer an emergency department *per se*, but one general treatment room for assessing patients and their needs before transferring them to other places such as doctor's surgery or a local large hospital. Despite signs on the roadway and at the front door of the main hospital block to the fact that no emergency treatment is offered and no doctor is on call at the service, people still continue to come into the hospital looking for treatment and medical advice. There are occasions when, once this information is explained, the people either make their own way to another treatment facility or are transferred by ambulance. However, one participant (no.31) recorded that a person entered the hospital seeking suturing for a wound he received at work, but when told that no doctor was on duty he became verbally violent and even threatened the nurse with physical violence.

There are occasions when abuse occurs presumably because the person themselves is a normally abusive person. An example of this, (according to participant no.24) was when a husband returned to the health service to pick up his wife after she had had a procedure. On her admission five hours previously he had literally dumped her at the reception desk and left. She was interviewed by staff about her medical history and although she seemed a little slow at answering, there was little concern for her understanding of the procedure nor for her knowledge of her own health interests. When the husband came for his wife the staff member involved started to read out to the patient (and the

husband who was standing in between nurse and patient) the details of the findings of the procedure. The husband immediately started to abuse the nurse stating that he was 'the senior member in this marriage' and as such was entitled to have all information directed to him not his wife. The nurse proceeded to explain that she was indeed talking to both and that the letter from the doctor was actually addressed to the patient herself and not to both of them. He continued to argue and became louder threatening the nurse with being reported and stated that his wife did not understand, that she was 'simple'. The nurse then asked why, if his wife was indeed so 'simple', he had left her at the door and had not attempted to assist her with changing into theatre gear nor with her answers to the medical questions asked. The wife was distressed and apologized saying that he was often verbally abusive to her but agreed that the nurse had done 'the right thing' by addressing them both. In this case it seems that the husband was a naturally abusive, manipulative sort of person and the actual complaint about the nurse was just part of his normal daily behaviour. Perhaps if he had not had a complaint about the way the discharge information had been given then he may have had some other complaint equally as upsetting to staff, patient and other patients and relatives within hearing distance.

Verbal abuse of nursing staff has also been recorded against members of the public who entered the hospital to make a phone call on the public phone in the foyer (no. 21). The phone was out of order and so the persons involved just commenced to swear at the staff in particular and hospital in general because of this. They felt that it was the hospital's responsibility to keep the phone

active and in good repair. Despite staff intervention, the situation quickly became out-of-hand and the people were asked to leave the hospital or the police would be rung to come to deal with the abusive people.

Friendly service is also expected, and is given by most nursing staff on most days. However, there are occasions where this is not so. Sometimes it is because of other issues within the health service such as extended workloads, stress over other patients' conditions, personal cares of the staff member/s involved or just the time of day. However, abuse because the nurse does not seem friendly was unacceptable to the respondents of this research questionnaire.

Abuse from colleagues usually equates to the workload on a given day. This would account for several of the respondents recording shortness by staff with others. Staff have to process patients in line with hospital policy, answer telephone calls, talk with relatives and friends of patients and with medical, clerical and domestic staff. All this takes time and some critical comments passed may be a result of stress rather than of a personal issue.

One case of staff abuse to another was cited by a respondent (no.14) who was slandered because of her colour. She is a 'dark' Asian, and the person who abused her was a 'white' Asian. The comment made was that because of her colour, she was less important than the other. The comment hurt more because both had left their country for a better lifestyle away from such

prejudices. The respondent was also offended because she had the belief that nurses were professional people, and so treated all patients regardless of colour, and so this issue should never arise amongst colleagues. It is a case for the Equal Employment Opportunity matter, but remained unreported because 'I didn't want to make more waves than I obviously already had.'

Verbal aggression from medical staff was of great concern. Again there are personal issues that staff have to deal with such as home and family problems, seemingly interminable theatre lists, procedures which do not go according to plan, and patients who do not respond to treatment as planned. All these issues, no doubt, affect a doctor, and there are issues of incompatibility between staff that arise in any workplace that may need to be addressed. The nurses who cited doctors as verbal abusers stated that they did so out of frustration or anger (for example Respondents 15 and 30). Tradition says that a nurse should always defer to the doctor, (Morrow, 1986, p217) and Gamarnsk, 1991. p122) and for many generations this has been the case. Now nurses believe that they should be given credit for their education and work. This is not always the case.

In this research the examples of verbal abuse given by doctors to nurses were for many reasons. The first concerns the use of poor or ageing surgical equipment. Several incidences have been recorded against doctors who had become abusive because they believed they were dealing with poor equipment. One example (no. 14) is that of an anaesthetist who had difficulty with a sphygmomanometer cuff. He was trying to place it around the arm of a patient in a theatre setting when the tubing connecting the cuff to the actual

sphygmomanometer flicked off and hit him in the arm. Angered and probably shocked, he ripped the rest of the tubing off the machine and in the process hit the scrub nurse across the face and neck and desterilized her gown. His words of abuse were heard throughout both theatres and the nurse was blamed for the tubing not being long enough for use. This tubing had been in place for at least five years with the anaesthetist having used the machine at least once a week over that time.

Another example of abuse following equipment failure was one cited by participant no. 30. Several pieces of tubing were fitted together for a particular doctor's use when he operated at the health service. This particular day the tubing did not work properly, there were leaks around the joins of the pieces of tubing and so the procedure was held up whilst staff were trying to fix the problem. The doctor became angry and abusive at the nurse declaring that she was responsible for the state of the equipment and he did not ever want to work with her again. Eventually the procedure was finished satisfactorily and the doctor thanked everyone including the scrub nurse. He, the doctor, apparently had no idea that his remarks had been abusive and hurtful. The only comment by management afterwards was that he was 'always like that – take no notice'.

Other issues which were deemed to result in abuse of staff by surgeons were time constraints, simple impatience on behalf of the doctor; doctor late so trying to hurry up surgical list to finish on time and annoyance at having a 'junior' nurse assigned to his surgical team. One nurse reported that she had only been on the theatre roster for less than a week and the doctor involved abused

her for being too slow. He was so angry at her perceived lack of speed that he threw a bloodied pack at her (no.15).

None of these issues giving rise to the aggression are within the range of a nurse's sphere of influence. The hospital buys the equipment, the time constraints are approved by Administration, the impatience of a doctor cannot be assessed except on a minute-by-minute basis, and the fact that a doctor starts his list late, or begins his rounds late is in no way linked to the nurse. The 'junior' nurse in the case cited was only 'junior' in that she had only been in the hospital a matter of weeks. She was, in fact, a very experienced nurse who knew her job well. The problem for the doctor was that she was a new face, and he had not learnt to trust her as he had other staff members who had worked with him for some time.

Along with verbal abuse there were some examples cited where doctors threw instruments during surgery. They were thrown in anger, not necessarily at a nurse, but such episodes, along with the epithets used, were of concern to the nursing staff.

Abuse by ward doctors was also reported. One incident involved a nurse new to the hospital. The doctor in question had no identification and arrived on the ward asking questions about a patient's condition. Being well aware of confidentiality matters the nurse (participant no. 36) was reluctant to give out such information and he declared he was a doctor 'for goodness sake' and called her an ignoramus. Staff are often asked by friends and relatives of patients about their condition and it is common practice (or should be) to check

on a person's right to that information before disclosing it. The nurse was made to feel inadequate and embarrassed because of this incident. The medical staff who frequent the health service are not required to wear name badges as are nurses so this could happen again.

Another nurse (no. 32) had a problem with a medication order written by a doctor. She knew that the drug ordered could react negatively with the other drugs the patient was already taking, so she suggested that perhaps a pharmacist should be contacted in regard to the compatibility and dosage of the drug. The doctor was angry that his orders were being questioned and appealed to the senior staff member on duty. She acknowledged that there may be problems with the combination of drugs but that the doctor would know that and so the nurse in question should give the new drug. She still refused asking again that the pharmacist be involved but the doctor continued to abuse her in the corridor of the ward 'for all to hear'. The nurse did not actually give the drug as her shift time was up and then she went on rostered days off. She states that she did not actually find out what happened in the end, but felt justified in questioning the doctor as she had been taught, and that his abuse was not warranted in this situation. She felt she was only doing her best on behalf of the patient and a phone call to the pharmacist could have sorted out the dilemma but this was not suggested by either the doctor or the more senior nurse. Regardless, she felt she had not expected nor deserved the public verbal abuse given her by the doctor.

Yet another example of doctor abuse concerned a nurse who rang a doctor at home because she was anxious about a patient's deteriorating condition. The

doctor was abusive because he was settled in at home, no doubt after a busy day, and did not want to be disturbed (respondent no. 10). He later admitted that she was justified in calling him but the immediate response by the nurse was one of anger and some bewilderment that he should attack her verbally, really just for carrying out her duty.

The problem seen with most of these episodes of doctor abuse is that they occur usually in public places such as ward corridors, theatres, patients' rooms, in front of the patient, their families and guests and other staff. If there is to be chastisement or criticism of staff members they deserve the right to be so challenged in private. It is inappropriate that such events are made public.

The respondents believed that abuse by medical staff just made life a little more difficult than it needed to be in the health service. For a nurse new to a specific area, be it ward or theatre, there must be some compromise between medical and nursing staff that the nurse has some learning time, time to adjust to different procedures, different expectations and to different staff. The expectation of doctors that new nurses should be as 'up-to-speed' as their better trained or more experienced colleagues. Medical staff should remember that most of them were slow to start with and their speed at surgery and other procedures has come about because of time and experience gathered on the job. An attitude of consideration should be shown to all staff regardless of status.

The International Council of Nurses, (1999, p8) sums up the effects of verbal abuse:

The consequences are similar to the effects of physical assault and have serious repercussions on provision of care ...with many nurses choosing to leave the career as a result. The loss of qualified nurses inevitably intensifies the stress placed on often a short staffed health unit.

3. Bullying

The third area of covert violence in the research survey involved bullying – for all four groups of people to nurses across the site, regardless of their work specialty. Lyons and colleagues use the following definition of bullying: 'persistent, offensive, abusive, intimidating, malicious or insulting behaviour, abuse of power or unfair penal sanctions, which makes the recipient feel upset, threatened, humiliated or vulnerable, which undermines their self-confidence and which may cause them to suffer stress'. (Lyons, 1995,p3). Namie and Namie, (1999, p44) also include making aggressive eye contact with the target, overuse of memos, e-mails, and messages causing the target to spend time replying, cross-examination of the target in order to belittle or confuse and ensuring that the target does not have the resources such as time, supplies or help to do the work allotted them, gives the target the 'silent treatment' or refusing to make 'reasonable accommodation' (their brackets) for a target returning to work with a disability.

Bullying from patients and their families accounted for 17.5 percent of the incidences of covert violence recorded for this study. The usual type of bullying behaviour was the threat of reporting a staff member to Administration for what they deem as unsatisfactory service. This is not often actually done by way of phone or mail complaint, but the threat remains and is unsettling to the nurse. One incident cited was when a person (a patient's son) reported a nurse and

the attending doctor to the Australian Medical Association (AMA) because his relative had not had a shower on the day that he had visited. The patient had been asked many times during the day if they would like to wash, but the nurses were turned down. Fortunately for the attending nurses, all had recorded in the patient's notes that she had refused to shower. The patient's daughters were present for most of the day yet when they reported the lack of hygiene to the son, had neglected to tell him that she had been asked several times. Without checking on the situation he rang the AMA from the ward and reported the incident. It was only when the parties were actually assembling in the court anteroom, that the situation was finally cleared up and the daughters admitted that they had heard their mother several times refuse the nurses' help with washing. This whole incident, an extreme of bullying, has left several nurses angry, unsettled and defensive.

The threat of job loss or of an official complaint being placed on their personnel files is a real issue for nurses, especially in the public system. Usually, when such a letter is received, the Director of Nursing (DON) investigates and, if the complaint is deemed fairly innocuous, he writes a letter back to the complainant. The problem is that the nurses involved rarely have the opportunity to answer back, and they feel almost cheated. Untrue and libelous complaints are rarely dealt with other than in-house and so the nurses feel that they have been victimized without any redress to the individual who has made the complaint. 'I had no way of answering either the DON or the woman herself and so I felt so frustrated and angry'.

Bullying by colleagues and medical staff is defined in American literature as 'horizontal' violence. Spring and Stern (1998, p1) define this sort of bullying as 'behaviour that we direct towards each other that would be totally inappropriate if we directed that same behaviour, action, word, tone, attitude, judgment, towards a patient'. Again, this is not new. 'Bully Online' report that in January 2002 50% of nurses in NHS hospitals experienced workplace bullying, or horizontal violence. A survey by the Royal College of Nursing (March 2001) reported that one in six nurses have experienced bullying.

This research noted various forms of horizontal violence that included:

1. physical threats or intimidation;
2. sexual harassment;
3. inappropriate or unwelcome physical contact;
4. elitist behaviour based on education, or clinical area; and
5. nurse managers belittling the concerns of nurses and disregard for their safety.

Why do nursing staff bully each other? The answer lies in the competitive nature of the job. In order to get ahead and achieve higher levels of nursing, one must not only be better educated, but also be seen to be achieving in his/her current area of work. There is bookwork to keep up with, meetings to attend, new staff to precept, personal concerns over job tenure, and quality assurance projects to handle. All these put a strain on any staff member, and although this is understood by the nurses who reported horizontal violence on the research questionnaire, it is still behaviour that respondents found distressing.

One nurse (no. 7) felt 'bullied' when senior staff on the ward she was sent to refused to explain the procedures and routine of the ward. Instead, they continued to criticize her for not working to their standards and for being so slow. This apparently occurred often, especially when the 'new' nurse was either truly new to the hospital, the job itself, or a nurse from an agency. With no real outline of work expected, no nurse should be expected to work to capacity.

A response from a nurse who works as a permanent casual (no. 16) wrote of her experience in a ward where the junior and casual staff – those who do not know the ward routine – are always placed together with the experienced staff always working together as a sort of elite group. The nurse felt that it would be fairer to the new and junior staff if a senior nurse was appointed with them. That way the routine could be learnt more easily and the 'them and us' environment would be broken down. This may have also assisted in the case of respondent no. 36 who recorded that, in a particular ward she worked on, the regular ward nurse, she felt, just did enough work to get by and left the more inexperienced nurses to do most of the work on their own. What work she did was evident in the mess she left behind. She was not the domestic and felt she should not have to clean up, and as surgical dressings, etc, are not usually cleaned up by domestic staff but by nurses, the juniors were always cleaning up after her as well as after themselves. This type of non-team spirit can be crippling to a ward and demoralizing to staff who are affected by it. Nursing is a difficult job constrained as it is by time and workload. No nurse needs other's loads to compromise their own work standards or time.

Being new to an area and feeling bullied by more senior staff was one of the comments recorded by respondent no. 37. She was new to theatre and was asked to set up some trolleys. She had been given no training in this procedure except for the two weeks she had spent in theatre during her training. The nurse in question admitted her ignorance and was pushed aside by the more senior nurse with the words 'You're not very theatre-minded are you?'

Another nurse (no. 17) noted that in a specific area a particular staff member harassed staff by asking them to do new tasks when the ones she had previously given them had not been completed. Because the work was not finished, the staff had to forego their tea break in order to catch up. This had apparently been going on for a while but when a nurse spoke to the duty co-ordinator she was told that the senior nurse in question had a right to demand the workload from junior nurses. Interestingly, the senior nurse found out about the complaints and refused to talk to the junior nurse for three days – yet another form of bullying.

A ward manager was reported (respondent no. 24) as being a bully regarding a nurse's timesheet. She, the nurse, had been asked by the hospital management to undertake a series of lectures that were being held about half-an-hour from the health service. The lectures started at 16.30 hours and the nurse who usually worked until 15.30 hours felt that the time difference would be manageable. However, after the ward manager was approached and told of the lectures she immediately rostered the nurse every Wednesday for the next seven weeks to finish at 16.30 hours. The nurse had to leave the ward at 1600 in order to attend the beginning of the lectures. At the end of the seven-week

course the nurse was given by the manager an account for the seven half-hours which she felt the nurse owed the ward. Her roster then went back to being a 15.30 finish on Wednesdays. When the nurse questioned the time problem to senior management they dismissed the 'bill' but she felt they did not really understand her anxiety and even anger at the ward manager's attitude to her taking the course.

Medical staff who bully staff seem to do so out of habit, and because it is rarely reported to nurse managers. Perhaps it is a result of outdated attitudes towards females in general (no male respondent reported medical staff bullying) and a devaluation of nurses in general? Perhaps it is a way of their exacting control over others? Pushy behavior often accomplishes for them what simple requests do not. Perhaps the very fact that this form of bullying is not reported just encourages it further? None of the nurses who cited bullying by medical staff could offer a true and valid reason why this happened, and none were happy with managerial responses on the occasions it was reported.

It is interesting to note that in Western Australia more than fifty percent (50%) of the new students enrolling in medicine to become medical practitioners are female. This gender bias (more female doctors than male doctors) may affect the incidence of bullying in the future.

Staffing and Workload Issues

This type of covert violence was reported across the health service site and involved both colleagues and medical staff. The nurses who recorded this as an incident of covert violence did so because they felt helpless at changing the situation, several felt that they had been tacitly blamed for the situation.

Examples of workload issues included:

1. changing of rosters without consent of the workers, often on a day-to-day basis;
2. the expectation that staff will work overtime when so asked.
Those who could not for family or personal reasons were considered to be selfish and accused of letting patients and staff down;
3. the deliberate placing together of staff who were obviously incompatible;
4. concerns about the staff/patient ratio being inconsistent with good nursing care; and
5. sending junior staff to other wards which were busy. It was felt by respondent 22 that perhaps all staff on the ward should take turns at being reallocated.

One respondent (no. 18) felt she was bullied because she had hurt herself and was under medical orders to undertake only light duties for a few weeks. The injury did not happen at work but was the result of a lifetime of sport and lifting, and heavy patients – no one reason. The nurse was challenged about why she

should be kept on staff. If she could not work in all areas then she would be seen as being unable to fulfill her contract. She decided to continue to work on the ward on which she was rostered regardless of her letter because she felt that her job was truly under threat. Her comment was that maybe next time she would not be quite so honest about her health situation, perhaps blaming the next episode or injury on 'work'.

Conclusion

Few of the four issues mentioned in this research paper were, in themselves, particularly difficult when the nurses involved looked back at them. The problem was that at the time each caused enormous personal stress. Rarely in any of the incidences cited was anything done to rectify the situation by unit managers, and so the nurses felt isolated in their stress. They felt that this just highlighted the problems and made covert violence more of a threat to their safety and psychological well-being. One stated simply that the issues were unresolved and eventually caused her to change wards (respondent no. 32). Feelings of unresolved anger, hurt and embarrassment and frustration at not being able to do much about the situations in which nurses find themselves compound often causing lingering stress, continued anger towards the patient or staff member, and a sort of hopelessness that drains energy and can lead to depression and nurses looking outside of nursing for another career.

The main concern with verbal violence was that it might escalate into physical violence. None was recorded in the questionnaire, but the threat remained. This was also a concern amongst colleagues and medical staff. Doctors and

even senior staff had been known to throw instruments and other equipment out of anger and frustration. Although most of this has stopped, especially in this health service, the tendency to do so always remains a possibility. People, particularly those under stress, are unpredictable and so some discomfort was felt by the nurses when a patient, their relatives or a staff member became abusive.

One interesting comment made by a respondent was that 'on another day, the situation would not have been seen as a problem'. This highlights the fluctuations of mood, setting, interaction of staff, and other less tangible forces that surround a health service on a day-to-day basis. This problem is probably very accurate and honest. What one finds unsatisfactory in one situation may not find the same in another.

The problem remains, though, that nursing staff still believe they are being covertly mistreated. They believe they do not deserve to be so treated and forty of them have decided that the time has come to speak out about this issue.

CHAPTER FIVE

DISCUSSION AND RECOMMENDATIONS

Introduction

This chapter will discuss some reasons for violence in our community and how it affects nurses in the workplace. It will also highlight four specific issues that need to be addressed in order to make the workplace more worker-friendly.

These include the need for management to acknowledge that covert violence happens, hurts and harms. The second is the need for a safer environment by ensuring that there is a consistent policy of non-violence throughout the site, and the third issue is the empowering of staff to be able to deal with, and diffuse violent episodes. Recommendations will be made for further research on this topic.

Reasons for Violence

The reasons for violence in society are varied but can be identified as belonging to one of six categories:

1. cultural factors;
2. personality factors;
3. biological factors;
4. mental illness;
5. media and peer influences; and
6. employment factors.

Cultural Factors

Societal norms play a large part in how people act in daily situations. They define behaviour and also violence as normal, legitimate and functional. There is a form of prestige about violence on the sporting field, at home and in schools which is seen as an accepted part of Australian life. Also violence to achieve an end is acceptable as an historical entity. Violent law breakers such as Ned Kelly, Moondyne Joe and 'Breaker' Marrant are feted as heroes, made all the more popular because they 'took-on' the police – society's watch dogs – and won, at least for a time. The idea that one has a duty to challenge the rules has an acceptability that is quite Australian in nature and evident in most locally produced television dramas and films. This may be one factor for people not accepting or conforming to the rules of a hospital or health centre – simply that rules are anathema to the Australian way of life and so are there to be broken or at least bent.

Economics may also play a part in violence in the community. Income inequality may affect a person's ideation and perception of hospital care. In Australia both victims of violence and violent offenders are drawn from the most disadvantaged socioeconomic groups (the Australian Institute of Criminology (AIC), 2002, p8). Lack of finances resulting in the inability to pay private health insurance may be the reason for some people being admitted to a public hospital and this in itself may be a source of anger, embarrassment and fear. Patients often state that they have waited a long time for fairly routine surgery (anything up to about three years for carpal tunnel operations or cataract surgery) because they cannot afford personal medical insurance where those who can rarely wait more than a few weeks. This long waiting time, especially

for those who are older or who are in pain, can have an impact on their attitude to hospitals, the medical service and to the nurses who they perceive as the health service's representatives.

The hospital itself is often seen as a means of frustration and anger. It is an older building with some inherent problems. For the hospital of this research study, the wards have been gradually modified and are relatively pleasing to the eye, but the Day Surgery Unit is old and has issues of lack of privacy. Each cubicle is separated from the other by only a curtain resulting in the dissemination of personal information throughout the ward regardless of how quiet the admitting staff member is. The Day Surgery Unit has only one patient toilet so that nervous clients have to wait to use it and the general lack of space means that visitors are necessarily kept to a minimum, further raising the stress and fear levels of some patients. Waiting for surgery results can also cause problems. Patients are admitted for surgery that may result in news of their needing further medical or surgical care, and so they are naturally anxious on admission. These feelings of fear, anxiety and disempowerment simply because they are in hospital and therefore out of their comfort zone can result in accidental covert violence often outside a person's normal repertoire.

Gender is another important issue to be considered. From the data collected for this study it is evident that more males are the perpetrators of covert violence in this particular workplace. Women are targets of violence, domestic and workplace related, more often than men.

Biological Factors

The AIC (2002, p5) states that 'men are ten times more likely to be charged with violent offences in the community. The most common age range for offenders is from 15 to 30. This phenomenon is accredited by the AIC as being related to testosterone levels in young men. This concurs with the data from participant 26 who wrote that most of her clients who were perpetrators of covert violence were 'male and aged between 15 and 30'.

Mental Illness

Many people in the community suffer from mental illness, not always diagnosed as such. For those who are being treated for conditions such as paranoid schizophrenia the medications prescribed may interact to produce behaviour that is more aggressive than would be normally acceptable. This may make the client more confused and uncertain as to what is going on around him and thereby making him more frightened and reluctant to comply with conditions and hospital policies. Only two of the forty respondents acknowledged that the perpetrators referred to in their anecdotes were suffering from mental illness but the results of their actions caused stress and concern for the staff involved.

Media and Peer Influences

Computer games, movies and television shows are portraying a society where violence is acceptable and rapidly becoming part of life. Action Man games and movies portray the idea that violence is masculine, aligned to sexual attraction (such as the James Bond movies) and acceptable – maybe even expected – and apparently always justified. Car chases, road rage, guns, offensive

language and other tough-man tactics are part of the everyday diet of the viewing public.

Peer pressure is often at the root of verbal violence or bad behaviour. People misbehave often in order to gain another's attention or esteem. When a reaction from a third party (the victim) is elicited, then the actions of the perpetrator have been effective in gaining attention and recognition from all within hearing distance.

Employment Factors

Clay, (1995 p1) cites employment issues which she relates to the increase in stress and violence in society. These include corporate downsizing, re-engineering and 'other trends rocking the business world'. This stress from workplace reconstruction may also be added to domestic violence and uncertainty tend to make people more unsettled and aggressive in their outlook, which can further 'ricochet into the workplace' (p1).

There are elements to nursing that can create stress on staff. There is now a competitive component, which did not appear to be present historically. One rose through the ranks, as it were, through time spent at the health service. Now this is not the case and there are many examples of a new nurse taking over the management of a ward or department because of their qualifications, yet knowing little about the specialty or ward work involved. This has tended to highlight the gap between hospital-trained and-university trained nurses. It has

also been the source of stress and ill-feeling between those who have been at the health service for a time and those who are new.

The problem with competition is that it can destroy a person's morale, enthusiasm for the job and for their career. Some issues, recorded in Appendix A under 'From Other Staff' such as inappropriate tasking, inappropriate expectations, unfair workloads and unhelpful behaviour, may have occurred because of the competitive nature of the job.

There are other work-related issues which affect a staff member's relationship with other staff around them. They include the constant threat of legal action (from patients or from other staff) should anything they say or write be taken as offensive or incorrect, poor working environment and equipment and poor work organization.

What is needed is a culture of caring, not competition, for fellow workers, and this includes all members of the staff from domestic, engineering, orderly, ancillary, nursing and medical to members of the Health Department who visit the health campus from time to time.

There was a Peer Support team selected from the health service personnel organized and trained to deal with issues of personality clashes, and as a sounding board for staff concerns. However, after the initial 'introduction' of the team to the health service by way of the inhouse newsletter, little, if anything, has been heard of the group since. The reason for this is unknown, although

some members of the Peer Support Team still continue with their role, although no official record of contacts is maintained.

Summary

Aggression toward public workers by clients and staff represents a huge social problem. Somerville, (2002, p15) cites statistics from the Australian National Workers Compensation Industry database to the effect that all public service industries are facing enormous mental stress claims due to the covert violence of customers. The figures quoted are for 1999 – 2000 with 244 claims in the retail industry, 83 in finance, 67 in the hospitality industry and 133 in the health industry. These figures are inaccurate in that many people refuse to report incidences or are discouraged from doing so because of peer and managerial pressure, but while the cultural norm is for an accepted level of violence, be it verbal, behavioural or physical, these figures will continue to rise as victims feel they are powerless to prevent or manage it.

Effects of Covert Violence

Spending the day attending to the demands of customers – listening to their complaints, placating their animosity, and all the while wearing a smile and trying to remain calm – can be a very demanding way to work. Somerville, (2002, p13).

Covert violence can have many short- and long-term effects on the nurses involved. These include:

1. guilt;

2. anger;
3. depression;
4. stress;
5. physical disorders;
6. lack of self-esteem and confidence; and
7. alterations in professional, personal and sexual behaviours.

Guilt is in part aligned to the non-reporting of violent incidences. Because nurses rarely speak out about it, and it therefore goes unreported, many nurses are convinced that they are responsible for these episodes. The idea that 'It must be me' or 'It must be my fault' is part of the justification process. The Queensland Nurses' Union, (1998, p2) concur – 'People subject to bullying...start to believe that their behaviour/actions have led to the bullying'.

Anger is the result of frustration at not being in control of a situation – in this case the perpetrators of the violence experienced. Green, (2002, p1) states that this anger which inevitably is vented towards staff and clients is not due to a person's lack of character but to being in a situation with little support and not having appropriate skills to deal with rage.

Given that covert violence can and has had an effect on the lives and working capacity of the nurses at the health centre, then the nurse themselves want something to happen that will enable them to continue working in their chosen profession safely and with dignity. To this end they, the participants, want three issues addressed – management acknowledgement of covert violence, a safer working environment and the power and knowledge to short-circuit any covert violence issue which they may encounter at the workplace.

Issues to be Addressed

1. Government recognition of the problem

If the government of Western Australia is genuinely concerned with the declining numbers of nurses in the state, it needs to offer health care systems that are safe places in which to work. There needs to be a state-wide policy aimed specifically at the elimination of violence in the health care system. To this end there should be the encouraging of workplaces in the healthcare industry to develop individual policies and plans to reduce and effectively eliminate violence at the workfront. To do this, the International Labour Organisation (2002) suggests that data needs to be gathered across the health service campuses to truly determine the rate of violence that occurs (p6). The Australian Nursing Federation has conducted a survey entitled 'Workplace Violence in Nursing (It's Not Part of the Job)', (2002). (See Appendix E) It is a questionnaire which was sent out to all Registered Nurses in W.A. Although not sponsored by the state government it could be adapted for use across the state. The questionnaire has a space to identify the individual workplace and, where this could be seen as threatening to workers, it is a legitimate method of

data collection in order to get a true picture of covert violence experienced in each workplace throughout Western Australia. Every healthcare workplace has a different clientele as well as different staffing issues, and there may be a case for implementing specific workplace policies for specific campuses as well as more general ones to cover all campuses within the health system.

In the light of some of the data collected for this study, a government act or paper such as the one described would be desirable to aid nurses in the process of complaint.

2. Employer Responsibility

The United Nations Declaration of Human Rights (2000) states that people have a right to:

1. dignity (article 1);
2. security of person (article 3);
3. freedom from degrading treatment (article 5); and
4. freedom from attacks on honour and reputation (article 12).

Given these basic tenets and also that nursing is a job dedicated to achieving the well-being of others, then nurses should be protected from attack or abuse on themselves or on their profession. It is understood by most nurses that healthcare units are inherently stressful:

people's lives are at stake and lives are changed in the blink of an eye ... control of lifestyles are often lost or greatly altered and both the patient and the family and the caregiver are affected by each case (Nurse Advocate, (1998a, p22).

There are also examples of non-deliberate violence or abuse, for example from patients who were demented, medicated, frightened or from those who did not speak or understand English, but the nurses who participated in this study stated that even given the patient's conditions and concerns, the result of the covert violence was a stressful workplace: 'I know he didn't mean to be rude and he apologized later, but it still hurt at the time' (Respondent 12). It has to be understood, too, that no single strategy is appropriate for managing covert violence at the health service, but the subject still needs to be addressed.

In line with the United Nations Human Rights Declaration, the Western Australian Government has outlined the duties of an employer in the Occupational Health, Safety and Welfare Act 1984, (Part 3, Section 19(1)): 'An employer shall, as far as is practicable, provide and maintain a working environment in which his employees are not exposed to hazards and in particular, but without limiting the generality of the foregoing, an employer shall:

1. provide and maintain workplaces ... such that ... his employees are not exposed to hazards;
2. provide such information, instruction and training to his employees ... to enable them to perform their work ... and that they are not exposed to hazards;
3. consult and co-operate ... regarding OHS and welfare in the workplace.

A policy of zero tolerance of violent (verbal and physical) episodes has been in place in the National Health hospitals and clinics in the United Kingdom since 1999 (Blick, 2000, p2). The aim is to reduce violence to staff by 30% by 2003.

They have clear, and specific workplace objectives for which they strive. They also have a system of reporting of incidences to staff. There is also the threat of banning violent patients 'for up to one year' who do not adhere to the zero tolerance guidelines. Those who make an 'offensive or sexual gesture or used threatening or abusive language' will receive a warning (*Mental Health Weekly*, 2001, p1).

In order to achieve a violence-free environment, 'as far as practicable', the health service in this study should be responsible for extending its policy of non-acceptance of violence to include covert violence as well. It already has a written policy which is displayed in most public access areas which covers situations such as physical violence due to drunkenness or drug use but does not include covert violence issues such as offensive or abusive language or threats to staff safety or security. A clear statement of commitment to zero tolerance of violence is needed from the Chief Executive Officer. Not every one who attends the health service will read the notices or co-operate with them, but it will be a starting point for the improvement of working conditions. The policy statement should provide a clear statement of what is considered to be inappropriate behaviour. It should include all people be they patients, relatives, staff members or members of the public who use the hospital's facilities. It should be made clear that each adult member of the public, regardless of their reason for being on site, is to be deemed responsible for their own behaviour, and if unsatisfactory, the person will be asked to leave the property or the police will be called to deal with the person.

Employers have the responsibility of ensuring that a workplace is safe and so they need to give consideration for the provision of adequate preventative measures and procedures to minimize the risk and the effects of covert violence. The collection of data and information about the covert violence which is experienced by nurses at this work place is a starting point. Once this data is collected then there can be appropriate information, training and instruction given to staff as to how to deal with these episodes as they arise.

Further, the health service, as an employer, needs to be aware of the impact that covert violence has on its workers. Employers are to set up a board or committee which deals with these issues to meet regularly and when the need arises. The committee could offer assistance – long- and short-term – to employees who are affected by violence. Legal aid may be offered if the situation is serious enough. Where necessary the board or committee could, if the episode was one of constant bullying, place a workplace 'order' on the perpetrator so that he/she might receive effective counselling for any inappropriate behaviour they might exhibit. The concept that 'they are always like that to new staff' should not be a reason for accepting such behaviour and should not be passed off as the norm for the perpetrators or for the health service.

3. Managerial Acknowledgement

It is important that management at the health service acknowledges covert violence exists in the workplace and causes concern amongst the nursing staff.

Comments such as 'just ignore it' (respondent 1) or 'it's all part of nursing' (respondent 10) is not an answer to the problem, indeed it just makes it worse for the victims. The International Labour Office cite that only one fifth of cases of covert violence ever get reported and that 'employers exert great pressure to withdraw such reports to avoid giving the institution a poor image for future patients' (2000, p9). In consultation with nursing staff there needs to be a form of debrief so that disturbing incidences can be discussed and dealt with as they happen. Management must be held partially responsible for setting the tone that allows (tacitly) inappropriate behaviours from patients and staff to continue. Managers need to show that they care for their staff members' mental as well as physical needs.

On a worksite if there is a hazard it is reported to the Occupational Safety and Health committee. Because it is in writing, the committee has to address the situation and investigate to see the legitimacy of the complaint. So, too, could incidences of covert violence be recorded. By putting the details of an incident in writing, then management would have to take responsibility to see that the episode is investigated. It is possible that there would be more reports from specific areas or wards than from others and in this case it may be beneficial for staff and patients that these areas be consulted to see if there is anything that can be done to limit incidences of covert violence, such as better pre-admission information so that the patient would know better what to expect at and from the hospital, or certain staff may be deployed elsewhere if they were incompatible with other staff. This would promote a higher and safer standard of patient care.

4. Nurses' Responsibility

Nurses across the site must also take an active role in communicating the basic principle of a violence-free workplace. This would include dealing with differences in culture and beliefs and a visible acceptance of other staff members.

A multidisciplinary team should be set up to deal with issues of covert violence. Their recommendations need to be supported by policies, protocols and procedures. Team members should include representatives from all departments of the health service including the Director of Nursing, Occupational Safety and Health Co-ordinator, Equal Opportunities representative, nursing staff, a representative of the orderlies as well as one from the reception staff. They all need to be involved in the administration of the policies in order for them to be site-wide in their application. Kim and Sabourin, (1998) are convinced that there is no room for secrecy within the organization regarding the workings of this team. 'The more information shared and communicated, the more comfortable the work force will feel, dealing with the changes occurring around them ...It is extremely important to listen to employee concerns' (p2). They warn of people within organisations who are not willing to accept organizational change and may attempt to frustrate the efforts of the team.

Training sessions for aggression management are already being held at the health service to enable staff to better deal with aggressive patients, but this should also be extended to other non-physical forms of aggression. For

example, there should be training offered in how to deal with verbal violence.

This would include four principles:

1. Understand the emotional messages that are being given by the perpetrator. These would not necessarily be open insults or obscenities, but the language and inferences may have the same gut-wrenching effect on the victim.
2. Know the kind of attack the victim is facing. To do this one needs to make judgments on both the motive and the goal of the perpetrator. Is he angry because he had just been criticized or because of fear or confusion, and is the motive to shift blame from himself onto another, to get more attention than he believes he is getting at that particular time, to improve his standing within the medical or nursing fraternity?
3. Align the response to fit the attack. To argue with a client or staff member who is obviously distressed about the current situation in which they find themselves would not ease the situation. If a patient is distressed over a procedure or an occurrence within the ward setting it may diffuse the situation if time is taken to explain what is happening or about to happen rather than inflame the situation further with ill- will and reciprocated verbal violence.
4. Know how to maintain the defense. Often those who are verbally violent do so in order to attract attention or to claim an emotional charge from it. By responding in a negative way the perpetrator has gained the upper hand and his or her goals are met. The natural tendency for one who has been abused is to verbally

strike back as a form of protection and status settling, but this often has the reverse effect.

Training across the site should also include how to deal with bullies. Bullies would include members of the public as well as staff members. Namie and Namie, (1999, p238) state that Targets fall into five general types:

1. those who refuse to be subservient;
2. those who are more competent than their aggressors;
3. those who are envied and resented for their cooperativeness and being liked by others;
4. those who report illegal/unethical conduct; and
5. those who are vulnerable in some way.

They define a Target as someone 'who is a team player, helps others, refuses to be a slave to a tyrant and/or has had some sort of negative experience in the past which has left them open to attacks by others'. Vulnerability, then, is a result of previous experiences and these may need to be addressed for individual staff.

Green, (1999, p5) suggests a set of rules that can be implemented in the workplace to counteract bullying or other forms of covert violence from other staff. None of these are difficult in themselves, the problem would be the difficulty of getting everyone to abide by them. They include:

1. have respect for each other;
2. lead by example;
3. do not shift the blame from oneself to another in order to feel better or to achieve colleague acceptance;

4. do not participate in gossip;
5. welcome newcomers as you would want to be welcomed if you were new;
6. compliment each other when applicable;
7. accept a fair share of the workload;
8. work together despite personal dislikes and differences;
9. do not denigrate to superiors;
10. stand up for peers in their absence; and
11. smile

Although the nurses surveyed believed that they should not have to tolerate offensive behaviour, the idea of prosecuting the perpetrators was considered to be unprofessional. However, it may become necessary as compensation claims continue to be made against violent patients and staff. As with the British National Health Service guidelines, this may become a reality in Australia.

5. Staff Empowerment

This may come when a comprehensive zero tolerance policy is instituted at the health service. At the moment there is no avenue whereby a staff member can dismiss or even chastise a patient who is displaying any form of violent behaviour. Neither is there a satisfactory method of dealing with issues between staff. There is no security staff as such through the day and the orderlies are not designated to deal with such issues. There is a security guard on duty in and around the car parks between 1700 hrs and 2200 hours each night, their main duty is to escort staff if necessary to and from the carpark and

to inform the local police if there is any vandalism of cars. No area has a security guard on duty through the daytime. With both a recording policy and a behavioural policy in place staff will then have a standard of behaviour, not only adhere to for themselves, but by which they can expect others to abide.

6. Client Responsibility

Clients and their families should also be made responsible for their behaviour whilst on the health service campus. They need to know that there will always be the inevitable delay in being seen by members of the medical or nursing staff, that their times for admission and for theatre may change, that they will be frightened and apprehensive about their procedures and results, but this will not be reason for their being verbally violent.

This might be achieved with the implementation of brochures which would be sent out to any prospective client regarding the policies of the health service. Certainly there needs to be an outline of what the health service offers as far as actual services are concerned, and there should also be a section outlining what the health service expects from its clients as far as behaviour is concerned. One problem with such a brochure is that not every client will read it and it would need to be printed in several languages, then there is the cost of printing and either posting them out or having them available at the time of admission, but at least it would emphasize the need to ensure a safe and friendly environment for all who have business at the health service. A second problem is that there are people who simply cannot read literature, even in their own language, so written information is not always appropriate to everyone.

Conclusions

This qualitative research project sought to identify, by an open-ended questionnaire, details of incidences of covert violence as experienced by trained nurses at a local health service. From the data received it is evident that such episodes are similar to those reported from the United States of America, Canada and from the United Kingdom. The international literature cited concurs that covert violence in the health care system is on the rise, that nurses are feeling powerless to stop it, and the effects of it on nursing staff are varied and for some, quite debilitating. It is recognized from this study that horizontal violence or bullying by staff members is also of concern.

The findings are that staff from all departments of the healthcare service have experienced episodes of covert violence from patients, staff and from other members of the public. There is also a lack of support from management in regards to the reporting of incidences so staff are reluctant to do so lest they be deemed childish, incompetent or foolish.

It is recognized that this study is only of one specific metropolitan health service and that the information gained was subjective and may not be applicable to other, more diverse health campuses. It is also recognized that the data received does not allow the issue of covert violence to be quantified in this workplace. The research study, however, has identified that the causes of covert violence in this health service are due to employment factors, cultural factors, personality factors, biological factors, mental illness and media and peer influences.

Recommendations

In order to limit the amount of covert violence in the workplace three approaches can be used. They are:

1. the preventative approach –reduce exposure to violence;
2. the protective approach – encourage appropriate, taught, actions when faced with an episode of violence; and
3. the treatment approach – limit the impact of the experience of violence.

To this end the following recommendations are made to the administration officers in view of the research findings:

1. the health service implement a policy of zero tolerance for covert violence similar to the one for physical violence that is in place now;
2. all staff be made aware that the zero tolerance includes their behaviour just as it does patients and other members of the public;
3. a system of written reports be established so that staff can document incidences of covert violence;
4. training programmes should be instituted on the subject of how to deal with covert violence;
5. a multidiscipline team be convened to deal with incidences of covert violence and their resolution in the same way the Occupational Safety and Health committee meet to discuss matters of safety within the service; and
6. staff be empowered to set the standard of behaviour within their department in line with the zero tolerance policy.

Recommendations for Further Study

Areas of future study have been elicited from this study. The most important exercise would be to replicate this study in a wide variety of health services including a larger, more diverse health campus and in private health care settings.

Another study could be designed to include other populations who work in a similar workplace. These might include ancillary staff such as X-ray, pathology personnel and physiotherapists. It could also include 'incidental' caregivers such as cleaners and orderlies.

Further studies could assess the direct influence that covert violence has had on nurses and allied personnel who have left the health-care setting. There is literature on this subject but very little hard data.

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Workplace Bullying Project (nd) North Adelaide, South Australia
North Adelaide Women's Centre.

RESEARCH DATA

| Repondent No. | TYPE OF ABUSE | | | |
|---------------|--|--------------------------|---|---------------------------------|
| | From patients | From relatives | From other staff | From medical staff |
| 1 | | | | verbal abuse |
| 2 | verbal abuse | offensive language | | rude jokes/offensive language |
| 3 | | | | offensive comments |
| 4 | | | constant shift changes | |
| 5 | | | inappropriate tasking | |
| 6 | (1)manipulative behaviour (2)inappropriate expectations | | | |
| 7 | | | ethnic abuse | |
| 8 | | verbal abuse/ job threat | | |
| 9 | | | (1)inappropriate expectations (2)horizontal violence | |
| 10 | offensive behaviour | | | verbal abuse |
| 11 | offensive language | | | |
| 12 | verbal abuse | | | |
| 13 | | | inappropriate timetabling | |
| 14 | | | | verbal abuse |
| 15 | | | inappropriate expectations | throwing equipment/verbal abuse |
| 16 | | | | vebal abuse |
| 17 | | | inappropriate tasking | |

| | | | | |
|----|----------------------------|---|--|--|
| 18 | offensive language | | tasking intimidation | |
| 19 | offensive language | verbal abuse/inapp. Expectations | | |
| 20 | physical/verbal abuse | | | |
| 21 | | | | (1)inapp. Tasking (2)offensive language |
| 22 | verbal abuse | | unfair workloads | verbal abuse |
| 23 | verbal abuse | physical threats | | |
| 24 | offensive language | | rudeness | |
| 25 | inappropriate expectations | | | |
| 26 | offensive language | verbal abuse | | |
| 27 | physical threats | | | |
| 28 | verbal/physical abuse | | | |
| 29 | | | | verbal abuse |
| 30 | | | | (1)throwing instruments (2)verbal abuse |
| 31 | verbal abuse | | | |
| 32 | | verbal/physical threats | | verbal abuse |
| 33 | offensive language | | | |
| 34 | verbal/physical abuse | | | |
| 35 | | inappropriate expectations | unfair workloads | |
| 36 | | | (1)inappropriate working (2)unhelpful behaviour | verbal abuse |
| 37 | verbal/physical abuse | | | |
| 38 | verbal abuse | | | |
| 39 | | (1)inappropriate expectations (2)inappr. Expectations (3)physical threats | | verbal abuse |
| 40 | inappropriate expectations | | | |
| | | | | |

APPENDIX B – LETTER OF INTRODUCTION

Dear Colleague,

I am a student at Edith Cowan University, completing a Master's Degree in Health Science (Occupational Health and Safety). My thesis is entitled 'Covert Violence in Nursing', and I seek your assistance in providing suitable data.

Covert violence includes verbal abuse, threats of physical harm, or job loss, and sexual or ethnic harassment, and may come from staff, patients or visitors. Although it is prevalent among health workers, there is very little hard data because there are no avenues for documenting such events, whereas 'true' violence that results in physical harm is almost always reported and the relevant forms filled out.

I have enclosed several sheets of paper - the first is a cover sheet giving basic details of your nursing experience, etc. and the others for recording incidences. No names should be included. When completed, please place in the envelopes provided and either post them or leave it in the D.S.U. box at A Block Reception.

This survey has been approved by the 'Bentley Health Service Ethics Committee'

When the thesis is completed, all information gathered will be shredded.

If you have any queries concerning this project, please phone me on 3630 (D.S.U.).

Susette Bakker
R.N. Day Surgery Unit

APPENDIX C – REASEARCH QUESTIONNAIRE

Page 1

Please document the following:

1. Employment position (e.g. Ward Manager, etc)
2. Area of Work (e.g. Mental Health, etc)
3. Gender
4. Length of time in present position
5. Length of time in nursing

Please document experiences of covert violence you have experienced whilst working at this Health Service. Add more paper as required.

1. What forms of covert violence have you experienced whilst working at this health service?
 2. What caused/contributed to the episodes of covert violence?
 3. How were these episodes dealt with/not dealt with?
-

APPENDIX D

FORM OF DISCLOSURE AND INFORMED CONSENT FOR RESEARCH

The purpose of this study is to identify the phenomenon of covert violence in nursing. All Registered Nurses in this Health Service will be asked to participate by means of a questionnaire and, if requested, by interview.

If you have any questions about the study please ask the researcher at any time. You may decline to participate if you wish. Confidentiality of response is assured as neither the research hospital nor the participants will be identified by name.

I (the participant) have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate in this activity, realizing that I may withdraw at any time.

I agree that the research data gathered for this study may be published provided that my name is not used.

.....
Participant

.....
Date

.....
Researcher

.....
Date

SIGNIFICANT STATEMENTSParticipant

- 5 (after reporting incident to management) 'I was told to do as I was told, then I would learn more.'
7. (black v white Asian) – 'It's typical of you blacks never wanting to learn anything new.' 'Manager said to forget it.'
8. (after being abused by a patient's relative) 'When I related this incident to a senior staff member, she asked if I had been hurt, if not then why make a big deal out of it. It happened all the time.'
10. (after dealing with an aggressive patient) 'I felt completely unsupported by both Nursing Admin. and the medical staff present.'
10. 'I felt really angry about the way I was treated (by a doctor) – like a second class citizen.'
13. Director of Nursing – 'Don't worry, she's leaving anyway'. (to level 1 nurse who had reported a level 3 for aggression.

14. Incident report filled out after doctor had injured a staff member with faulty equipment – 'Incident was reported to Theatre Manager who was concerned about the outcome of the Report. She was not concerned with the scrub nurse's condition.'
21. 'I felt intimidated ...felt she was using her position to undermine mine'. (nurse having been verbally abused by an anaesthetist in front of patients).
26. 'I have never experienced physical violence from visitors although I have felt intimidated.'
29. Preceptor – 'Don't worry, he's always like that.'
(doctor abusing new nurse for not handing him the right instrument).
32. Dr (abusing nurse in front of patients) – 'I say what I see fit when I see fit.'
33. 'I felt frustration and disbelief that this man (a patient) could use words of such hatred towards staff.'
34. 'Don't worry about her – she is always like this, she treats all new grads poorly.' (nurse to participant concerning senior nurse's bullying).

ANF Nurses Survey

Workplace Violence In Nursing

(IT'S NOT PART OF THE JOB!!!)



1 Have any of these things happened to you in your workplace in the last year? (tick any that apply)

- ☐ Intimidating behaviour – shouting, ordering, arguing
- ☐ Abusive language
- ☐ Physically threatening behaviour
- ☐ Physical assault (unarmed)
- ☐ Physical assault (with a weapon)
- ☐ Other (please specify) _____

2. How often do you experience violent incidents at work?

- ☐ Daily
- ☐ Weekly
- ☐ Monthly
- ☐ Other (please specify) _____

3. Did you report these violent experiences?

- ☐ All
- ☐ Some
- ☐ None (please state why you did not report them) _____

4. If you did report some or all of these experiences, were you satisfied with its outcome, and the response you received?

- ☐ Yes
- ☐ No (please state why) _____

5. Have you been physically injured as a result of workplace violence?

- ☐ Yes (please specify) _____

5b If you answered Yes to the above question, did this/these injuries cause you to have time of work? And if so, please also state how long you needed to have off. _____

6. Have you had any training in dealing with violent/potentially violent situations?

- ☐ Yes
- ☐ No

If you answered 'Yes' to the above question, how effective do you think the training was? _____

If you answered 'No' to question 6, would you be interested in learning how to deal with violent/potentially violent situations in an effective and professional manner?

- ☐ Yes
- ☐ No

7. Who do you think should provide the funding for such training?...i.e. Health Department of Western Australia, Health Services, employer _____

8. What ideas or thoughts do you have to reduce the potential for violent incidents in your workplace? _____

Workplace _____

Level _____ Area _____

Age (optional) _____

Please send the completed form to the ANF by fax 9218 9455 or post to 260 Pier St Perth 6000. Other comments are also welcome.