



COPYRIGHT NOTICE

Please note:

The material contained in this document can be used **ONLY** for **personal** study/research and therefore can be copied but only for **personal** use.

Any form of copying for distribution purposes requires copyright permission from author/university.

UNIVERSITY OF KWAZULU-NATAL

**WORKPLACE VIOLENCE AS EXPERIENCED BY NURSING PERSONNEL IN
A PRIVATE HOSPITAL IN THE DURBAN METROPOLITAN AREA**

LISA KING

2007

**WORKPLACE VIOLENCE AS EXPERIENCED BY NURSING PERSONNEL IN
A PRIVATE HOSPITAL IN THE DURBAN METROPOLITAN AREA**

A RESEARCH DISSERTATION SUBMITTED TO THE:

FACULTY OF HUMANITIES

SCHOOL OF PSYCHOLOGY

UNIVERSITY OF KWAZULU-NATAL

AS A PARTIAL REQUIREMENT FOR THE DEGREE:

MASTERS IN PSYCHOLOGY (CLINICAL)

BY:

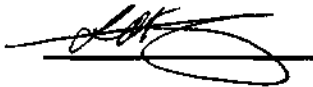
LISA KING

SUPERVISOR:

PROF. L. WILBRAHAM

DECLARATION

I hereby state that apart from items referenced and cited in the body of this research dissertation, that the content contained herein is my own, unaided work. This dissertation has been submitted to the School of Psychology (Humanities Faculty) at the University of Kwazulu-Natal, Durban in partial fulfillment of the requirements for the degree: Master in Psychology (Clinical).



Lisa King

Supervisor: Prof. L. Wilbraham

07 December 2007

ACKNOWLEDGMENTS

I hereby wish to acknowledge and thank:

- The Department Of Health for their interest in this research and for permitting me to undertake the study.
- The management and staff of the participating health institutions for permitting me to undertake the study.
- My supervisor, Prof. L. Wilbraham for all her guidance and support.

ABSTRACT

Title: Workplace violence as experienced by nursing personnel in a private hospital in the Durban Metropolitan Area.

Aim: The purpose of this study was to explore and describe the experiences of hospital workplace violence on nursing personnel currently employed in a specific context (an operating theatre) in a private hospital in the Durban Metropolitan Area (DMA).

Methodology: The broad paradigm of this research study is located in the qualitative research field. The researcher specifically used an interpretative phenomenological approach (IPA) following the guidelines of Smith, Jarman and Osborne (1999). IPA was used because the researcher was interested in identifying, describing and understanding the subjective experience of individual nurses in respect of their cognitive interpretations and subjective experiences of nursing workplace violence; and because the researcher intended to make sense of the participants' world through a process of interpretative activity. A focus group and two thematically semi-structured interviews were conducted with each subsequent participant by the researcher. A total of eight participants took part in the study, five were interviewed separately and eleven interviews were done. The IPA as suggested by Smith et al. (1999) was used to identify the connections and themes in respect of shared meanings and references and /or in respect of hierarchical relationships in each transcript. Themes that were found to be common were grouped together i.e. clustered by the researcher. The researcher then derived a master list of superordinate themes and sub-themes from the clusters of themes.

Findings: The participants' lived experiences of workplace violence in the operating theatre indicated that workplace violence had impacted and was impacting on their everyday work experience. A range of workplace violence experiences as precipitated and perpetuated by doctors, fellow nurses and hospital management was noted. These included verbal abuse, bullying, intimidation, process violence, physical assault and sexual harassment. Differences between the types of workplace violence perpetrated by doctors, nurses and hospital management were found. The participants articulated a range of subjective meanings and explanations for their colleagues' behaviours (intrapersonal, interpersonal and institutional) - all of which were found to have impacted on their psychological wellbeing. A variety of defense mechanisms and coping strategies were identified and discussed.

Conclusion: Following McKoy and Smith (2001), the researcher identified a number of factors that made the nursing workplace and/or the healthcare environment more susceptible to the occurrence of workplace violence, e.g. low staffing, a reduction in trained staff, and the profit-motives of private hospitals in the healthcare industry (managed healthcare). These were found to have impacted on each of the participants in this study in respect of their experiences of workplace violence. In sum, the study has provided a clear, department specific picture about the experiences of theatre nurses in respect of workplace violence. A number of interventions to facilitate and retain the services of theatre nurses in the operating theatre have been suggested.

TABLE OF CONTENTS

TITLE PAGE	i
DECLARATION	ii
ACKNOWLEDGEMENTS	iii
ABSTRACT	iv
TABLE OF CONTENTS	vi
1. CHAPTER ONE: INTRODUCTION	01
1.1 Background to the study	01
1.2 Problem statement	03
1.3 Purpose of the study	04
1.4 Research objectives	04
1.5 Research questions	04
1.6 Significance of the study	05
1.7 Operational definitions	05
1.8 Conclusion	06
2. CHAPTER TWO: LITERATURE REVIEW	07
2.1 Introduction	07
2.2 Definitional disputes	07
2.3 Psychological sequelae and support	11
2.4 South African specificities	15
2.5 Under-reporting of workplace violence	17
2.6 Financial implications of workplace violence	18
2.7 Strategies to prevent and manage workplace violence in healthcare settings	20
2.8 Limits of interventions	23
2.9 Legal aspects of workplace violence	26
2.10 Conclusion	32
3. CHAPTER THREE: METHODOLOGY	35
3.1 Introduction	35
3.2 Research strategy and approach	35
3.3 Sampling design	36
3.4 Selection of participants	38
3.4.1 Participant demographics	40
3.5 Data collection process	40

5.5.1	Setting and interview process	43
3.5.2	Field notes	44
3.5.3	Difficulties experienced in conducting the research	45
3.6	Data analysis	46
3.7	Ethical considerations	48
3.7.1	Negotiating consent	48
3.8	Trustworthiness of the research	52
4.	CHAPTER FOUR: THEMATIC FINDINGS	57
4.1	Introduction	57
4.2	Workplace violence perpetrated by doctors	60
4.2.1	Verbal abuse	60
4.2.2	Intimidation and bullying	61
4.2.3	Humiliation	63
4.2.4	Physical assault	64
4.2.5	Sexual harassment	65
4.3	Interpreting the occurrence of workplace violence as experienced from doctors	66
4.3.1	Lack of respect for nurses and class consciousness	67
4.3.2	Surgeon temperament, perfectionism and the 'artist'	67
4.3.3	Surgeon insecurity and inadequacy	68
4.3.4	Surgeon expectation: unrealistic performance and service expectations	69
4.3.5	Being spoilt, expectations of entitlement and control issues	70
4.3.6	Misogyny	71
4.3.7	Differential treatment of staff, racism	71
4.4	Workplace violence perpetrated by nurses	72
4.4.1.	Verbal abuse	72
4.4.2	Abandonment	73
4.4.3	Ignoring	74
4.4.4	Bullying, victimization and double standards	75
4.5	Interpreting the occurrence of workplace violence as experienced from nurses	77
4.5.1	Expectations, standards and performance pressure	77
4.5.2	Territoriality	78

4.5.3	Personality, attitude and the bringing of personal problems to work	79
4.5.4	Victim blaming, self blame	79
4.5.5	Feelings of insecurity and inadequacy	80
4.5.6	Short staffing and exigencies of the service	81
4.6	Hospital Management and workplace violence	82
4.6.1	Victim blaming	83
4.6.2	Lack of support and fobbing off of staff complaints	83
4.6.3	Grievance procedure	85
4.7	Interpreting management's handling of workplace violence incidents	86
4.7.1	Fiscal considerations	86
4.7.2	Social considerations and other vested interests	86
4.8	Effects of workplace violence for the self	87
4.8.1	Doubt, loss of confidence and self esteem	87
4.8.2	Loss of trust	88
4.8.3	Avoidance, Resentment	88
4.8.4	Feelings and emotions	89
4.8.5	Stress, exhaustion, and being mentally drained	90
4.9	Strategies for coping with workplace violence	91
4.9.1	Keeping the peace, keeping quiet, stoicism	91
4.9.2	Prayer and professionalism	92
4.9.3	Avoidance and withdrawal	93
4.9.4	Intellectualization, rationalization, minimization	94
4.9.5	Over-compensation and humour – the 'court jester'	95
4.9.6	Venting to colleagues, support networks, crying and comfort eating	95
4.9.7	Altruism, ethical conduct, and honesty	97
5.	CHAPTER FIVE: INTERPRETATIVE ANALYSIS	99
5.1	Introduction	99
5.2	Direct (personally experienced) and indirect (witnessed) experiences of operating theatre nursing personnel of workplace violence.	101

5.3	Meanings given by operating theatre personnel to their experiences of workplace violence	104
5.3.1	Intrapersonal level	104
5.3.2	Interpersonal level	106
5.3.3	Institutional level	109
5.4	Understandings of workplace violence	112
5.4.1	Perceptions of workplace violence	112
5.4.2	The blaming triangle	115
5.5	Coping strategies	119
6.	CHAPTER SIX: CONTAINING AND MANAGING WORKPLACE VIOLENCE	123
6.1	Introduction	123
6.2	Participant expectations and workplace violence prevention programmes	123
6.3	Recommendations for hospital management	127
6.4	Recommendations for the nursing profession	128
6.5	Recommendations for further research	130
6.6	Additional considerations, specific methodological critiques and strengths	131
6.7	Conclusion	134
7.	REFERENCES	135
7.1	Additional readings	138
8.	APPENDICES	139
8.1	Appendix one – interview and focus group schedule	139
8.2	Appendix two - ethical clearance documentation.	143
8.3	Appendix three - letter requesting permission for the study to the department of health.	145
8.4	Appendix four - letter granting permission for the study from the department of health.	149

8.5	Appendix five - letter requesting permission for the study to health care institution.	150
8.6	Appendix six - letter granting permission for the study from the participating institution.	152
8.7	Appendix seven - covering letter to participants advising them about the study and inviting them to participate and consent form.	153
8.8	Appendix eight – workplace violence poster inviting participants to the focus group.	156
9.	LIST OF TABLES AND DIAGRAMS	
9.1	Table 4.1: superordinate themes and sub-themes	058
9.2	Diagram 5.4.2: The blaming triangle	116
9.3	Diagram 5.5.1: The cycle of workplace violence: effects and outcome	121

CHAPTER ONE: INTRODUCTION

1.1 Background to the study

A recent interpretative phenomenological study by King (2005a) identified and documented a variety of hospital workplace experiences that had contributed to the resignation of registered nurses in the Durban Metropolitan Area (DMA). The experience of workplace violence was found to be common to the majority of participants in the study. The episodes of workplace violence ranged from verbal abuse and rudeness, to malicious gossiping, intimidation and physical assault.

The most frequent sources of verbal abuse and assault experienced by the participants in the above study were from patients and their relatives at both public and private institutions (King, 2005), followed by verbal abuse and rudeness at the hands of doctors in private hospitals, and from senior nursing colleagues at both public and private health care institutions.

In a meta – analysis and review of current literature pertaining to violence in the nursing workplace in the United States, Canada, Sweden, Britain and Australia, Jackson, Clare and Mannix (2002) note that workplace violence may be regarded as encompassing incidents of physical aggression and assault, harassment, sexual harassment, bullying, and intimidation. They further describe workplace violence as being inclusive of the following: rudeness, verbal abuse, humiliation and denial of opportunities.

Jackson et al. (2002) argue that organisations have a central role in the perpetuation of workplace violence in that they perpetuate existing cultures of oppression by not having clear policies for dealing with incidents of workplace violence and through decisions that contribute towards increasing their personnel's exposure to workplace violence. King (2005a) notes that the nurses who had experienced workplace violence in her study, e.g. incidences of intimidation, bullying, verbal abuse and assault, regarded it as part of the job, had tried to ignore it in the hope that things would just get better and did not know how to go about remediating their respective situations without having to resort to resigning from their posts.

Given that the nursing profession in South Africa is currently experiencing an ongoing shortage of nursing personnel, and that the shortage of nursing personnel has been exacerbated by substantial losses of nursing personnel due to either internal migration, (movement of health care personnel across sectors or out of the health care professions), or to external migration (movement of health care professionals to international destinations) (Geyer, 2004), it is crucial that negative hospital workplace experiences that have been identified as having contributed to the resignation of nursing personnel are explored and remedied so that retention of the remaining nurses may be enhanced. This may be done, for example, by improving their working conditions and interpersonal relations.

King (2005a) argues that sub-optimal and negative hospital workplace experiences, e.g. the experience of workplace violence, has precipitated the exodus of nursing personnel

from the nursing profession. King (2005a) and Geyer (2004) further note that the shortage of nursing personnel directly impacts on the quality and amount of nursing care available to patients in the health care system, and further places a burden on the remaining nursing workforce. King (2005a) argues that having a clear localized picture about the hospital workplace experiences of nursing personnel facilitates the development of interventions to retain the services of nursing personnel. This provides the background against which this study is set. Given that nursing personnel work in a variety of contexts each with their own unique workplace dynamic and stressors, the researcher intends to delimit the field of study with regard to the phenomenon of workplace violence and to study the phenomenon in a specific context (see below).

1.2 Problem statement

King (2005a) documents that sub-optimal, negative hospital workplace experiences have contributed to the resignation of registered nurses (nursing personnel) in the DMA, and cites the experiences of nursing personnel with regard to workplace violence as being significant in this regard. While exposure to and experiences of workplace violence may have precipitated the resignation of certain nursing personnel in King's (2005a) study, what is not known are the subjective experiences of the remaining nursing personnel with regard to workplace violence, i.e. the experiences of those who have either experienced or who have observed (witnessed) incidents of workplace violence and who have not resigned.

1.3 Purpose of the study

The purpose of this study is to explore and describe the experiences of hospital workplace violence on nursing personnel currently employed in a specific context, an operating theatre in a private hospital in the DMA.

1.4 Research objectives

- 1.4.1** To explore the workplace violence experiences of operating theatre nursing personnel.
- 1.4.2** To explore the subjective meanings of workplace violence as made by operating theatre nursing personnel.
- 1.4.3** To explore possible measures of intervention and remediation in respect of containing and managing workplace violence in the operating theatre. These interventions are from suggestions by the participants and from the interpretation of the participants' subjective experiences by the researcher.

1.5 Research questions

- 1.5.1** What are the direct (personally experienced) and indirect (witnessed) experiences of operating theatre nursing personnel in respect of workplace violence?
- 1.5.2** What meanings are given by operating theatre nursing personnel to experiences of workplace violence?
- 1.5.3** How do operating theatre nursing personnel understand workplace violence?
- 1.5.4** How do operating theatre nursing personnel manage experiences of workplace violence?
- 1.5.5** How could workplace violence in the operating theatre be effectively contained and managed?

1.6 Significance of the study

The primary contribution of this study relates to the creation of localized awareness at middle and senior hospital management level of the hospital workplace experiences of nursing personnel with particular reference to the experience of workplace violence. In the South African context, there is little department specific literature that discusses the effects of workplace violence. The researcher posits that having a clear department specific picture about the hospital workplace experience of nursing personnel, e.g. in respect of experiences of workplace violence, will facilitate the development of interventions to retain the services of nursing personnel. It is envisaged that the solutions and recommendations as derived from suggestions by the participants and from the researcher's interpretation of their subjective experiences will further aid the development of these interventions. In sum the researcher, with Geyer (2004), argues that if the retention of nursing personnel is improved, then the quality and quantity of nursing care available to the patient population will be improved.

1.7 Operational definitions

Nursing personnel: registered nurses who have graduated with a recognized degree, or diploma in nursing, and who are registered with the South African Nursing Council as registered nurses.

Workplace: for the purposes of this study the term 'workplace' refers to the private hospital setting and to the operating theatre setting in particular. The focus on the hospital environment was chosen because hospitals are the largest employers of nursing personnel, and the theatre setting was chosen because it is a recognized high stress environment for nursing personnel (Jackson et al., 2002).

Workplace experience: in this study 'workplace experience' refers to both the material and non-material aspects of being an employee within an organisation, e.g. the experience of the nurse in respect of the organisational climate in respect of his or her physical working conditions, supervisory and professional support received, and the psychosocial climate in which the nurse operates.

1.8 Conclusion

In this chapter it was noted that the experience of workplace violence had been identified as a precipitant to the resignation of nursing personnel in the DMA in a previous study by King (2005a). What was not known were the subjective experiences of the remaining nursing personnel with regard to workplace violence, i.e. the experiences of those who have either experienced or who have observed (witnessed) incidents of workplace violence and who have not resigned. Given that a shortage of nursing personnel directly impacts on the quality and amount of nursing care available to patients and further places a burden on the remaining nursing workforce, it was noted that having a clear department specific picture about the experiences of nursing personnel in respect of workplace violence would facilitate the development of interventions to retain the services of nursing personnel, and ergo improve the quality of nursing services. The study focuses on a specific context - an operating theatre in a private hospital in the DMA. The dynamics for this selection and the difficulties defining workplace violence are explored in greater detail in the literature review below.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

This chapter discusses nursing workplace violence literature as reviewed by the researcher. Definitional disputes surrounding the concept of workplace violence are examined followed by a discussion pertaining to the psychological sequelae of nursing workplace violence. South African workplace violence specificities, under-reporting, financial implications and strategies to prevent and manage workplace violence in healthcare settings are examined, and the limits of interventions with regard to workplace violence are discussed. The chapter concludes with a typology and examination of the legal aspects of workplace violence.

2.2 Definitional disputes

In a meta – analysis and review of current literature pertaining to violence in the nursing workplace in the United States, Canada, Sweden, Britain and Australia - Jackson, Clare and Mannix (2002) argue that workplace violence is a major factor affecting the recruitment and retention of nursing staff and that violence against nurses is a significant problem in the nursing workplace internationally. The paper published by Jackson et al. (2002) sought to: explore what was known about nursing workplace violence in the above countries, to present possible solutions, make recommendations for further research and further proposed a number of recommendations to remediate situations in which nursing workplace violence occurred.

Jackson et al. (2002) posit that incidents of nursing workplace violence are under reported in the developed world and cite a study conducted by Erickson and Williams-Evans in which seven incidents of workplace violence out of an observed 686 incidents were reported in support of this argument. Notwithstanding the under reporting of these incidents, Jackson et al. (2002) argue that their determining of the exact extent and nature of the problem of workplace violence was further complicated by the fact that few studies used observational methods to explore the phenomenon, and that most of the studies reviewed used 'self report' retrospective survey methods. The use of these methods was considered to be problematic because the studies relied on the participants' recall of lived events and were thus affected by subjectivity and 'vagaries of memory' (Jackson et al., 2002).

Notwithstanding the above, workplace violence was described as encompassing incidents of physical aggression (e.g. assault), harassment (e.g. by means of property damage, stalking, telephone harassment), sexual harassment, bullying, intimidation, rudeness, verbal harassment (e.g. use of abusive and /or aggressive language, the use of obscenities and offensive language, distasteful jokes, insults, gossip and speculation), written harassment (e.g. through letters and email), humiliation, denial of opportunities, the use of unjustifiable excessive supervision, unjustifiable over-ruling of the individual's authority, the setting of impossible targets, changing objectives or guidelines without consultation and the reporting of an individual to a supervisor without justification (Jackson et al., 2002; Lehane, 2005). While the contexts in which the above occurred were predominantly linked to specific clinical areas, e.g. accident and emergency units

and psychiatric units (well known areas in which nursing personnel experience high levels of occupational stress and violence), Jackson et al. (2002) note that “there is increasing evidence that general wards are equally as hazardous” (p. 14).

While a proportion of workplace violence was attributed to patients, relatives and friends of patients, a significant source of workplace violence was found to be that perpetrated by doctors and by fellow nurses (Jackson et al., 2002). In this regard, Taylor (1999), as cited in Jackson et al. (2002), noted that bullying is a particular form of workplace harassment that is a recognised occupational stressor for nurses. In the United Kingdom, Lehane (2005), in an article on bullying in the nursing workplace specifically defined bullying as “unwanted behaviour based on the unwarranted use of authority or power” (p. 28) and Jackson et al. (2002), in commenting on bullying in the nursing workplace in the developed world, noted that line managers were evidenced as repeatedly being prone to bullying subordinate staff. This was evidenced through,

“excessive verbal abuse and criticism, intimidation, threats, ridicule (in front of spectators), making excessive and impossible demands, withholding information, inequitable rostering practices, rumour mongering, blocking opportunities for promotion or training, removing responsibility, and misuse of power to incite others to marginalise or exclude the victim” (Jackson et al., 2002, p.15).

Lehane (2005) noted that the persistent bullying of an individual not only gradually eroded their self confidence but further resulted in the individual experiencing physical symptoms such as stomach complaints, ulcers, an inability to concentrate, headaches, and tearfulness. Lehane (2005) further noted that bullying had the potential to exacerbate any health conditions that might already be present in the individual, e.g. insomnia and depression.

Lehane's (2005) views are further augmented by the arguments put forward by Gerrit Van Wyk (2003) in a South African study on trauma in the workplace. Van Wyk (2003) divides workplace violence and trauma into critical incident trauma (e.g. rape, hijacking, fire and armed robbery) and process trauma (e.g. workplace incidents that break down self esteem and confidence). He argues that process trauma is not necessarily caused by an isolated event and that often the long drawn out nature of such workplace trauma is also traumatic for the individual's concerned. He notes that while process trauma does not usually lead to the formation of a post traumatic stress disorder as with critical incident trauma, it is the "cause of adjustment disorder and other conditions like anxiety states and depression, conditions that can be highly incapacitating" (p. 11). Van Wyk (2003) notes that workplace violence has its own dynamics which may lead to a belief about a loss of safety in the workplace, and which may further give rise to issues of anger and blame as employees now search for the reasons and causes for the incident of workplace violence in their workplace. The researcher argues that this is particularly the case in South Africa where the health system has been undergoing transformation since 1994. Transformation in terms of a more equitable redistribution of health care resources and personnel has added racial tension to the workplace, and allegations of racism (the 'race card') are often called upon to explain negative workplace incidents. King (2005a) similarly found allegations of racism used to explain certain colleagues' behaviours.

In addition to collegial acts of violence and aggression, Jackson et al. (2002) have further argued that violence in nursing does not occur in isolation, and that organisations have a central role in the perpetuation of workplace violence. Workplace environments

perpetuate existing cultures of oppression by not having clear policies to deal with incidents of workplace violence, and through managerial budgeting and staffing decisions that contribute towards sub-optimal working conditions that in turn increase their nursing personnel's exposure to workplace violence, e.g. in situations where hospitals are short staffed and where personnel are expected to work with increased workloads (Nabb, 2000 as cited by Jackson et al., 2002) as in both the public and private health care systems in South Africa.

2.3 Psychological sequelae and support

With reference to the findings of Jackson et al. (2002), the effects of workplace violence on nursing personnel in developed contexts evidence that in addition to having to deal with poor interpersonal relationships with colleagues, nursing personnel suffer the effects of post traumatic stress, e.g. anxiety, insomnia, and impaired concentration. These effects impact on their work performance and on patient care (Jackson et al., 2002). Additional research from South Africa has evidenced that the above findings correlate with increased incidences of absenteeism, sick leave, drug and alcohol abuse, burnout and high staff turnover rates (Van Wyk, 2003).

While acknowledging that South African nursing workplace environments and contexts are as heterogeneous as the contexts in the above study by Jackson et al. (2002), Kgosimore (2004) in an article in *Nursing Update*, notes that workplace violence in South Africa has become a daily occupational hazard, and that the Democratic Nursing Organisation of South Africa (DENOSA) has evidenced that there has been an increased

number of complaints from nurses who have suffered abuse in the workplace. With reference to the literature reviewed to date it is evident that nursing workplace violence, irrespective of context is a global problem. Notwithstanding the universality of nursing workplace violence, the researcher posits that with regard to workplace violence in the South African context, there may be particular dynamics related to South Africa's socio-political past (e.g. race, class and patriarchy) and present (South Africans live in an extremely violent society) that impact on South African nurses' experiences, perceptions and handling of workplace violence. Specificities regarding South Africa are explored further on.

Karen Higgins (past president of the Massachusetts Nurses Association (MNA) in the United States) as cited by the MNA (2005a) notes that it is "becoming all too common for nurses to be victims of workplace violence ... [and that workplace violence is] ... an unnecessary job hazard" (p. 1). A 2004 survey study by the MNA- as commissioned by the MNA's Congress on Health and Safety - revealed that more than half of their 172 respondents (who were working in a variety of speciality units in three different institutions) had reported that nursing workplace violence had been a serious problem for them over the last two years (MNA, 2005b).

The survey results indicated that 30% of nurses were regularly and frequently threatened physically, i.e. were pinched, scratched, spat on and/or had their arm or hand twisted; 50 % had been punched at least once, 7 respondents indicated that they had been strangled, 8 had been sexually assaulted and 2 respondents noted that they had

intentionally been jabbed with a contaminated needle (MNA, 2005b). In this survey, the majority of perpetrators of this workplace violence were patients (MNA, 2005b). Of those who had experienced an incident of workplace violence, less than 2% were sent home to recover and less than a quarter were offered relief so that they could stop working and go home to recover if they needed to (MNA, 2005b). While the majority of the respondents in the study said that their respective management structures were supportive in the wake of these incidents, they noted that nothing was done to solve the problem (MNA, 2005b). The respondents felt that management was ultimately not concerned about their workplace safety and specifically about problem of workplace violence. The majority of respondents attributed the primary cause of workplace violence to poor staffing conditions (short staffing) (MNA, 2005b). The above findings are similar to those derived by Jackson et al. (2002) in their meta-analysis of current literature on nursing workplace violence in developed contexts.

As a result of this survey, the MNA submitted proposed legislation to the Massachusetts Legislature's Public Safety Committee regarding the prevention of nursing workplace violence – the Act will require health care employers to develop and implement programmes to prevent nursing workplace violence and will make it mandatory for hospital management to provide comprehensive workplace violence prevention programmes and to make counselling available to victims of workplace violence (MNA, 2005a). While the broad aim of the Act is to improve the working conditions of nurses, the MNA argues that the legislation of a workplace violence prevention Bill will hold management structures responsible and accountable for how incidents of workplace

violence are precipitated, managed, resolved and/ or remediated (MNA, 2005a). While the majority of nursing workplace violence incidents in the 2004 MNA survey was found to have been perpetrated by patients, clarification on inter-collegial acts of workplace violence and organisational accountability regarding workplace violence was not forthcoming. A further limitation of this survey study was that specific contextual and subjective accounts and meanings associated with the experience of workplace violence were not detailed.

The phenomenon of nursing workplace violence additionally extends across cultures as is evident in a recent study by Kwok et al. (2006). Kwok et al. (2006) conducted a cross sectional questionnaire study in a university teaching hospital in Hong Kong. One of the main objectives of their study was to determine the prevalence and nature of nursing workplace violence. Kwok et al. (2006) additionally wanted to determine how nurses dealt with the aggression of workplace violence and further sought to identify the risk factors that predisposed and precipitated the phenomenon of nursing workplace violence.

Of those participants who returned the questionnaires, 76% (confidence interval 72% to 80%) reported having experienced abuse in their respective place of work. Kwok et al. (2006) noted that verbal abuse (reported by 73% of the participants), bullying (reported by 45% of the participants), physical abuse (reported by 18% of the participants), and sexual harassment (reported by 12% of the participants), were the most prevalent forms of workplace violence. Working in male wards and in certain specialties such as the Accident and Emergency Department (Casualty / Out Patient Department), and

interestingly the Community Nursing Service, were identified as high risk areas for workplace violence (Kwok et al., 2006). Kwok et al. (2006) concluded that workplace violence against nurses is a significant problem in Hong Kong, and recommended that additional large-scale studies should be conducted to explore the problem further. While this study evidences that workplace violence against nurses is a significant problem in Hong Kong, it was further evident that a large proportion of the study's participants' (42%) modus operandi when faced with an incident of workplace violence was to ignore the incident. The position taken in this study is that the ignoring of such incidents is not an effective means of resolving issues and does not prevent such incidents from reoccurring. A limitation of Kwok et al.'s (2006) study is that no clear recommendations pertaining to the management and containment of the phenomenon of nursing workplace violence are made. Notwithstanding the clear picture regarding the nature and prevalence of nursing workplace violence – as derived from the demographic data of the study, the voices and lived experiences of the nurses themselves are not apparent.

2.4 South African specificities

While the survey studies discussed above provide a clear indication of the occurrence of the phenomenon of nursing workplace violence globally, King's (2005a) phenomenological study of the hospital workplace experiences of registered nurses in South Africa and in particular in the DMA revealed that the majority of her participants had experienced violence in the workplace in a variety of contexts. It was noted that episodes of workplace violence ranged on a continuum from verbal abuse, malicious gossiping and intimidation to actual physical assault. In one incident a registered nurse

had been assaulted by a nursing colleague who was upset at not being given the charge position that she wanted on a particular shift.

King's (2005a) study also noted that male registered nurses' experiences of workplace violence differed from that of their female colleagues. While workplace violence in respect of concerns about physical safety was not an issue for the male registered nurses, their experience of verbal abuse from the patients and public was also less. This was attributed to the fact that patients and their relatives often thought that male nursing personnel were doctors and not nursing staff and were accordingly more respectful.

McKoy and Smith (2001) note that the perpetrators of workplace violence could be anyone – patients, their family members, customers, employees (co-workers) and employers. In addition to these potential perpetrators of workplace violence, the MNA (2005c) add physicians, supervisors and managers to the list. King (2005a) similarly noted that the most frequent sources of verbal abuse and assault experienced by the participants in her study were from patients and their relatives at both public and private institutions, and that the next most common source of abuse for the participants was the verbal abuse and rudeness at the hands of doctors in the private hospitals, and from senior nursing colleagues respectively. This abuse was poignantly illustrated by the following excerpt from a participant in King's (2005a) study:

“The doctors are always screaming and shouting especially in theatre ... there is certain doctors that ... make you feel like you don't know anything, and **they're** the 'doctor'; it affects you psychologically because he actually belittles you. He doesn't call you aside and say 'listen this or that or that – please can I have this and that, and that for the next time' – it's **in front of the patients** and you ... [are made to] ... look like you don't actually know what you are doing” (p. 69).

When confronted by verbal abuse by doctors and from nursing colleagues – usually from senior colleagues, most of the participants in King’s (2005a) study reported that they felt unhappy with the situation, but that they felt unable to do anything about it because if they reported it to management either nothing would be done about it or they would be branded ‘trouble makers’. In the private hospitals, the participants were of the opinion that nothing was done about these incidents because of management’s attitude that the doctors were the customers and that the nurses were just employees who must get on with the job and go the ‘extra mile’. Most of the participants in King’s (2005a) study who had experienced incidences of intimidation, bullying, and verbal abuse regarded it as part of the job, tried to ignore it in the hope that things would just get better or did not know how to go about remediating the situation without having to resort to resigning from their post.

While King’s (2005a) study evidences that workplace violence is experienced by nursing personnel in the DMA, and mentions the experience of nursing workplace violence as being perpetrated by patients, doctors and senior nursing colleagues in a variety of contexts, it does not explore the occurrence of workplace violence in a specific context and hence recommendations to deal with the occurrence of workplace violence are very broad and non-specific. This present study attempts to ameliorate this.

2.5 Under-reporting of nursing workplace violence

In McKoy and Smith’s (2001) study which was aimed at exploring the reasons for the underreporting of violence in healthcare institutions and which further reviewed the legal aspects of workplace violence, a number of factors that made the nursing workplace

and/or the healthcare environment more susceptible to the occurrence of workplace violence were identified. These were low staffing, high acuity patients, current cost cutting initiatives and the widespread downsizing of the healthcare industry (managed healthcare) as a whole, the stressful nature of illness and uncertainty, and a reduction in regular trained staff.

Notwithstanding these factors and the role that each plays in precipitating and perpetuating violence in the workplace, a variety of reasons given for failing to report such incidents were noted by McKoy and Smith (2001) – namely: peer pressure not to report such incidents, ambiguities inherent in defining violence, fear of job loss, perceptions that violence is ‘just part of the job’, fear of being blamed in respect of somehow having caused the incident, perceptions that if one reported the incident then these would be viewed by the employer as having occurred due to negligence or poor job performance, the belief that the reporting of such incidents are futile because nothing gets done about them, i.e. there is no personal benefit to reporting such incidents and intrapersonal conflict relating to the nurse’s perception of his or her professional role (putting the patient first) versus the role of being a victim.

2.6 Financial implications of workplace violence

Hutton (2006) notes that the financial implications of workplace violence in healthcare institutions in the United States of America amounted to approximately 4.2 billion dollars per annum. Hutton (2006) further argues that if even ‘minor’ incidents of workplace violence, e.g. incivility (i.e. verbal abuse), were remedied, then the financial and human

resources that could be retained would be immense. This sentiment is echoed by Lehane (2005) in an article on bullying in the nursing workplace in the United Kingdom. He notes that the consequences of workplace violence, and in particular of workplace bullying, are too costly for employers to ignore. He cites statistics that show that approximately two million people report that they are bullied at work and further that “18.9 million working days are lost every year as a result of workplace bullying” (p. 28). The financial implications of absenteeism are self evident and are further exacerbated should an individual decide to leave an organisation due to being bullied or abused.

In considering the above and in relation to the specific domain in which this study is located, Pieterse (2006) notes that in South Africa, while it is not difficult for health care organisations to find medical and surgical personnel to utilize their facilities, it has become increasingly difficult to find skilled perioperative practitioners (theatre nurses). Pieterse (2006) argues that it is the theatre nurse that essentially promotes a surgeon’s skill and advertises his or her competence, and that this in turn impacts on a hospital’s profit making. Pieterse (2006) argues further that theatre nurses are the unrecognised driving force behind the health care organisation’s profit making. Clearly a shortage of skilled theatre nurses serves to undermine the effectiveness of a health care service, additionally has a negative impact on healthcare outcomes, and ultimately impacts on the health care organisation’s profit making.

2.7 Strategies to prevent and manage workplace violence in healthcare settings

Workplace violence in nursing does not occur in isolation – organisations have a central role in the perpetuation of workplace violence (Jackson et al., 2002). Workplace environments are found to perpetuate existing cultures of oppression and ergo workplace violence through not having clear policies to deal with incidents of workplace violence, and through their managerial budgeting and staffing decisions that contribute towards conditions that increase their nursing personnel's exposure to workplace violence – e.g. situations where hospitals are short staffed and personnel work with increased workloads (Jackson et al., 2002).

In an article in the *Medical Journal of Australia*, Forster, Petty, Schleiger and Walters (2005) argue that the prevention and management of workplace violence in Australian healthcare settings are pivotal health and safety issues. They emphasize that hospital management needs to integrate and balance occupational health and safety obligations to their staff with the duty of care that is 'owed' to their patients. The purpose of the article was to highlight the key elements of any program designed to prevent the occurrence of behavioural violence and aggression in healthcare settings. Forster et al. (2005) identified the following as key components of any workplace violence prevention programme: risk assessment of workplace violence, staff education and training, the use of patient contracts, and management practices, e.g. in terms of policies about workplace violence and in terms of intervention strategies to be implemented to manage and/or contain incidents of workplace violence.

McKoy and Smith (2001) note that prevention and avoidance are among the most important strategies that employers can implement in order to avoid the occurrence of violence in the workplace. They note that in the United States of America, the Occupational Safety and Health Administration (OSHA) and the Joint Commission on Accreditation of Healthcare Organisations (JCAHO) have established guidelines that stipulate the employer's legal obligations to provide a reasonably safe and healthy workplace for employees. Legally, managers and administrators (employers) have a duty to "deter and control violent incidences in the workplace" (p. 9), and are further accountable for recognizing the potential for violence in the workplace irrespective of whether the violence originates inside or outside of the workplace.

However Fisher (2005), in an article commenting on the prevention of workplace violence in the United States, notes that despite the fact that the OSHA requires companies to provide their employees with a safe workplace, less than 1% of employers have a formal anti-violence policy. Fisher (2005) attributes this to assumptions held by employers that workplace violence (specifically physical assault and homicide) is random and to the belief that there is no way of telling when a 'troubled' employee will 'snap'. Fisher (2005) argues that these assumptions are flawed, and further notes that an incident of workplace violence is almost always pre-meditated; and is usually preceded by warning signs which follow a clear and detectable pattern, e.g. a pattern of verbal threatening and intimidation that then escalates over a period of time and which then culminates in an incident of workplace violence. Fisher (2005) thus argues that an integral part of a workplace anti-violence policy is to educate employees about the

consequences of abusive talk and threatening behaviour and to further educate employees about the importance of reporting threatening behaviours long before it results in an incident.

Turning to South African hospitals, King (2005b) notes that the planning and implementation of strategies to prevent and manage workplace violence need to be conducted on a number of levels: intrapersonal, interpersonal, and organisational. King (2005b) argues that interventions need to secure the 'buy-in' and commitment of all participants and stakeholders, and that these need to be implemented simultaneously. For example, individuals would engage in life skills training programmes, while management disseminate and implement policies on workplace violence; in addition focus groups or support groups could be used to foster awareness of and /or stimulate consciousness pertaining to workplace violence and these could be used simultaneously to provide feedback on the incidence and prevalence of workplace violence. King (2005b) notes that those affected by workplace violence need to be empowered to take the necessary steps to combat workplace violence.

The notion of 'empowerment' is complex. Following Minkler and Wallerstein (1992) King's (2005b) argument refers to empowerment as "a social action process through which individuals, ...[groups]... communities and organisations gain mastery over their lives in the context of changing their social and political environment ... [i.e. their workplace] ... to improve equity and quality of life" (p. 251).

As noted above, King (2005b) argued that any interventions devised to facilitate the process of empowerment in respect of eliminating workplace violence must create the change on a personal (intrapersonal), interpersonal and organisational level. King's (2005b) intervention strategy was orientated towards facilitating behaviour change in individuals (the intrapersonal dimension), the group (nursing personnel, and the interpersonal dimension) and as pertains to the healthcare organisation (the organisational level). King's (2005b) intervention strategy was guided by a model of behaviour change, the theory of reasoned action / planned behaviour (Fishbein and Ajzen as cited by Nutbeam and Harris, 1999), and an organisational change model.

2.8 Limits of interventions

A critique of the behaviour change models from Airhihenbuwa and Obregon (2000) notes that these models are cognitive models that assume that individuals are rational decision makers. Airhihenbuwa and Obregon (2000) further argue that research has evidenced that individuals do not necessarily approach health issues (e.g. workplace violence) from a logical and rational perspective. Naidoo and Wills (2000) argue that this is because theories of behaviour change are underpinned by assumptions that disregard the individual's context. These assumptions are that an individual's behaviours are determined by: their attitude to the behaviour, their perceived behavioural controls and subjective norms - all of which in turn inform that individual's intention to adopt specific behaviours. King's (2005b) strategy to address workplace violence attempted to overcome these limitations posed by using a cognitive behavioural model by simultaneously using a model of organisational change. Notwithstanding this, Nutbeam

and Harris (1999) argue that while the behaviour change models have been useful in the context of traditional preventive health initiatives, e.g. health education programmes, a number of limitations exist with regard to their applicability in complex situations and with regard to socially determined behaviours, e.g. responses to workplace violence:

“[These models are] ... limited to accounting for as much of the variance in an individual’s ... behaviour as can be explained by their attitudes and beliefs. It is clear that other forces influence ... actions as well...” (p. 21).

The forces referred to are those pertaining to socio-structural (e.g. race and patriarchy), socio-economic (class), environmental and organisational conditions – forces which create and maintain barriers to behaviour change and ergo which create barriers to the empowerment of nursing personnel in respect of their being able to effectively manage workplace violence. While the easy view would be to see this as a particularly South African problem, global literature has addressed such pressing issues of context and culture cogently.

From a United States perspective, an example of an organisational condition that perpetuates unhealthy workplace relations is that of the ‘blaming triangle’ (Lanza, 1992 as cited by McKoy and Smith, 2001). McKoy and Smith (2001) note that in addition to facing an emotional dilemma in respect of whether or not to report on an incident of workplace violence, that the situation is further compounded by the organisational dynamics of the ‘blaming triangle’. In these situations, the victim of the workplace incident blames him or herself or authority figures for the incident, colleagues blame the perpetrator of the incident and the organisation in turn blames the assaulted worker. The

'blaming triangle' serves the organisation in that it enables it to maintain that no problem exists and therefore no actions to remedy the situation are taken (McKoy and Smith, 2001).

Paterson, Leadbetter and Miller (2005) in a paper that explores contemporary organisational approaches to workplace violence in health care settings in the United Kingdom, corroborate the above in that they have observed that there is a tendency for workplace violence intervention programmes to focus on the individual – in terms of providing personnel with training programmes to manage workplace violence effectively. Paterson et al. (2005) suggest that this approach is reductionist because it suggests that the problem of workplace violence is an outcome of interpersonal conflict, and does not recognise the organisational and societal roots that have precipitated and /or which perpetuate the violence. They argue that a radical (organisational) cultural shift is needed such that the precipitants of the violence are recognised and remedied (Paterson et al., 2005).

In addition to socio-economic, environmental and organisational conditions, McKoy and Smith (2001) note that gender distribution and experience of workplace violence may be linked to the structural variables of patriarchy and to the traditional role socialization of women. McKoy and Smith (2001) argue that while nursing has historically been a female profession, and that the traditional role socialization of women does not extend to being 'victims of violence', nurses as women first and foremost are socialized to "focus on listening, nurturing, affiliating ... [and to be] ... sensitive to the needs of others" (p. 7).

This traditional role socialization does not foster the development of egalitarian work ethics, mutual respect or power sharing in the workplace, or between healthcare professionals themselves. King (2005a) argues that patriarchal ideology has devalued the status of the nursing profession and that nursing personnel are therefore more vulnerable to abuse in the workplace.

While Ms. Shaida Bobat (2006, personal communication, May 12) argues from a South African perspective that the experience of workplace violence is not unique to nursing personnel and the nursing workplace, United States researchers have found that, although violence can occur in any environment, healthcare workers are at high risk for violence (McKoy & Smith, 2001; Hoel & Brennan, 2005). McKoy and Smith (2001) quote statistics from the United States that healthcare workers are “at 16 times greater risk for violence than other workers” (Bureau of Labor Statistics, 1994, as cited by McKoy and Smith, 2001, p. 5), and argue that nurses are more frequently assaulted than any other worker group.

2.9 Legal Aspects of Workplace Violence

Human dignity, the achievement of equality and the advancement of human rights and freedoms, non-racialism and non-sexism are the foundations of the *Constitution of the Republic of South Africa*. The Bill of Rights enshrined in Section Two of the Act specifically articulates that everyone has inherent dignity and the right to have their dignity respected and protected; that everyone has the right to be free from all forms of violence from either public or private sources and that everyone has the right to fair

labour practices (Act 108 of 1996). From the discussion and literature review evidenced above, it is clear that the rights of those nursing personnel who have experienced and who continue to experience workplace violence have been infringed upon.

In the absence of explicit South African studies focused on legal frameworks of hospital workplace violence, McKoy and Smith's (2001) exploration of United States legislation provides useful guidelines. McKoy and Smith (2001) note that employers have a duty to provide a safe work environment, and that they furthermore have a duty to 'deter and control' violent incidents. Employers who fail to provide a safe work environment may be found liable for not having done so, and McKoy and Smith (2001) note that workplace violence litigation in the United States has "increased dramatically, with an average out-of-court settlement of \$500 000,000 compared with \$3 million for a jury award" (p. 10). Aside from lawsuits that have been brought against the employer by victims of workplace violence and/or their families, it is a general expectation among employees that employers provide a safe and peaceful work environment (McKoy & Smith, 2001).

In respect of the legal considerations pertaining to workplace violence, McKoy and Smith (2001) cite a number of legal theories that may be used by a victim of workplace violence to bring a case against an employer namely the doctrines of 'respondeat superior', 'negligent hiring', 'negligent retention' and 'voluntary assumption of the duty to protect'. Each of these doctrines will be discussed below.

The doctrine of *respondeat superior* is based on the concept of vicarious liability and it is traditionally used to find liability (on the behalf of the employer) based on negligence, e.g. in respect of providing a safe and peaceful work environment, and in particular in respect of holding the employer responsible for the actions of others, e.g. other employees or customers. McKoy and Smith (2001) note that in order to find an employer liable for an act of workplace violence the employee will need to establish that their injury (physical and/or psychological) was caused by the employer's breach of duty to provide a safe work environment, i.e. that there was a causal connection between the employer's breach of duty (i.e. negligence) and any injury sustained. In the South African context, this researcher has noted that a provincial hospital in the DMA is currently being sued by a nurse for "serious injuries due to the negligence of a fellow nurse" (Beharie, 2006, p. 7). The case is being pursued under the doctrine of respondeat superior, and relates to a charge of malpractice, which resulted in the nurse suffering serious physical and psychological trauma, and loss of earnings due to her not being able to work for three months. A key limitation of the respondeat superior doctrine however is that it does not hold employers responsible for the intentional acts (torts) committed by their employees and/or customers, and as McKoy and Smith (2001) note, incidents of workplace violence are usually intentional in nature and therefore litigation grounded in the doctrine of respondeat superior may be of limited use unless the plaintiff can show otherwise.

The doctrine of *negligent hiring* refers to the hiring of employees who are not suited to a particular workplace environment as evidenced by their having previously manifested a history of sub-optimal and/or violent behaviours in these contexts (McKoy & Smith,

2001). In contrast to the doctrine of respondeat superior, the doctrine of negligent hiring obliges employers to:

“hire and retain employees who would not pose a danger to other employees [and hence] ... a worker injured as a result of violence could recover damages due to the employer’s breach of duty in hiring the violent offender” (McKoy & Smith, 2001, p. 10).

Should an employer not conduct a thorough pre-employment screening, and should it be evidenced that an employee had a history or propensity towards violent behaviour, then this doctrine unlike the doctrine of respondeat superior, holds the employer directly responsible for the act of violence (McKoy & Smith, 2001). While it is evident that a victim of nursing workplace violence may be able to use the doctrine of negligent hiring in situations of workplace violence that involve nursing colleagues, it is evident that the application of this doctrine in the private health sector in South Africa may be difficult. This is because in the private health sector, e.g. where a doctor has been identified as the perpetrator of an incident of workplace violence, she or he is not considered to be employed by the healthcare facility but is rather perceived to be its customer. It thus follows that a suit based on a doctrine of negligent hiring would be unsuccessful.

The doctrine of *negligent retention* holds employers directly liable for retaining those employees whose behaviour has been found to be unsuitable to a particular work environment. In essence, the doctrine of negligent retention argues that once an employer is aware that an employee poses a threat, then they have an indisputable responsibility to ensure the safety of third parties (McKoy & Smith, 2001). As with the doctrine of

negligent hiring, while this argument may hold in respect of incidents of workplace violence perpetrated by colleagues, its applicability in South African cases where some members of the health care team are not accountable to the healthcare facility's management structures is in doubt.

In terms of the doctrine of *voluntary assumption of the duty to protect*, employers are obliged to provide adequate security in the workplace (McKoy & Smith, 2001). Security in this instance refers to the provision of reasonable safety measures that are consistent with potential and/or identified threats. As discussed previously, there are growing concerns regarding the safety and security of nurses in the South African context (Kgosimore, 2004). A recent serious physical assault of a heavily pregnant nurse on duty in the Pretoria Academic Hospital casualty unit has served to highlight the problem of workplace violence and the inadequacy of hospital management in assuring the safety and security of their employees (Hosken, 2007). In this case, while hospital management were of the opinion that security services were adequate at the hospital, it is clear that on this occasion the service was inadequate and failed the staff member concerned.

In reviewing the above legal theories, this researcher takes the position that nurses have a legal right to take action against their employers for incidents of workplace violence that involve fellow employees, members of the public and /or patients. What was not clear was how nursing personnel could legally address incidents of workplace violence that were more insidious, e.g. petty victimization and/or sexual harassment, and in the particular institutional / organisational dynamics of the South African private sector.

In their paper, McKoy and Smith (2001) concluded that since nursing personnel were often the targets of workplace violence, they should play a pivotal role in its prevention. They suggest that this could be done by means of sensitizing nurses to workplace violence, e.g. by getting nursing personnel involved in the policy making regarding workplace violence and to participate in risk management initiatives. They further note that nurses “need to have a better understanding of their legal rights related to the issue of violence in the workplace” (p. 13).

In the South African context, in an article on workplace violence in the operating theatre, Pieterse (2006) notes that aside from the fact that “skilled peri-operative practitioners are leaving South Africa at an alarming rate ... [because of] ... the attitude, work pressure, stress, and lack of consideration that they have to put up with at the hands of employers, doctors and ... colleagues” (p. 32), operating theatre nurses are often denied basic rights afforded to them under the *Basic Conditions of Employment Act* (Act 75 of 1997 as amended), e.g. lunch and tea breaks. This is ostensibly done to accommodate the requirements of the surgeon and management team. This ‘forfeiting’ of lunch, tea, going off duty timeously and being ‘on call’ everyday to cater for possible emergency cases is allegedly undertaken ‘willingly’. There is nothing on paper that demands that the staff forfeit their tea and lunch breaks and work in excess of 12 to 14 hours per list, however the pressure to keep the customers/ doctors ‘happy’, to meet financial targets at the end of each month and to do as much work with as few people as possible, has resulted in the above situation becoming ‘the norm’ in South African private hospitals.

Where nurses have protested regarding the above having become a norm, hospital management are quick to refer them to a clause in their job descriptions which states that the nurse is required to be on duty as and when required to 'cater for the exigencies of the service' (King, 2005a). King (2005a) argues that the term 'exigency of the service' refers to an emergency situation, e.g. in the operating theatre context to waiting for and receiving a patient with a gunshot or stab wound, and that it does not pertain to non-emergency situations, e.g. booked (cold) cases. It is clear that this clause has been interpreted out of context and is open to abuse – particularly where it has been invoked to persuade staff to stay on duty for non-emergency cases, to finish over-booked slates and to cover the unit when short staffed. This thesis takes the position that the practice described above is a form of bullying of nurses by hospital management and as such that it is form of process violence as described by Van Wyk, (2003). As Pieterse (2006) notes, "nurses become part of an oppressed group ... dominated by doctors, administrators and nursing service managers" (p. 32). Clearly South African theatre nurses need to develop a keener understanding of their legal rights.

2.10 Conclusion

It is evident from the literature reviewed that the concept of workplace violence is broad and that it has ambiguous boundaries. On the one hand, workplace violence is narrowly defined as, "violent acts (e.g. physical assaults and threats of assault) directed toward persons at work or on duty" (United States Centers for Disease Control and the National Institute for Occupational Safety and Health (CDC/NIOSH), 1996 as cited by McPhaul & Lipscomb, 2004, p. 170); and on the other, it is broadly defined as encompassing,

“physical and psychological violence, abuse, mobbing or bullying, racial harassment and sexual harassment... [in respect of] ... interactions between co-workers, supervisors, patients, families, visitors and others” (McPhaul & Lipscomb, 2004, p. 170). McPhaul and Lipscomb (2004, p. 170) note that in order to assist employers and policy makers in their management and intervention in situations of workplace violence, the University of Iowa Injury and Prevention Research Center in the United States, developed a typology of workplace violence and classified workplace violence into one of four categories namely:

Type I (Criminal Intent): Results while a criminal activity (e.g. robbery) is being committed and the perpetrator has no legitimate relationship to the workplace.

Type II (Customer/client): The perpetrator is a customer or client at the workplace (e.g., health care patient) and becomes violent while being served by the worker.

Type III (Worker-on-Worker): Employees or past employees of the workplace are the perpetrators.

Type IV (Personal Relationship): The perpetrator usually has a personal relationship with an employee (e.g. domestic violence in the workplace).

While McPhaul and Lipscomb (2004) acknowledge that healthcare workers are exposed to all of the four types of workplace violence, the emphasis in their study was on Type II violence (threats and physical assault against nurses by patients, their visitors and/or their families). In the literature reviewed to date, little research on Type III violence - incidents

of workplace violence that occur between healthcare professionals - is evident both in international and in South African contexts.

In examining the available literature with regard to the context and type of workplace violence incidents reported internationally and nationally it appears that many of the factors associated with Type II incidents of violence in the nursing workplace appear to be global in nature, e.g. staff shortages, and increased patient acuities (McPhaul & Lipscomb, 2004). In contrast to the Type II incidents of workplace violence, reported Type III incidents suggest that workplace violence is both precipitated and perpetuated by the environment in which nursing personnel operate (Pieterse, 2006). In other words, different contexts (internationally and nationally) have different rules that govern workplace interaction, communication and that which is deemed to be acceptable or unacceptable behaviour.

This thesis thus posits that a closer analysis of the organisational and social roots of workplace violence, and in particular with regard to the operating theatre nursing personnel, will lead to a better understanding of that which precipitates and perpetuates Type III incidents of workplace violence.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter discusses the interpretative phenomenological approach (IPA) research design that the researcher employed in conducting the study, the population and sample of theatre nurses who were included in the study, and the procedures that were followed in order to obtain the sample. Data collection processes involving interviewing, and the mode of analysis following the IPA guidelines of Smith, Jarman and Osborn (1999) are discussed. The chapter concludes by addressing several ethical considerations, crucial in a study concerning sensitive issues related to workplace violence; and validation of the process and findings, including consideration of the researcher's privileged position of access to and experience in hospital settings.

3.2 Research strategy and approach

The broad paradigm of this research study is located in the qualitative research field. While acknowledging the heterogeneity of qualitative research approaches, the researcher specifically used an IPA. The IPA was used because the researcher was interested in identifying, describing and understanding the subjective experience of individual theatre nurses in respect of their cognitive interpretations and subjective experiences of nursing workplace violence; and because the researcher intended to make sense of the participants' world through a process of interpretative activity. These two aspects of being concerned with an individual's personal perceptions and the process of

interpretative activity are foundational to IPA (Smith et al., 1999). Smith et al. (1999)

note that the specific aim of the IPA is to:

“explore in detail the participant’s view of the topic under investigation ... [and] ... that it is concerned with an individual’s personal perception or account of an object or an event ... [and that the researcher] ... makes sense of that other personal world through a process of interpretative activity” (p. 218).

Crotty (1996) likewise argues that an interpretative phenomenological method uncovers the meaning of human experience in its situated context, and that the approach enables a researcher to describe and interpret the meaning of each of the study’s participant’s subjective experiences in relation to their individual contexts. Thus in this study it was the lived experiences of workplace violence of theatre nursing personnel that the researcher intended to make intelligible.

3.3 Sampling design

The population for this study was all registered theatre nursing personnel who were employed in the operating theatre complex of a private hospital in the DMA.

This population was chosen by the researcher because theatre nurses were identified by Pieterse (2006) as being particularly vulnerable to incidents of workplace violence as perpetuated by co-workers. This population was further chosen by the researcher because operating theatres are generally regarded as being high stress clinical areas and because they are closed units, i.e. operating theatre nursing personnel do not rotate with nursing

personnel in other clinical areas due to the highly specialized nature of the field. Given that patients are anaesthetized intra-operatively and are therefore not an active part of the interpersonal work dynamic intra-operatively, the researcher was thus able to focus this study on the interpersonal dynamics of operating theatre personnel.

This research was carried out in a private hospital in the DMA which was purposively selected as the research setting. The rationale for approaching a private hospital was grounded in a study by King (2005a). King (2005a) noted that while the phenomenon of workplace violence was common across both private and public hospitals in the DMA, it was found to be more of a problem in private institutions. The participants in King's (2005a) study attributed this to their respective institution's management attitude towards maximizing organisational profits at all costs, i.e. to the notion that doctors generated profits while nurses generated costs. This researcher thus posited that a private hospital was the preferred setting in which to explore the phenomenon of nursing workplace violence.

The specific private hospital that was approached by the researcher was additionally chosen for the following reasons: its size, as one of the largest private organisations employing nursing personnel in the DMA; its prominence in the community; and because, as a 'training' institution which conducts nurse education and training programmes, it is primarily affected by internal, external and 'out' migration of nursing personnel and thus has a key interest in retaining its nursing personnel.

3.4 Selection of participants

The sampling design that was employed by the researcher in this study was non-probability purposive sampling since it involved a deliberate choice of participants (Polit & Hungler, 1997; Willig, 2001). Willig (2001) argues that data collection in interpretative phenomenology is “usually based on purposive sampling, whereby participants are selected according to criteria of relevance to the research question” (p. 58). The participants in this study had to meet inclusion criteria for the study, as follows:

- Qualified nurses (Registered nurses)
- Currently working in the operating department (theatre)
- Not in a line management position
- Able to speak and understand English
- Willing to meet with the researcher and be interviewed
- Experience of the phenomenon of workplace violence.

Having obtained ethical clearance for the study from the University of KwaZulu-Natal (see Appendix Two), permission to conduct the study was obtained from both the Department of Health and the relevant authorities at the institution concerned, i.e. the Chief Nursing Services Manager and the Theatre Manager (see Appendices Four and Six). Once permission to conduct the study on hospital premises and to approach the staff had been obtained, the researcher then approached the theatre secretary for a list of theatre nurses working in theatre. In addition to making contact with the theatre nurses by means of a covering letter - wherein the researcher explained the purpose of the research and requested those personnel who were interested in participating in the study to contact the researcher (see Appendix Seven) - the researcher also displayed a notice on the

theatre notice board inviting theatre personnel who met the inclusion criteria for the study to take part in a focus group (see Appendix Eight). Ethical considerations are discussed in more detail below.

Four theatre personnel responded to the focus group notice and the researcher then conducted a focus group discussion with these four participants. The purpose of the focus group was to explore the participants' subjective experiences of workplace violence and was further intended as a filter to identify suitable participants for the study proper – suitable participants being those who had experienced workplace violence and who were further prepared to participate in the study. The focus group session was additionally used as an aid for obtaining the purposive sample described above, through the sampling technique of snowballing. While only one of the theatre nurses in the focus group was selected for further participation in the study, an additional four theatre personnel were identified by these nurses as having experienced workplace violence incidents. These participants were then contacted by the researcher by means of the covering letter as described above. All four of these participants elected to take part in the study.

The voluntary nature of participation in the study was emphasised, and the participants were all advised that if they decided to participate in the study, they could withdraw at any time. Given the sensitivity of these discussions about workplace violence, anonymity and confidentiality in respect of all matters discussed was assured (see more on ethics below).

3.4.1 Participant demographics

A total of eight participants took part in the study. The sample was mixed in terms of racial grouping. All of the participants were female and most of the participants were in the 30 to 50 year age bracket with the youngest participant being 32 years old and the oldest being 47 years old. The participants' area of speciality was operating theatre nursing and their sub-specialities (surgical domain within the theatre) included general, ENT (Ears, Nose, Throat), orthopaedic, cardiac, eyes, plastic, vascular and neurosurgery.

The qualifications of the participants ranged from those who had qualified as registered nurses by means of the bridging course, to those who had qualified by means of the three year diploma in general nursing, to those who held the four year diploma in nursing (general, community and psychiatric) and midwifery. All of the participants had achieved the Diploma in Operating Theatre Nursing Science as a post basic qualification.

In terms of the nursing hierarchy, the participants represented the level of professional (registered) nurse. Some of the participants had been at their institution for a considerable length of time and had done their basic training at the institution. Three of the participants had been with the institution for over 10 years.

3.5 Data collection process

Given that the researcher intended to provide the participants with an opportunity to share their personal experiences with regard to the phenomenon of nursing workplace violence, it was decided that data would be collected by means of a focus group session and two

semi-structured interviews conducted with each participant by the researcher. The focus group session and all interviews were conducted face to face.

A thematically semi-structured interview format was used. In phenomenological research any questions posed to the participants must be open-ended and non-directive, because these are intended to facilitate the participant's sharing of their experiences (Willig, 2001). Notwithstanding the above, Kvale (1996) additionally notes that the semi-structured interview format accommodates any specific questions and issues that the researcher may need to address and simultaneously allows the researcher a degree of flexibility in terms of 'the order' in which aspects of a phenomenon may be considered. A semi-structured interview format was further selected because interpretative phenomenology specifically works with transcripts of thematically semi-structured interviews (Willig, 2001).

In addition to the above, the semi-structured format permits the interviewees to speak more widely on issues that will be raised either by the researcher or themselves (Denscombe, 1998). Denscombe (1998) argues that the semi-structured interview format "permits... interviewees to use their own words and develop their own thoughts" (p. 113). Thus the researcher posits that the interview format used in this study is suited to the investigation of personal accounts of experiences and feelings, and that it complements the IPA utilized in this study.

The focus group session and first interview were based on open-ended questions that were designed to elicit the participants' direct and indirect experiences of theatre nursing workplace violence and the meanings attached to them (see Focus Group and Interview Schedule, Appendix One). Interview questions (and prompts) were carefully formulated firstly to directly address the five research questions of the study (see p. 4); and secondly, to avoid explicit mention of the concept of "violence", which might have different emotional/ physical connotations for participants. The interview was thus built around the following five questions as thematic clusters:

1. How would you describe your current interpersonal relationships in the operating theatre?
2. Are there specific items or incidents that come to mind in respect of workplace incidents that have affected you personally, e.g. a situation in which you felt less than pleased with the events or outcome?
3. What effect did the witnessing of the incident have on you?
4. When X [*a disclosed incident or experience of workplace violence*] happens to you / has happened how do you react to the situation?
5. How should negative workplace incidents be handled?

The second interview was a verifying and follow up interview in which the researcher presented the summarized material from the first interview to each participant, in order to obtain confirmation and clarification of the material. Participants were afforded the opportunity to add new material to the interview at their follow up interviews.

Written consent pertaining to each individual's participation in the study was obtained from each participant prior to the focus group session and the interviews. Furthermore, written consent for the tape recording of interviews was obtained from each participant (see Appendix Seven).

3.5.1 Setting and interview process

Eleven interviews including the focus group interview were conducted with eight female participants. The focus group and individual interviews were conducted at times that were convenient for both the participants and the hospital. The venues for the interviews were mutually agreed upon by the researcher and the participants. The majority of the initial interviews took place within the hospital setting – usually in an unoccupied tea lounge, conference room or area elsewhere within the hospital. Two interviews (RN F and RN M) were conducted away from the hospital. These were conducted in private venues as per each participant's choice.

The privacy of each interaction was ensured and a concerted effort was made to ensure that interruptions were kept to a minimum. Where possible the researcher placed a notice on the door to the venue advising that a 'meeting' was in progress. Despite these efforts, a number of interruptions presented with certain interviews – usually doctors or nursing staff looking for something. Where interruptions occurred, the interview was halted and the tape recorder was turned off until the situation had been resolved. Prior to each interview commencing the voluntary nature of participating in the study, and matters pertaining to confidentiality were emphasized.

At each individual interview a pseudonym (a letter of the alphabet) was chosen by each participant in order to ensure that her identity in the study remained anonymous and that her participation in the study remained confidential. Any incidents of workplace violence that were potentially recognizable were appropriately modified to protect the participants' confidentiality and anonymity (see more on ethical considerations below).

3.5.2 Field notes

Field notes were compiled during and immediately after the interview. The field notes provided the researcher with information regarding the verbal and non-verbal communication patterns of the participant, and on the quality of the rapport established with the participant. The field notes additionally included basic demographic information regarding the age and gender of the participants, and information such as the time, place and duration of the interview.

A synthesis of the field notes with regard to the verbal and non-verbal communications of the participants evidenced that the majority of the participants were uncomfortable discussing matters pertaining to certain collegial relationships in the workplace. This discomfort was conveyed through a noticeable reduction and/ or avoidance of eye contact, by means of a change in body posture (arms folded across the chest), and also by *fidgiting*. With certain participants, discomfort was also conveyed by means of giggling, inappropriate laughter / jokes and silences when awkward situations were discussed.

While a number of participants were emotive in their responses, a large degree of discomfort was expressed by one participant who became flushed and tearful when discussing certain incidents of workplace violence that she had experienced (physical assault and sexual harassment). Where participant discomfort was evident, the researcher asked the participant if she would like to halt the interview, withdraw or reschedule the interview. None of the participants opted to withdraw or to reschedule their interview. Despite the discomfort and tension conveyed by the non-verbal communications of certain participants with regard to specific matters, the majority of the participants were enthusiastic about taking part in the study and wanted to have their opinions and voices heard. The researcher attempted to create a good rapport with the participants by utilizing a basic listening sequence (attending and listening behaviours) that included maintaining appropriate eye contact, summarizing, paraphrasing, and the mirroring of verbal and non verbal patterns.

3.5.3 Difficulties experienced in conducting the research

Despite obtaining ethical clearance from the University Ethics Committee in September 2006 and having submitted the proposal in September 2006 to the Department of Health (see Appendix Three), permission to conduct this study from the Department of Health was only received on the 8th of January 2007. The private hospital was approached on the 10th of January and it took an additional seven weeks for the institution to process the request and to grant the researcher access to their facility. This permission was received on the 28th of February 2007.

It was decided by the researcher and several of the participants that it would be easier to interview them at their place of work. This meant that participants were interviewed while they were either 'on duty' or immediately after the end of their shift. For those participants who were on duty this was problematic because they were not able to relax fully and were constantly watching the time to ensure that they were not late in getting back to their theatres. Two participants agreed to be interviewed on their 'day off' at a venue of their choice. This was found to be more conducive to the interview process. A further problem encountered by the researcher was that many of the participants – although eager to participate, initially regarded the study and the researcher with a degree of apprehension – as if the study was part of a 'spying operation'. The researcher found that she had to spend time allaying participants' fears, and had to repeatedly emphasize the fact that she was not aligned to any of the institutions or their management structures, that participation was voluntary and that all material was confidential. Once this had been established the participants were more at ease with being interviewed and with discussing their interpersonal relationships in the workplace, incidents of workplace violence (either those personally experienced or witnessed) and other relevant matters.

3.6 Data analysis

While Kvale (1996) posits that the analysis of qualitative data evidences a continuum between description and interpretation, Smith et al. (1999) argue that data analysis in IPA is primarily a dynamic and interpretative process. Notwithstanding this, Willig (2001) argues that any description and interpretations that arise from the data, e.g. themes, clusters of concepts, and categories, must be grounded in the data itself. Generally, there

are three phases of qualitative data analysis: first, the structuring of the interview transcript; second, clarification of the material by eliminating superfluous items, e.g. repetitions, digressions and anything regarded as irrelevant to the research question; and third, the analysis 'proper' (Kvale, 1996).

In terms of structuring the data to be collected in this research, the researcher personally transcribed each of the interviews from the taped recordings made. Each transcription (hard copy) was then checked against the relevant recording and "cleaned" of obvious speech hesitations or repetitions. This process, together with the reading and re-reading of each text facilitated the researcher becoming immersed in the text and in each participant's narrative. When conducting the analysis 'proper', the researcher worked through each transcript line by line in accordance with the guidelines set out by Smith et al. (1999, p. 220), as follows:

1. Read and re-read each interview transcript; use one margin to record initial thoughts, observations, associations and preliminary interpretations in response to the text, and use the other margin to document emerging theme titles and/ or key words that capture the "essential qualities" of the material.
2. On a separate sheet, list the emerging themes from each transcript and look for connections between them and/or for themes that cluster together.
3. Check back to the transcript to ensure that the connections are grounded in the *primary source material*.
4. Produce a coherent and ordered master list of themes.
5. Translate the themes into a narrative account.

The researcher thus read and re-read each transcript several times and used the left hand margin to record initial thoughts, observations, associations and preliminary interpretations in response to the text, and the right hand margin to document emerging theme titles and/ or key words that captured the “essential qualities” of the material. The themes that emerged from each transcript were then recorded on separate sheets of paper and the researcher then examined these looking for connections and for themes that clustered together. Given that the interview was thematically structured by the scheduled questions, Smith et al. (1999) note that themes will form natural clusters in respect of shared meanings and references and /or in respect of hierarchical relationships. Themes that were found to be common were grouped together, i.e. clustered by the researcher. Having reduced the data for each transcript in this way the researcher then produced a master list of themes which contained both superordinate themes and sub-themes. The master list of themes and the researcher’s interpretative analysis of them was then used by the researcher as the basis for describing and interpreting the theatre nurses’ subjective experiences and perceptions of workplace violence (see Table 4.1).

3.7 Ethical considerations

3.7.1 Negotiating consent

Ethical clearance and written permission to conduct the study was obtained from the University of KwaZulu–Natal’s Faculty of Humanities, Development and Social Sciences Research Ethics Committee (see Appendix Two). Thereafter, written permission was obtained from the Department of Health in Pietermaritzburg and from the Chief Nursing Service Manager and Theatre Manager at the private hospital selected to take part in the

research study (see Appendices Four and Six). The Department of Health, as one of the conditions in giving their approval for the study, has requested a copy of the research study.

It is noted that the researcher's prior professional training and experience as a theatre nurse, and her prior research study with the Department of Health (King, 2005a), may have contributed to gaining access to the hospital. Access may have been further facilitated by the researcher stipulating that no costs or inconvenience were to be incurred by the hospital, and through the suggestion that the benefit to the hospital would be in terms of the results obtained and how these could be applied by middle and senior hospital management to aid in the recruitment and retention of nursing personnel in the operating theatre. A copy of the dissertation will thus be given to hospital management. Gaining permission to conduct the study was a vital step in ensuring access to the institution, and further enabled the researcher access to the hospital's premises and information regarding personnel at the institution, i.e. the names of the registered nurses working in the operating theatre complex. All of the participants in this study were informed that the Department of Health and hospital management would be given copies of the study and that permission to conduct the study had been received from the relevant authorities in the covering letters sent to them (see more on ethical considerations concerning confidentiality and anonymity below). This above process was necessary in order to show that:

- The rules and regulations with regard to the organisation had been complied with – in respect of conducting research on their premises.
- Management had given permission for the participant's details (names and current units that they were working on only) to be released to the researcher, and
- Those staff who wished to participate in the study were permitted to do so.
- The researcher was committed to being transparent in terms of to whom the study's results were to be fed back.

As stated previously the initial communication with participants was:

- Via the theatre manager and theatre secretary who informed their personnel of the research undertaking, thereby formally establishing the researcher's credentials;
- Via a notice on the staff notice board inviting potential participants to a focus group on workplace violence.
- Via a covering letter that was given to each registered nurse who potentially met the criteria for the study.

The participant covering letter (see Appendix Seven) explained the nature of the research study and emphasized that participation in the study was voluntary. Participants were advised that they could withdraw at any time from the study, and that their privacy and right to confidentiality and anonymity would not be breached in any way. This was particularly important since the perception had to be countered that the research study was instigated or aligned with hospital management, and thus fears of being victimized were allayed. Confidentiality was maintained by: ensuring that the names, identity, employee and contact numbers of the participants were not recorded on any of the transcripts, and by using pseudonyms on these documents. The participants' names, pseudonyms and contact details were kept in a safe, locked place away from the

transcripts. Participant anonymity was assured by suitably modifying any potentially recognizable workplace incidents. The anonymity of the organisation was additionally ensured by blanking out the organisation's identifying details in all correspondence entered into (see Appendices Five and Six).

Although participation in this study denoted the informed consent of the staff member concerned, written permission to record the interviews and written consent pertaining to their taking part in the study was further obtained from each participant. A consent form was attached to each covering letter and this was completed and signed by each participant prior to the commencement of each interview. During the research process, the tapes were kept in a safe, locked place. The researcher's contact details, and credentials were recorded in the covering letter, and this has given all of the participants the opportunity to contact the researcher if they wished to do so. Given that the research topic may have been experienced as traumatic and stressful for the study's participants, provision was made for free, professional counselling at the School of Psychology clinic. The contact details for the Clinic Director were included in the participant covering letter.

After the research study was completed all of the participants' tapes and transcripts were destroyed by the researcher and a full set of transcripts without identificatory details were lodged with the researcher's supervisor as per University of KwaZulu-Natal ethical protocol. These transcripts will be kept for five years, kept in a secure, locked place. After five years these will be destroyed by the researcher's supervisor. As stated

previously, a copy of the dissertation will be given to the Department of Health and to hospital management.

3.8 Trustworthiness of the research

There are four broad criteria by means of which the trustworthiness of a qualitative study may be established: truth value (credibility), applicability (transferability), consistency (dependability) and neutrality (Guba, as cited by Krefting, 1991).

Given the heterogeneity of qualitative research methodology, establishing the trustworthiness of this IPA study required the researcher to focus on validation measures pertinent to interpretive studies. With reference to the above, seeking validation by means of the criterion of neutrality was not appropriate in this study. This is because gaining access to an insider's perspective of the phenomenon of nursing workplace violence was "complicated by the researcher's own conceptions ... [which] ... are required in order to make sense of that other personal world through a process of interpretative activity" (Smith et al., 1999, p. 219). This subjective and interpretative process means that the criterion of neutrality was of limited import in this study. However, where neutrality has been taken to mean 'confirmability' of the study such that "the data are linked to their sources for the reader to establish that the conclusions and interpretations arise directly from them" (Holloway & Wheeler, 1996, p. 168), the researcher has sought to establish the confirmability of the study by using and linking the participants' own words and expressions - used in illustrating and clarifying themes identified and points made - back

to the text (more on this below). This practice is supported by Smith et al. (1999) who note that “good ... [interpretative phenomenological] ... qualitative work clearly distinguishes between what the respondent said and the analyst’s interpretation or account of it” (p. 227).

The credibility of this research has been approached in several ways. Smith et al. (1999) further emphasize that when using IPA, the researcher needs to engage with the data in a reflexive and interpretative manner and thus part of establishing the credibility of the IPA research study requires the researcher to acknowledge the reflexive and interpretative process undertaken. As Kvale (1996) posits, the difference between a bias and a perspective is that bias is hidden and is not acknowledged. In establishing the credibility of this study further, The researcher acknowledges the following perspectives with regard to the phenomenon of nursing workplace violence in a private hospital in the Durban Metropolitan Area, in one operating theatre complex.

The researcher’s own experience of having worked as a registered nurse in operating theatres in public and private sectors, both nationally and internationally, has lead to the belief that the turnover of nursing personnel is directly proportional to the management styles and work conditions in operation at an institution. Thus, the experience of workplace violence is ingrained in the everyday lived experience of being a nurse and particularly in respect of being a nurse in a high stress occupational context such as an operating theatre.

It is noted that the researcher has conducted and published research regarding the hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban Metropolitan Area (King, 2005a). The researcher's prior research has suggested that where poor employee/ employer and other interpersonal relationships exist, and where nurses are subject to less than satisfactory work conditions, it is inevitable that job dissatisfaction and migration of personnel results (King, 2005a). The researcher firmly believes that financial gain is not the sole motivator in precipitating migration across sectors and /or out of the nursing profession. The researcher additionally believes that the traditional view of nursing as a 'woman's profession' has done irreparable damage to the profession and its practitioners, and that this is especially so in a patriarchal and divided society like South Africa where women (and nurses) are still regarded as social inferiors – despite a progressive Constitution that espouses equality between men and women. The researcher has further observed that nurses are treated with contempt and disdain by their doctor colleagues and others in health care disciplines, and posits that this has exacerbated the current low morale evident in the profession, and that it has further exposed nursing personnel to unacceptable experiences of workplace violence.

In essence the above acknowledgment by the researcher of having worked as a registered nurse in the operating theatre previously and of having a perspective regarding the nursing profession and in particular with regard to the phenomenon of workplace violence, and having conducted and published research in this field, lends credibility to the study. This is because it conveys the information that the researcher, although not an

'insider' in this operating theatre, has not only been reflexive about the phenomenon but has further been able to engage with and interpret the participants' data in a dynamic and understanding manner.

Additional measures taken to ensure the credibility of the study was by means of the researcher ensuring that while the identities of each of the participants and the participating organization were not documented in the study (being referred to throughout by means of pseudonyms), that the participants were accurately described by means of appropriate demographic information. Prolonged engagement with each participant in the form of an initial interview followed by a clarifying interview further enhanced the credibility of the study. The clarifying interview enabled the themes, connections and clusters identified by the researcher to be presented to each participant for verification and clarification. By engaging with each participant in an earnest, unobtrusive manner the researcher was able to establish rapport and build trust with each participant, and this in turn encouraged a more spontaneous and authentic (credible) response from each participant (Holloway & Wheeler, 1996).

Credibility was further enhanced by the researcher presenting the data, data analysis and conclusions drawn for 'peer debriefing'. 'Peer debriefing' involved the researcher presenting the data (transcriptions), data analysis and conclusions to a researcher/supervisor who has experience in research, and in the research method used in the study, for evaluation. The strategy of 'peer debriefing' ensured that rigour was applied in the

research process, ethical considerations, data collection, analysis and in respect of the conclusions drawn in the study (Holloway & Wheeler, 1996).

Transferability of the study was facilitated by the researcher providing the reader with a thick description in respect of the demographics of the individuals who participated in the study, their workplace context and experiences of workplace violence. Readers will thus be able to assess and decide on the transferability of the findings of this study to their own context (Krefting, 1991).

The dependability of this study was established by means of external checks and by a process of audit - by means of which the data analysis and conclusions drawn were authenticated by the researcher's supervisor. Where the researcher has used the participants' words to illustrate points and themes, these have additionally been referenced in a particular way so as to facilitate the auditing process e.g. 'TT/5/44' means 'transcript of Sr T, page five, segment 44. In this way the data was directly sourced from a participant's account. Member checking was additionally employed – the researcher presented the summarized data and conclusions drawn from each interview back to the respective participants for validation and clarification. Brink (1996) argues that this process enables the researcher to obtain feedback about the accuracy of the content of the interview and thus increases the dependability of the study.

CHAPTER FOUR: THEMATIC FINDINGS

4.1 Introduction

This chapter describes the thematic findings of the study. These findings are interpreted, discussed and contextualized in relation to the research questions and reviewed literature in Chapters Five and Six. This study used the IPA process suggested by Smith et al. (1999) and identified the connections and themes in respect of shared meanings and references and /or in respect of hierarchical relationships in each transcript. Given that a thematically semi-structured interview schedule was used, themes that were found to be common were grouped or clustered; and other themes appeared in a more emergent way. Having reduced the data for each transcript in this way the researcher then produced a master list of superordinate themes and sub-themes. The list of eight superordinate themes and associated sub-themes is presented and discussed in this chapter. A summary is presented as Table 4.1 below. The eight themes are clustered as follows: first, workplace violence as perpetrated by doctors and the meanings attributed to these; second, workplace violence as perpetrated by nurses and the meanings attributed to these; thirdly, workplace violence and the culpability of management and the meanings attributed to these, and finally, the psychological effects of workplace violence on the theatre nurses and the strategies employed by the nurses to cope with workplace violence.

Table 4.1: Superordinate themes and sub-themes

Superordinate themes	Sub-themes
Workplace violence perpetrated by doctors	<ul style="list-style-type: none">• Verbal abuse• Intimidation and bullying• Humiliation• Physical assault• Sexual harassment
Interpreting the occurrence of workplace violence as experienced from doctors	<ul style="list-style-type: none">• Lack of respect for nurses and class consciousness• Surgeon temperament, perfectionism and the 'artist'• Surgeon insecurity and inadequacy• Surgeon expectation: unrealistic performance and service expectations• Being spoilt, expectations of entitlement and control issues• Misogyny• Differential treatment of staff, racism
Workplace violence perpetrated by nurses	<ul style="list-style-type: none">• Verbal abuse• Abandonment• Ignoring• Bullying, victimization and double standards
Interpreting the occurrence of workplace violence as experienced from nurses	<ul style="list-style-type: none">• Expectations, standards and performance pressure• Territoriality• Personality, attitude and the bringing of personal problems to work• Victim blaming, self blame• Feelings of Insecurity and inadequacy• Short staffing and exigencies of the service

<p>Hospital Management and workplace violence</p>	<ul style="list-style-type: none"> • Victim blaming • Lack of support and fobbing off of staff complaints • Grievance procedure
<p>Interpreting management's handling of workplace violence incidents</p>	<ul style="list-style-type: none"> • Fiscal considerations • Social considerations and other vested interests
<p>Effects of workplace violence for the self</p>	<ul style="list-style-type: none"> • Doubt, loss of confidence and self esteem • Loss of trust • Avoidance, Resentment • Feeling belittled, degraded and humiliated • Feelings and emotions • Stress, exhaustion, and being mentally drained
<p>Strategies for coping with workplace violence</p>	<ul style="list-style-type: none"> • Keeping the peace, keeping quiet, stoicism • Prayer and professionalism • Avoidance and withdrawal • Intellectualization, rationalization, minimization • Over-compensation and humour – the 'court jester' • Venting to colleagues, support networks, crying, and comfort eating • Altruism, ethical conduct, and honesty

4.2 WORKPLACE VIOLENCE PERPETRATED BY DOCTORS

In this study a variety of workplace violence experiences, both those experienced personally and those witnessed and as perpetrated by doctors, were evidenced in the participants' accounts of their work experiences and interpersonal relationships.

4.2.1 Verbal abuse

The researcher noted that all of the participants had experienced and/or had witnessed verbal abuse as perpetrated by their doctor colleagues. Experiences of verbal abuse are illustrated in the following excerpts:

"In theatre it ... [the verbal abuse] ... is more from the doctors to nurses than nurses to nurses ... it is doctors to staff' TFG/34/678-680.

"Some ... [surgeons] ... get very loud, some become a bit ... verbally abusive ... they will like become extremely personal ... and ...they swear!" TI/2/38-40.

"I don't do plastics generally ... if I have to I will ... and you know ... I wasn't fast enough for him, I wasn't draping quick enough ... and then under his breath he ... continuously mumbled these nasty remarks ... but I can hear him because I am here right next to him ... and ... he is like ... [saying] ... 'you know aren't you even awake? When did you wake up ... when did you even get here? Heh you fucking people man" TT/6/88-90.

"I scrubbed up with him one weekend and I had to hold something ... I am right handed so I cannot really cut with my left hand ... all he said to me is 'has nobody ever 'effff' ...[fucking] ... taught you how to cut with your left hand?"TT/6/84.

"There is another surgeon that misbehaves and swears staff ... and chases them out ... I have witnessed him swearing ... [at the] ... nurses ... chasing them out ...; he ... is revved up – he is like a bull! And a staff member will walk in there and she will just take a packet and he will say 'Fuck off out the fucking theatre!'.... Just exactly like that, 'you are fucking making noise man!' ...'.... She will be taken out the theatre and somebody else will be put in ... and every time he swears or misbehaves ... same thing" TI/7/159, 167, 171.

While verbal abuse was commonly experienced by all the participants it was further evident that the verbal abuse was predominantly perpetrated by one surgeon in particular and that the verbal abuse ranged on a continuum from sarcasm, to vitriolic and personal attacks on the nursing personnel as illustrated by the following:

“He is rude ... he swears ... he shouts ... he will throw things on the floor ... he is like a ... a spoilt child ... and he picks on your ... sort of sensitive points. Like one of the girls that works there is a Catholic ... very strong Catholic and he **will prod** [*strikes the table with her hands to emphasize her point*] her with that and make comments about the Catholic religion – and ... it affects her ... he gets intensely personal ... when I was a vegetarian he used to do that with me” TFG/23/420-422.

“he is so **abusive** towards Sr Q ... she leaves his theatre constantly in tears” TFG/23/436.

“well it is like the way he says ... **‘you are an idiot!’** ... one day he had a confrontation with someone on the telephone ... [during a case and the scrub sister] ... said to him ‘maybe you should continue communicating with that person after the case’ ... [and he said] ... **‘who the hell do you think you are to tell me what to do and how to do it?’** and she said ‘well ... it is just that I know that you are stressed by the procedure that we are doing now and that person on the other end of the phone is making the situation worse ... and the more angry you get the worse it is for this patient that is on the table’ ... [and then he says] ... ‘are you trying to tell me I am incompetent? **I am not an incompetent fool like you**” TM/14/119.

4.2.2 Intimidation and bullying

The experience of being intimidated and/ or bullied by surgeons was not uncommon to the participants. The following excerpts evidence intimidatory and bullying behaviours:

“On Friday when she went back into his theatre to relieve somebody ... he said ‘get out!’ ... She just stood at the door ... and he said to her ‘...Get out..!’” TFG/27/503-505.

“You know what he is just plain out nasty! When I first went in there one day ... I was sent there to go and relieve someone for tea ... I went in and I said to the person ‘I am relieving you for tea’ ... [whispers] ... so she went out... and then I stood there and he turned around from the table and he said to me ‘what are you doing here?’. So I said to him ‘... I have to relieve someone for tea here ...’; then he turned around and continued his case. You are **not** allowed to ... [even] ... crinkle paper in that theatre” **TT/5/80**.

“He would come from scrubbing up ... [and] ... I am standing with my back against ... a trolley where they put all their specimen containers ... I am standing with my back there, away from the table – the table is ... [over] ... there ... then he will walk straight to me – he will stand in front of me and he will say to me ... he **has** done this, ‘you are in my way’ – but I don’t know where else to go because I am with my back against the further side of the wall ... [voice trembles] And all I could do ... I ... I just stood there and I said ‘where do you want me to go?’ ... then he turned around and he walked to the table” **TT/5/80**.

“One of the other sisters... told me this ... she says she was doing charging and in the back of her head she heard him say ‘has anybody ever thrown a scalpel at you?’... she ... [said that she] ... didn’t even hear him because ... [she was] ... busy with something else and that she thought he was talking to the scrub sister or the anaesthetist or someone else ... and she continued doing things. ... she says the next thing ... out the corner of her eye she sees shoes. And when she looked up he stood in front of her and he said to her ‘has anybody ever thrown a scalpel at you?’ – because she was doing charging in his theatre... said she just kept quiet and looked at him and he turned around and walked back to the operation” **TT/6/82-84**.

“One of our staff members that worked over here ... one of the doctors (Dr X) called her a kaffir bitch ... and she went through to Council, she took it the ten yards ... I tell you she took it all the way. And he mocked and laughed about her ... about how he was going to sue her and sort her out! Put the fear of daylight in the rest of us!” **TI/21/477**.

Most of the participants had experienced intimidation and bullying by certain of their doctor colleagues. Overt intimidation was indicated through an individual’s demeanour e.g. pacing restlessly up and down, by shouting at staff to get out of the theatre for no reason and through being obstructive, e.g. by cornering staff members and making out as if the staff member was in one’s way. Covert intimidation and victimization were

additionally evidenced in the account of Sr I who had witnessed a particular surgeon referring to a staff member - who had dared to stand up to him- in derogatory terms and by inferring that he was 'going to sue them'.

4.2.3 Humiliation

The experience of being humiliated by surgeons was not uncommon. For Sr M standing up for the rights of an HIV positive patient with regard to the maintenance of proper aseptic techniques resulted in her being humiliated by the surgeon in front of her colleagues and in being hauled before the theatre management:

"He said '... who do you think you are to talk to me like that?'. I said 'I am Sr so and so and I am speaking up for my patient ...', and he ... went irate and stormed out the theatre with his gloves on ... to the matrons office and he said 'matron – this sister I don't know who the hell she is – how dare she question me!'. ... And he said he doesn't ever want me working with him again and ... I have no right – where did I study to get a **doctorate** ... and I don't know more than **him**" **TM/11/88-90**.

Sr F had similarly experienced belittling and humiliating episodes in theatre:

"I didn't have a problem with most of the surgeons ... just one in particular who everyone has had a problem with ... [he is prone to] ... screaming at you, yelling at you ... belittling you in front of everyone in front of the theatre – trying to show you up to be [incompetent] ... telling me '... you are stupid...' [and] ... being told that you should be in sheltered employment" **TF/12/185**.

Sr B likewise experienced humiliation when a surgeon inexplicably and unilaterally decided that he didn't want her working with him for a particular case:

“I was scrubbed up for a minor, minor procedure which was a little lesion on the forehead ... and this particular surgeon ... spoke to my line manager and said that he wants another scrub sister. So ... the line manager phoned ... to see if anybody was available and there was nobody available. So he physically went ... and brought ... another sister and that made me very angry because she had qualified the same year that I had qualified and we had done the theatre course together. I found ... that to be totally degrading” TB/6/96.

Sr B was never given an explanation regarding the above incident. It was noted that feelings of humiliation and of being belittled tended to occur when surgeons had shouted at participants, made accusations of incompetence and treated them like deviant children.

4.2.4 Physical assault

While only one participant, Sr I, had experienced an actual physical assault on her person by a surgeon, the nature of the assault was such that it has remained firmly etched in her memory:

“I was about 8 ½ months pregnant ... the surgeon came to me and said to me ‘...could you please get me two tubes of chloromycetin ointment...’. So I went and fetched it and I held it out – and he took it from me, grabbed me by my shirt ... and then emptied a tube of Chloromycetin into my eye ... he then proceeded to try and do the second eye! ... I became hysterical, I was crying ... he was saying how ‘F-ing stupid I was ... how I should have obeyed his rules ... he was just trying to show me something...’ ... and he then proceeded ... [to say] ... that I was over reacting because I was ... pregnant” TI/2, 3/46-48.

While the remaining participants had not personally experienced a physical assault there was consensus that certain indirect physical behaviours by surgeons were as damaging (threatening) as being directly physically assaulted. The behaviours referred to occurred in non-emergency situations and involved the snatching and/or knocking of surgical instruments out of the scrub sister’s hands, the throwing of instruments onto the floor and

the purposeful throwing of bloody swabs and human tissue either at the scrub sister or onto the floor. The above are illustrated by the following:

“Mr. X has done the same thing ... I was in the theatre and Sr P was scrubbing ... and he threw a swab and it hit the clock. **Boom!**” TFG/33/655.

“It would ... [happen] ... while you were assisting him or even if you were flooring – while you were working in the theatre during surgery ... things being thrown ... like breast tissue ... scalpels” TF/12/189-191.

“You would come with something ... [an instrument] ... and he would knock it out of your hands” TF/13/213.

4.2.5 Sexual harassment

Two of the participants had experienced sexual harassment from doctors. In her follow up interview, Sr F confided how a surgeon had pulled her out of the theatre into the passage, had pushed her up against the wall and kissed her without her consent before walking off. She recalled how she had been very taken aback and shocked at this behaviour but then rationalized the incident and took it in her stride as being ‘Dr. M just being Dr. M’. She stated that because she had been wearing a facemask at the time, (and although the mask had been crushed against her face), and that it had been his birthday at the time, she wasn’t sure if this incident could be counted as an incident of sexual harassment. Since that incident, she noted that this surgeon had made a habit of coming to her for his ‘birthday kiss’ once a year.

For Sr I, who had previously experienced a physical assault from a surgeon, in the time that had elapsed from her first interview with the researcher to her second interview

(approximately a month), a second assault had occurred. Sr I recounted how she had been scrubbing up for a procedure when a doctor had come up behind her and molested her. He had placed his hands on her breasts and had squeezed them. When she had reacted angrily telling him to move away from her and pulled away from him while simultaneously calling for help, she reported that he then threatened her saying that she could report the incident but because there had been no witnesses (he had sent the other nurses out of the theatre on errands) no one would believe her. He furthermore said that she must remember that as a doctor he was 'a customer', and that she must remember what had happened to a nurse at Hospital C who had tried to report a doctor for sexual harassment. The nurse had reportedly been branded a trouble maker by the hospital management and had been transferred to another hospital.

The participants concerned noted that their respective incidents had happened 'out of the blue'. However it was apparent from Sr I's account that her medical colleague had seen fit to send her nursing colleagues out of the theatre on errands before assaulting her and for Sr F, the surgeon had taken the time to pull her out of theatre into a side passage. These actions suggest that the events might have been premeditated by the perpetrators.

4.3 INTERPRETING THE OCCURRENCE OF WORKPLACE VIOLENCE AS EXPERIENCED FROM DOCTORS

A variety of meanings, possible reasons and explanations were given by the participants in accounting for their doctor colleagues' (surgeons and anaesthetists) behaviours and associated workplace violence incidents.

4.3.1 Lack of respect for nurses and class consciousness

A number of participants attributed their medical colleagues' behaviour and proclivity towards verbal abuse to a lack of respect by the doctors for the nursing profession and to the snobbery of class consciousness. This is illustrated in the following accounts:

“Basically there is a huge lack of respect on his part ... that is the biggest thing ... the loss or lack of respect ... when ... they behave in an unprofessional manner... and ... in unfounded ways” **TF/18/280**.

“A lot of verbal abuse ... [is because of] ... a lack of respect for nurses ... lack of respect! ... Doctors ... are rude ... in ... the way they speak to us ... especially surgeon X and surgeon Y. ... They look down upon us ... and even with the other doctors even though they treat us reasonably well, we are definitely not on their level ... although we are educated ... [it is a sort of class consciousness] ... yes ... it is. Our kids go to government schools ... their kids go to private schools” **TI/22/495-504**.

4.3.2 Surgeon temperament, perfectionism and the ‘artist’

The temperament of the surgeon was additionally cited by all of the participants as being a key variable in determining the nature and quality of interpersonal relationship with doctors in the theatre. This is illustrated in the accounts of Srs F, B and T who have worked a lot with surgeons in most of the speciality areas:

“The kind of surgery that we do that tends to attract a ... a more decent kind of fellow, but ... **our** surgeons have been ... gentlemen – have been great ... professional, and treat you like a human being in every respect ... **but** ... in other surgical disciplines ... they are not as congenial ...’ **TF/11, 12/ 183**.

“ well ... the surgeons that I work with ... have got a particular ... temperament ... which is just so nice and calming and wonderful to work with ... there is no screaming and no shouting” **TB/2/30**.

“It depends on who they are ... the... vascular surgeons I am fine with ... [and] ... all the orthopaedics surgeons ... that I work with – they are no problem really; they are loud mouthed but I have come to know them; and nothing they ... ever say is ever personal. Oh they will moan and they will joke – ‘Ortho’s’ are a total different type of discipline to anything else ... it is very comfortable, it is very relaxed – there is a lot of joking but seriousness when we all need to be serious ... our general surgeons as well I have no problem with them. I do not like the plastic surgeons that we have ... Dr. Y is fine ... but he can be a bit ‘bitey’ ... bitchy ... but ... his bark is worse than his bite. Dr. X ... I do not like... I have never ... worked with him where he has been nice ...’ **TT/4/66-72.**

In the focus group account, the following was offered as an explanation for a particular surgeon’s behaviour and penchant for verbally abusing the staff:

“He is a perfectionist ... an artist. Dr Z said yesterday ... ‘...you know what the problem with Surgeon X is ... he is so intelligent and ... he is a frustrated artist...’. He will look back at the job ... whatever it is ... facelift, boobs ... whatever ... abdoplasty and he will say ‘mmmph – not happy’ ... and he will re-suture it’ **TFG/26/482.**

4.3.3 Surgeon insecurity and inadequacy

A number of the participants articulated that they believed that feelings of insecurity and inadequacy lay behind the behaviour of certain of their doctor colleagues. This is evident in the following excerpts:

“They are not just dealing with some dog that they are cutting up ... it is their profession ... it is their livelihood ... [they need to] ... feel confident” **TI/17/399.**

“I think ... most of these guys ... [surgeons] ... prefer to have specific staff ... I think that they ... **need** to know that the staff know **their** way of working. I know that with Dr. Y ... when Sr V is on leave she has to come in on his operating days” **TT/8/122.**

“The surgeon ... is very experienced **but** when it comes to new staff in the theatre he is not very much for it ... [accommodating] ... he will say ‘ I don’t mind them scrubbing but ...’ - he **expects** the senior staff in that particular theatre to double scrub with them for every case” **TM/7/59.**

“They also want you to be there for all their cases ... they don’t want you to ... share it out ... [when it is] ... Dr. C’s ... day she will try to be there and when it is Dr. D’s main day she will also try to be there with him – but sometimes it doesn’t always work like that depending on the shifts ...’ **TFG/101-103.**

“You know how I look at his swearing ... because ... I worked there the other day and he did a lot of swearing ... and ... I thought ‘...you know what, you are just trying to compensate for your inadequacy by swearing all the time ... actually that is what you trying to do ... you are probably nervous...’... and I think that is why he behaves like he does and starts swearing ... he ... he is showing off too” **TFG/24/459.**

“I think also if something had to go wrong they know that you would know what to do and would help to handle it - and they don’t have to get as stressed as ... [when]... someone they don’t know is there and they have to delegate and say what they need” **TFG/6/113.**

4.3.4 Surgeon expectation: unrealistic performance and service expectations

Additional explanations for surgeon behaviour related to their having unrealistic performance and service expectations of the nursing personnel:

“I finished my case ... [and] ... I quickly went in and I said ‘Sr O how are you doing?’ ... [and the surgeon shouted] ... ‘...Sr Z! **You should be here for every major case..!**’. I said ‘...Dr Q, I can’t it is impossible...’... [and then he shouted] ... **you should be doing this case..!**’ ... he says ‘...I don’t care about Dr M ...’ he said. ‘... **I want you in every single case ... when it is our day you must be here..!**’. I said, ‘... Dr Q it is not always possible ...’. I said ‘... and today it was just unfortunate, the rep let Sr O down – everything was planned...’. I said ... [and in any case it was you who had] ... ‘...brought the case forward” **TFG/7/124.**

“There are expectations ... [the] ... doctors’ expectations are high ... [in respect of] ... standards, productivity ... [and] ... work ethic ... our guys don’t like laziness! They don’t like shoddy work – you do a case they want you to do to it well ... be prepared..!’ **TFG/1, 2/8-16;** ‘... [but] ... **Don’t lose your concentration with him ... that is it, you are not allowed to lose your concentration”** **TFG/4/53.**

“He is pacing up and down wondering when the next patient is going to come into the theatre – because the turn around time is so quick ... obviously you have got take one patient out in order to bring the next patient in ... but he expects miracles! ... He fails to realize that when you take the first patient out you have got to tidy up the theatre before you bring ... the next patient in. You cannot bring a patient in to an untidy theatre ... [standards]” TA/3/54.

4.3.5 Being spoilt, expectations of entitlement and control issues

Almost all of the participants further attributed their surgical colleagues’ behaviour to the fact that they had been spoiled over the years by the theatre staff, and therefore that they now had expectations of being treated in a similar manner even though the unit was short staffed. It was furthermore believed that this state of affairs was complicated by their predominantly male colleagues’ penchant for wanting to be in control at all times and subsequent expectations of entitlement:

“He is the kind of person that what other people think of him doesn’t matter. He ... he will do exactly what he wants to do – what **he** wants to do and he feels that because he is a doctor he is entitled to do it!” TM/13/103.

“He is human ... shouldn’t treat them as God ... **but** we kind of do ... demi-gods ... because that is their behaviour and that is what they have always commanded” TFG/36/736-738.

“They are spoilt ... they are spoilt!” TFG/7/120.

“So I said, ‘...Mr. J if I had to pick you out about all the little things that you forget...’ ... [and] ... he said ‘...I am entitled to...’... [because I am a doctor]” TFG/4/53-55.

“They also like to be in charge ... and if you be cheeky ... [assertive]... back to them they feel that they are not longer in charge” TFG/36/740.

4.3.6 Misogyny

A number of participants attributed certain surgical colleagues' behaviour to misogyny:

"I don't think he likes women ... because ... there is a certain male staff member that we used to have here ... when this guy is in the theatre ... the doctor ... [surgeon X] ... is a total different person. Then the theatre is like completely relaxed. Even when he has got a female anaesthetist – because his anaesthetist is male ... and it is always the same one, ... when he has got a female anaesthetist he is also ... funny ... [difficult to work with] ... because then there are more women in the theatre than men ... but I just do not think that he likes females very much ... that is just my feeling ... he takes whatever happens at home out on us here" **TT/8/112**.

4.3.7 Differential treatment of staff, racism

It was noted by several participants that the staff employed in the operating theatre were treated differently by the doctors. Aside from male – female considerations it was noted that there were further divisions when it came to the staff as a whole. It was felt that this differentiation in terms of hierarchy, status and race underpinned certain incidents of workplace violence. For Sr T, it was felt that racism coloured her interpersonal relationship with a particular surgeon:

"we have noticed ... when I say we - it is myself and my colleagues that have noticed that this particular doctor can be sarcastic and racialistic... he targets the non-whites ... you will find that the tone in which he speaks to white person is **much** different to the voice ... which he uses to speak to a non-white ... I am qualified for a long [time] ... and I have got lots of junior ... [white] ... staff working with me ... but the tone in which he talks to them and the tone in which he talks to me it will still be different... and you can see it ... It is just his **bossy** tone! **Bossy, angry** and you never know when they going to just come in with a gun and just shoot you" **TB/4/50, 62, 64**.

For one of the focus group participants, it was apparent that perceptions of hierarchy and status underpinned the surgeon's behaviour towards certain nursing personnel:

“I feel sorry ... for my nurses in theatre ... he takes years to acknowledge you as a sister ... to call you by your first name ... he has worked with them ... my nurses ... for four years ... he has never said their name ... [it is always] ... won't one of you ... [phone my rooms or whatever] .. you know how hurtful that must be ... when you are never called by your first name and yet you have worked in that theatre with that doctor for four years..! ... Is he a racist ..? I don't think he is ... but why can't he just say ... 'nurse X please phone my rooms' – after four years ... I ... I find that very hurtful for them... because they give so much of themselves to ensure that the list ... runs smoothly ... it ... is a team effort ... and yet they are not acknowledged”
TFG/37/742-747.

4.4 WORKPLACE VIOLENCE PERPETRATED BY NURSES

The experience and witnessing of workplace violence as perpetrated between nursing colleagues was additionally noted in each of the transcripts. The nature of the workplace violence incidents varied:

4.4.1. Verbal abuse

For Sr T the incident occurred over a disagreement over charging responsibilities and prosthetic consignment stickers which were needed for ordering stock and for charging:

“So unfortunately it became a screaming match ... there was no one else in theatre but the two of us” TT/13/182.

In Sr M's account of having witnessed a certain incident of nurse colleague verbal abuse, the disagreement was grounded in perceptions of who should have been scrubbing up for a case:

“While Sr G is gone Sr I is in my ear about it ‘...Sr G is like this and Sr G is like that...’ ... [Then] ... Sr G walks in and she says ‘... if you don't mind I will take over the case’. [And Sr I shouts] ... ‘**Oh no – you will do no such thing!**’. So Sr G says ‘you not happy to do the case so let me do the case’ ... very calmly. ‘**I said I will do it!**’ Sr I says... and they go on ... [arguing] ... and ... then she starts screaming... [at her]” TM/10/82.

Sr F had experienced verbal abuse with colleagues on a number of occasions:

“It was **very unpleasant** – it was very unpleasant because the only time she actually spoke to me was when she was screaming her head off” **TF/9/127**.

“It was a team leader again – she was under a lot of stress and pressure ... and whenever she’s under stress and pressure ... she’d would yell and scream at me” **TF/9/139**.

4.4.2 Abandonment

For two of the participants being abandoned in the middle of a case by their nursing colleagues who had been allocated to that theatre had led to significant difficulties:

“My very first ... triple AAA – abdominal aortic aneurysm repair with the surgeon that I always work with ... and this patient start bleeding and we couldn’t get it to stop. And the senior sister who was supposed to be there wasn’t there. And everybody just seem to have disappeared and the anaesthetic nurse was sent out by the anaesthetist to go and get something for him. And then you turn around and then there is **no one** to help you ... and they don’t say listen I am just going this way or that way or the other thing ... I **really** needed those people ... at least one person to be there” **TT/3/54-56**.

Sr B had similarly been deserted by a colleague:

“You have got to be in there ... to know ... what the scrub sister needs ... there were two times when the doctor ... needed something ... when we needed things to be opened in theatre and she wasn’t even there on the floor – and she had opened two wrong items! Now as we all know this is a private hospital and every little thing counts ... and ... this child is only 8 weeks, has had four procedures and the medical aids are going to enquire about every single thing that is opened” **TB/8, 9/123**.

Abandonment and ignoring were process types of workplace violence that were evident in the accounts of a number of participants. Being abandoned by your team in the middle of a case refers to the situation where only the scrub sister, surgeon (s) and anaesthetist have been left in the theatre at some point during a case. The anaesthetic nurse and floor nurse (s) have inexplicably left the theatre and there is no one on the floor to open swabs,

suture material and/or prostheses, change the suction bottles or to run for a desperately needed item. Given the critical nature of theatre work and that theatre functioning revolves around good team work, being abandoned by the team not only puts a patient at risk, but also predisposes the scrub sister to heightened tensions from medical-surgical colleagues who then assume that the person is incompetent and 'cannot control their staff'.

4.4.3 Ignoring

In addition to being verbally abuse by a colleague, Sr F additionally had to endure being ignored by a colleague for an extended period of time which made things very tense in the workplace:

"I mean even in the department that I have been in now ... with another nurse ... [who has] ... been there for a longer time than me ... she would just ignore me ... from the time I arrived there as a newcomer. I was just point blank ignored, and when she was flooring for me ... I had to ask the anaesthetic nurse to help me all the time because I got ignored ... and she never communicated with anything to me – I sort of found out things by default ... and so there was total lack of communication there ... and a very bad vibe as well ... she'd scowl at me if I said anything and I'd just be ignored point blank! ... This was when I first started in this department ... for about the first seven months" TF/7/104-106, 110.

"It was basic ignoring ... very difficult to ... work in a team situation when there is no communication and ignoring going on. It was very unpleasant ... [at the time] ... I tried to speak to her but I actually couldn't get anywhere ... she wouldn't listen ... [she] ... ignored me when we were working together and wouldn't help me or anything like that"TF/9/129-131.

The ignoring of a colleague, e.g. in respect of a request for assistance and/ or for information, not only creates an unpleasant work climate but additionally predisposes the colleague to being at the receiving end of verbal abuse from doctors.

4.4.4 Bullying, victimization and double standards

Almost all of the participants had experienced bullying behaviour from their nurse colleagues. This was illustrated in the following excerpt from Sr F:

“[I] ... got called aside and told that ... she would prefer it if I chatted less to ... the doctors and ... did my work ... I ... feel that she was looking for things to pick on ... and ... she called me aside she told me that she didn't appreciate my tone of voice when I spoke to her ... and my ... attitude towards her – and that she felt that I was belittling her ... [and] ... I tried to clarify what she meant ... and ... [she] ... was very vague ... she was just grasping for straws ... obviously I ... had got to her in some way ... [annoyed and irritated her] ... and she was looking for some way to put me in my place..... just to ... to remind me that ... **she** is the team leader and ... and this is **her** theatre” TF/3/48 – 52, 68, 70.

For Sr B, the bullying was perpetrated by the theatre management:

“I was **forced** to go into a theatre and ... it was for ... an operation that I have never done, I have **never** watched ... and on pointing this out to ... the unit manager ... she was quite arrogant ... she said to me ‘oh well I will just have to go and do it because there is nobody else to do it!” TB/9/130.

In addition to her experience of being bullied, Sr F reported witnessing the following victimization of a colleague and malicious conduct by a colleague:

“I had a colleague who has left ... she had a really, **really hard** time with her. They... had big fights, and ... my friend used to be upset quite a lot of the time and ... this team leader would ... do some malicious things ... to her ... [for example] ... getting all her ... scrub outfits and throwing them in the bin ... and sticking them in the far corner of ... the equipment room ... [where] ...she couldn't find them for ages until I happened to have stumbled across them. And she wouldn't own up to it then but she told everybody else about what she had done ...and how **she** was teaching **her** a lesson” TF/6/84.

For Sr F inconsistencies in professional practice (double standards) and pettiness were additionally a source of unhappiness and frustration:

“I was called back and ... was picked out about a small thing – about not writing the diagnosis on the pink card ... whether I had or hadn’t done that because there is ... more than just me who does the writing ... I am not sure, but I couldn’t disprove it so I just apologized ... needless to say **she** never writes it on ... but ... I don’t say anything about it. I am not about to stir up a hornet’s nest and nobody else says anything either” **TF/5/68.**

“I just battle to take ‘orders’ from them sometimes ...[nursing colleagues] ... I don’t mind taking orders that is not a problem but it **is** when two sets of rules apply ... [for example] ... when I am given instructions I will do them – but when they come down heavy on me for some silly little thing – and then they ... do something wrong ... [the same thing] ... and then **that’s** “ok” - I just battle ... with that” **TF/2/26.**

Bullying behaviour was evident in certain incidents described and most notably in the accounts of Sr B and Sr F. Sr B had been bullied by management into taking a case that she had never seen or scrubbed for before because they were short staffed and Sr F had experienced and witnessed several bullying and malicious conduct incidents involving senior staff towards junior staff. In this study double standards referred primarily inconsistencies in professional practice and to systematic pettiness. Double standards were a source of frustration and annoyance for Sr F who felt that these were tantamount to bullying and victimization by specific nursing colleagues.

4.5 INTERPRETING THE OCCURRENCE OF WORKPLACE VIOLENCE AS EXPERIENCED FROM NURSES

A variety of meanings, possible reasons and explanations were given by the participants in accounting for their colleagues' behaviours and workplace violence incidents:

4.5.1 Expectations, standards and performance pressure

Pressure to maintain standards of care and aseptic techniques were cited by a number of participants as precipitating and perpetuating increased tension and stress between nursing colleagues in the workplace, and instances of flared tempers and verbal abuse.

These expectations regarding standards and performance pressures are illustrated by the following excerpts:

"It is exhausting to try to keep the standards up all the time – especially when you are working with others that are not so efficient ... it is very, very difficult and also sometimes it is ... very frustrating because you constantly have got to say [monitor the situation and aseptic techniques used] ... and some people don't take criticism very well - whether it be positive or negative, they don't like you to tell them how to do their job" TFG/3/33.

"I do get irritated with some people ... usually ... [due to their]... incompetence ... I am a perfectionist so ... some people are just not like that. When you ... get new staff I do understand - because we all start there, ... that you need to be lenient and try and help ... but when you have been here for a month or two then you are not really new staff anymore ... you shouldn't have to be told any longer and that ... type of thing irritates me ... I do not want to keep on saying the same thing for a whole list where we do just about the same thing" TT/2/40-44.

"I am the person who is responsible for that theatre because I am the sister who scrubbed ...; ... when you are being put on the spot [i.e. are taking a case] ... you want to be able to rely on the people who around you ... I get conscious of the people who are on the floor for me because I am new. And then they send me in new people who don't know the department but I am still relying on them so heavily to get me through the case ... and ... that is where my tension levels sort of shoot up" TFG/17/314, 303.

4.5.2 Territoriality

The number of the participants attributed their experiences of workplace violence to the territorial attitudes and behaviours of certain nursing colleagues. It was felt that territoriality increased levels of tension and stress in the theatre, increased a surgeon's insecurity when having to work with a 'new' scrub sister and predisposed the 'new' scrub sister to being on the receiving end of verbal abuse. Territorial behaviour may be extrapolated from each of the following accounts:

"Nobody else can scrub in that theatre because **it has been made** that way" **TI/9/190**.

"Sr Q ... had an appendix out ... it was on a ... Wednesday ... and Friday he had a list. And she came in on that Friday to do his list! Appendix or not!" **TT/9/132**.

"There is no such thing as being sick or on leave ... if they are on leave, they come in from their leave! Yes! Sr V will come from her leave to scrub for Dr Y ... or Dr Y will go on leave ... they only go on leave when their surgeons go on leave"
TI/10/219-225.

"Sr Q doesn't really allow other people to scrub there, she will do it all ... she will do it **all** - so then when they are sick or on leave ... and other people have to go in there ... now they don't know him ... it is the same with Sr V and Dr Y. ... I have done a few of his breast augs ... [augmentations] ... and a few little things ... [and I have asked] ... 'Sr V can I scrub?' ... [and she always says] ... 'No - it upsets the equilibrium of the theatre'" **TFG/24/444**.

"We have a ... staff member who is also qualified and she has sort of like become extremely territorial over one theatre ... [and over] ... two surgeons ... today we did a below knee amputation and it was this sister's day off. She came **in** on her **day off** because this surgeon was working today! ... So she came into the theatre and I said 'my goodness Sr T what are you doing here, aren't you supposed to be day off?' ... [and so] ... she says to me '**this is my theatre and I am supposed to be here!** When **they** work I must be here otherwise it will be scooped from underneath me...'
TI/13/269-279.

4.5.3 Personality, attitude and the bringing of personal problems to work

A number of the participants were of the opinion that their workplace experiences were mediated by their nursing colleagues' personalities and attitudes, and were to a certain extent understanding of incidents of workplace violence (verbal abuse) which were felt to have been triggered by tensions and stresses due to a colleague's circumstances, e.g. where the colleague was experiencing social and or other home problems. The above is illustrated by the following excerpts:

"Sometimes you have to take into account some people's personalities and where they are at ... at that particular time of the day ... I mean some people are just not morning people ... so they come to work moaning and groaning ... but as the day progresses they get a bit easier. And some people moan and groan all the time ... so you also just got to bear with it" **TM/1/16-19.**

"I just think that it is personality clashes ... and ja ... us women we have all these moods and things as the months ... pass" **TT/12/172.**

"I ... think that that they are going through ... personal issues ... and ... they are bringing it to work with them. Generally ... the one is a very easy going person ... very happy and lately all she does is moan and groan ... and ... if I say to her 'did you by any chance use this instrument ... do you know where it is?' ... [*then she will shout*] ... 'I wasn't the last one to touch it! I sent it to the back ... I don't know where it is!' That is ... the reaction ... and ... she obviously ... is not handling it very well so it is coming out in all her relationships" **TM/1, 2/22-24.**

4.5.4 Victim blaming, self blame

Several participants in searching for reasons and/or explanations for their colleagues' behaviours blamed either the colleague who had experienced the incident or themselves (an internal attribution) as having in some way precipitated the incident:

“In myself I know that ... he will never be satisfied with what I do, it can be the most minor thing, it can be the most ... delicate thing but I know that he will never be totally ... satisfied with whatever I do, so ... my expectations are not high when I work with him” **TB/7/116 -118.**

“I am so stupid’ ... ‘I am such an idiot ... I wish I had more experience” **TI/17/375.**

“I think it is a language thing for me ... I emphasize on the wrong parts of the words so ... I come across as ... [having an] ... attitude and rude” **TI/11/248.**

“Well ... if she doesn’t have the requirements ... equipment and instrumentation wise, sundries and stuff like that ... everyone of us ... [must] ... check our stuff before we go and get scrubbed up ... it is ultimately the person who is scrubbing for the procedure ... [who has] ... to be responsible for whatever goes on in a theatre” **TB/10/148.**

“We ... all ... blame the sister that scrubs there” **TI/8/190.**

“With Sr W ... she is quite new, but what she does – it is **attitude**. She tends to argue ... [and gets herself into trouble]” **TFG/27/510.**

“You can actually see in those people or those particular people that they became a nurse because they and nothing else to do ... I have noticed that their attitudes tend to be the ones ... that are not committed in helping others ... they just nag ... moan about everything ... generally .. and they do complain about ... not being relieved for lunch and tea ... and then you think well we haven’t been relieved for lunch either but you kind of get on with it ... and take it later ... we are so used to it ... not much tea and that ... in our theatre” **TFG/19/350; 357-364.**

4.5.5 Feelings of insecurity and inadequacy

For a number of participants, the rationale for their colleagues’ behaviour was rooted in the belief that the behaviour stemmed from feelings of insecurity and perceptions of self inadequacy. These are illustrated in the following extracts from the account of Sr F and the focus group respectively:

“Generally I can say it is ... usually ... nursing colleagues. They are usually middle aged women – sort of old ... older than myself ... and ... I tend to see it as an insecurity thing on their part – maybe something of being threatened ... if I can be so bold as to say that. I think because I get on and I do my work, and ... I sort of treat them as equals ... that we are there as colleagues to work together ... and I tend to have quite high standards ... I think that maybe they feel shown up at times and that tends to bring out the insecurity” TF/2/26.

“I thought that Sr I felt insecure ... and that was why she reacted the way she did ... she reacted aggressively, because she was so insecure ... she was so unsure of herself that she didn’t trust herself so she couldn’t trust her team ... she ... felt that she couldn’t rely on Sr G because she couldn’t rely on herself actually... and Sr G then felt like ‘you know what I am giving my all here and it is not good enough’ ...so she felt inadequate” TFG/20/378.

Interestingly Sr I’s account of the above incident corroborated her colleague’s perceptions of what had precipitated the incident of verbal abuse between herself and a colleague, Sr G:

“I scrubbed for a case that I didn’t really know much about – the person who was flooring ... [Sr G] ... was supposed to scrub ... I said to her ‘... you have done this case a few times ... don’t you want to just elaborate and help me..?’. And she like skimmed through my trolley and said ‘oh you have got everything here’, and I knew I hadn’t even though I didn’t know much about the case. I said to her ‘please do me a favour, go and get Sr Z because Sr Z knows this case well’ ... She took offence ... said that I was unwilling to learn from her ... [and that] ... I was being difficult. And the next thing I was in the matron’s office! ... To do ... [the case] for the ... first or second time ... it is a bit nerve wracking ... I just wanted someone to show me and say ‘... ok, he is going to start with that - he will do this, then ... he will do this and do that” TI/ 14, 15/329-339.

4.5.6 Short staffing and exigencies of the service

A number of participants attributed the occurrence of tensions between nursing personnel to the unit being short staffed, having inadequately trained staff as part of the team and to their colleagues ignoring each other’s basic needs:

“Not having lunch ... not having tea and the surgeons just want to finish the list - and there are not enough staff because on that day, nine of our staff were sick ... so I was just ...**everybody** ... was stressed” **TT/12/180**.

“I think that everybody was just majorly stressed ... **too many staff off** ... you start in one theatre and then they change you to another ... so it was a very insecure day actually ... [it] ... helps a lot ... [when] ... then there are at least **three staff** ... [excluding the scrub sister] ... on the floor and one of us knows ... [the routine] ... so we all try and help and then usually you don't get that ... [verbal abuse and heightened tensions] ... but now what has recently happened with the regular staff ... one ... has gone overseas and one has left for Westville because he was unhappy with the management and the way they treated him. So he resigned ... transferred” **TT/17/232-234**.

“I think that it is mostly ... people having short lists and ... and not coming to relieve someone else for tea that has been working the whole day without a break ... I think that is ... mostly the biggest ruction that you can find and the reason for it” **TT/12/174**.

“There are some people that **always** take their full tea break, their full lunch break on time ... and it doesn't matter who they leave in that theatre, you can be by yourself ... it doesn't matter, they will go” **TFG/18/339**.

“The fact is ... they have got staff there that has not been taught properly...”; ‘...you are faced with staff that haven't been there long enough ... they are still trying to learn the doctor's way – their basic anaesthetic knowledge is very limited ... they were not handled properly and taught” **TT/13/184 & TT/17/238**.

4.6 HOSPITAL MANAGEMENT AND WORKPLACE VIOLENCE

Analysis of the transcripts suggested that the theatre and hospital management structures played a pivotal role with regard to the handling of workplace violence incidents. In this study the theatre and hospital management (nursing and medical) are referred to as a single entity.

4.6.1 Victim blaming

For a number of the participants it was evident from their accounts that they were usually blamed by management for an occurrence of workplace violence – that is the attitude and behaviour of management suggested to them that the nurse was to blame for the occurrence of the incident. This management stance is illustrated in the following excerpts from Sr I and Sr T’s transcripts respectively:

“I was very ... very upset. I was treated like ‘Oh you must have done something to aggravate him’ ... from the management’s part. They treated me as if ‘I must have’ ... [caused the physical assault with the chloromycetin]” **TI/5/98.**

“I sometimes think though, that they just think it is our fault ... [that] ... we are just ... complaining about whatever ... I ... think that they are not proactive enough”
TT/15/204.

4.6.2 Lack of support and fobbing off of staff complaints

For Sr I her experience with the theatre and hospital management in terms of assistance and intervention in the aftermath of the physical assault on her as perpetrated by a surgeon was less than optimal:

“I wrote everything down, I gave it to them ... [management] ... she said that she would definitely sort it out – I never heard anything again. She reassured my husband that they were going to sort this out and that there was going to be some sort of solution ... and a conclusion. We never heard anything and still up until today ... we have heard nothing! ... **Nothing! Not even an apology ... nothing!**”
TI/6/120 – 133, 135.

All of the participants felt that the tolerance by hospital management of certain unacceptable behaviours - as perpetrated by doctors - played a role in the precipitating

and perpetuating of these behaviours. This complacency and lack of management support for the staff with regard to workplace violence incidents is evident in the following accounts from Srs T, I and F respectively:

“They ... [management] ... don’t step in and ... haul him ... [the surgeon] ... in with who ever and talk about it and say ‘... now listen we got so many complaints from the staff, verbal complaints ... where is this going to? You cannot do this to our staff...’. I just really feel that ... the management is just like ... ‘...Whatever! ... [dismissive] ... If you don’t document it - it didn’t happen...’. Even if all ... of us are complaining about the same thing” **TT/15/206**.

“They say, ‘...ah just ignore him he is probably in a bad mood...’; it is taken too lightly” **TI/20/465**.

Similar feelings were articulated about management’s handling of incidents with fellow nurses, as illustrated in the following excerpt from Sr F:

“I wrote a statement and my manager took it to the chief nursing service manager – and she said that she ... [the perpetrator of the verbal abuse] ... was way out of line and that ... she would ... set her straight. Needless to say she never ever took the situation up with her ... nothing came of it” **TF/10/145- 148**.

In contrast to the above, the handling of the recent sexual harassment incident by the theatre and hospital management appears to have been better managed. On reporting the incident to the unit manager, Sr I noted that the theatre manager had confronted the doctor with his behaviour. He was reportedly apologetic and a formal grievance had been laid.

4.6.3 Grievance procedure

While it was clear across all of the accounts that the participants' were aware that there was a grievance procedure, it was evident that not all of the participants were aware of their rights with regard to the grievance procedure, and of when it should be used. There was further evidence that many of the participants felt uncomfortable using the grievance procedure because they felt that they would not be supported by management, that they would be ridiculed by their colleagues (medical and nursing) and that they would be victimized if they instituted a grievance against a colleague. This is illustrated by the following excerpts:

"We are not encouraged to use it ... [the grievance procedure] ... **not** encouraged ... when I said ... let's do a grievance about it ... everybody hummed and hawed and hesitated. I said '...it is our right...' – but nope. Absolutely not! Nobody will stand together and do it ... [and] ... we ... the staff are not rated as important as what we should be. We don't have somebody ... that we can go to and say 'this and this happened' ... and know that it is going to be dealt with fairly. No! They are on a buddy - buddy system ... they have lunch together ... so where ... are our rights going to be put? Where? How seriously are they going to take us? When they speak to the doctor it is a big joke" **TI/20/447, 451,459,461.**

"But when you standing up for yourself ... and you are ... standing there, and you look behind and there is ... **no one** behind you! Who else is going to stand up again! ... [The other staff say] ... '... Ah do you see Sr I, she wrote a grievance or she did this ... and ... now she is victimized. Now the surgeon rips her off and laughs at her every time she walks into the theatre..!'. They rip you off, they laugh at you, they make fun of you ... it is a big joke ... a **big** joke! One of our staff members that worked over here ... one of the doctors (Dr X) called her a kaffir bitch ... and she went through to Council, she took it the ten yards ... I tell you she took it all the way. And he mocked and laughed about her ... about how he was going to sue her and sort her out! Put the fear of daylight in the rest of us!" **TI21/469, 475-477.**

4.7 INTERPRETING MANAGEMENT'S HANDLING OF WORKPLACE VIOLENCE INCIDENTS

A variety of explanations and meanings were given by the participants for management's handling of workplace violence incidents:

4.7.1 Fiscal considerations

The most common explanation given by the participants for management's inaction with regard to complaints about doctors related to fiscal considerations:

"But nothing is going to get done about it anyway because of his influence in the hospital ... and ... I have heard ... that unlike ... Surgeon R ... who doesn't work with us anymore ... he was basically kicked out ... that will **never** happen to Surgeon X because of his shares and how much money he brings in to the hospital"
TFG/20/534-538.

"He is a reconstructive surgeon a lot of his things are done privately which means there is a lot of revenue for the hospital. Because there ... is a lot of cosmetic surgery ... the patients pay private rates ... [and] ... the patients will stay a day or two at least ... [plus] ... theatre time and all of those type things ... the hospital gets a **lot** of money for it" **TT/10/142.**

4.7.2 Social considerations and other vested interests

Another common attribution for management's behaviour pertained to that of management having vested and social interests in maintaining a status quo within the organisation. This is illustrated in by excerpts from Sr I and Sr T's accounts respectively:

"It is a buddy-buddy system between the management and the doctors ... They are on a buddy-buddy system ... they have lunch together – they chat and ... [socialize] ... together" **TI/20/459-461.**

“Unfortunately he has also done ... cosmetic surgery on some of the matrons ... it always makes me wonder how far they will tolerate him... [and his behaviour]”
TT/10/142.

4.8 EFFECTS OF WORKPLACE VIOLENCE FOR THE SELF

A range of consequences and effects of workplace violence for the self in the workplace were verbalized by each of the participants:

4.8.1 Doubt, loss of confidence and self esteem

For the majority of participants the sequelae of a workplace violence incidence resulted in them doubting their abilities, losing their confidence in themselves and to a loss of self esteem. This is illustrated by the following excerpts from Sr F who had experienced verbal abuse from a surgeon:

“I didn’t enjoy it ... you ... feel belittled and stupid and incompetent when you are treated like that and you are told things like that ... and then you start to doubt your own competencies and your own ... confidence in the situation. You need a certain amount of confidence to do your job ... **you know that you are not** ... [incompetent] ... but you feel stupid. And then you might even end up doing things wrong”
TF/12/203.

“It’s not good ... your confidence is shaken ... [and] ... your self worth – your self esteem obviously ... you feel beaten down ... ja ... and of course it makes you unhappy, you find it very hard to be light and full of sunshine” **TF/17/263.**

Srs I and M similarly expressed the following respectively:

“[And the thought that is going through my mind is] ... I am so stupid ... I am such an idiot ... I wish I had more experience. I start feeling useless, and ... I lose more confidence ... I feel like just taking my gloves off and my gown off and just running away. I feel embarrassed” **TI/17/375-379.**

“I would have ... a complete break down if I had ... [to work] ... with him ... [on a regular basis] when I am allocated to do his list I can't see beyond that – I find it very intimidating, I ... I am a nervous wreck when I go and work with him. A simple thing like cutting a suture will become a major task for me because I will think ‘have I cut it long enough, have I cut it short enough ... what am I doing?’. I question myself continuously it makes me ... very unsure of myself” **TM/14/117.**

4.8.2 Loss of trust

For a number of participants their experiences of workplace violence from their colleagues had led to them experiencing a loss of trust in these individuals. For Sr T who had been deserted by her colleagues during a critical case this was evident in the following excerpt:

“There are some people that I do not trust ... in the way of having them where I need them” **TT/4/62, 64.**

For Sr I, who had experienced a physical assault, the loss of trust is illustrated by the following:

“It is still with me ... I am wary of him ... when I work with him ... he is sort of like extra friendly, and tries to overcompensate with me ... but ... I don't ... scrub for him at the table, I don't go anywhere near him – if he talks to me I talk to him and that is about it” **TI/6/76&141.**

4.8.3 Avoidance, Resentment

Avoidance of and resentment towards a perpetrator was found across the majority of participants' accounts:

“I’d rather actually not spend much time with her or ... [even to] ... just chat sort of socially and generally ... as you do with colleagues ... because I just find that it is too much of an effort and too exhausting now ... because ... I don’t feel free to be myself - like I was before” **TF/3, 4/52.**

“Nobody wants to go in those theatres ... they ... [Surgeons X and Y are] ... limited to one scrub sister each and they are the **only** scrub sisters who scrub there” **TI/10/217.**

“Lets put it this way ... a leopard never changes its spots – he is not a very good surgeon in that he compromises his patients and ... I would prefer not to work with him for my patient’s sake and for my profession’s sake because I just think that I am lowering my standards working with him” **TM/12/97.**

“When I came back the next day ... [and] ... fortunately we don’t work with him every day... by the time you will get to work with him the next time that feeling has almost subsided ... the anger has almost gone. Well a bit of it still stays in you ... memory is something that you can’t wipe out you know” **TB/7/112 – 114.**

“It just makes me resent him more and if I can avoid him I will – at every cost” **TT/15/218.**

4.8.4 Feelings and emotions

A range of emotions and feelings were generated in the participants due to their experiences of workplace violence. These ranged from irritation and frustration through to fear, anxiety, anger and hopelessness to feeling belittled, degraded and humiliated.

These feelings and emotions are illustrated in the following excerpts:

“He physically went ... and brought ... another scrub sister and that made me very angry because she had qualified the same year that I had qualified and we had done the theatre course together ... I found ... that to be totally degrading ... on that day I must say I really lost my self esteem” **TB/6/96.**

“I was frustrated, I was irritated, I was stressed” TT/3/56.

“[If] ... I ... knew I had to scrub for him the next day ... I battled to sleep the night before ... it affected my sleep ... I would arrive at work and ... be in that state of fear ... my mouth would be dry ... feeling a bit shaky ... if I knew I was going to be working with him” TF/13/223-225.

“Oh gosh ... I do have a bit of tachycardia ... and stuff like that, and ja I just pray and hope that the morning or afternoon goes by and ... it is not going to be as unpleasant as I expect it to be” TB/8/118.

“I was angry... I was frustrated ... and I was very ... very upset ... I just lost interest. I lost ... self worth. I thought to myself ‘I have been working here for all these years... I come to work, I do my work – and this is not supposed to be a place where I get hurt’. This is supposed to be a safe place – it is my workplace where I am supposed to be protected, **my rights were taken away from me, and I was invaded ... totally,** and ... I felt ... ‘oh well who is next, what is next?’. He can now hit me and ... what [will happen] ...? Is he going to get a smack on his hands: ‘don’t do that again’? ... This is the place where I work! I ... I don’t come to work to be abused; I don’t come to work to be hurt! [*Tearful, neck and face start to flush*]” TV/5/98, 102.

“We are afraid ... somehow you just can’t perform at your maximum level because you are nervous and you are under tension ... sometimes ... you wish ... you wouldn’t be able to come to work, maybe you just wish that you were sick and ... [could] ... stay away ... [but] ... we have to come to come to work and just face our drama. The drama is just going into **that** particular theatre ... you never know when you are going to be picked on” TB/3/46.

4.8.5 Stress, exhaustion, and being mentally drained

The experience of workplace violence further resulted in the participants feeling stressed, exhausted and mentally drained:

“Afterwards? It is exhausting ... because you have to have this front up the whole time ... you are trying ... to defend yourself ... and show that you don’t care and that he is not getting to you ... and at the end of the day you are exhausted! ; ... it is mentally draining” TFG/23/425-434.

"It becomes very stressful ... everybody is stressed and on edge and making mistakes and ratty with one another ... and ... they all clump together in one corner... it is like they are hanging onto each other for security ... you look up when you are scrubbed and there they ... [are] ... standing in the corner ... out of 'peripheral vision' -- because you are not allowed to be in his peripheral vision! So they are ... in the corner ... one is outside the door doing charging ... and the rest are all ... nervous in the corner there" **TI/9/207**.

4.9 STRATEGIES FOR COPING WITH WORKPLACE VIOLENCE

All of the participants utilized a number of coping strategies to cope with workplace violence:

4.9.1 Keeping the peace, keeping quiet, stoicism

For a number of participants a stoical keeping of the peace was the coping strategy of choice:

"I just keep quiet and I think '...you know what this case is going to be finished just now...'" **TT/6/92**.

"You ... just got to bear with it" **TM/1/18**.

"With him you just keep quiet, you don't even ... say I am sorry ... keep quiet. Don't even try ... don't offer any explanation or anything" **TFG/36/715-718**.

"I guess it was sort of like a little thing ... [and] ... I felt ... it wasn't happening on a regular basis – it was like a one off – well a second off thing ... it has happened once before but ... I would rather just leave it – I'd rather not blow things up ... rather just leave it alone - not get things going ... keep the peace"**TF/10, 11/161 -167**.

"Some people do generally feel a bit intimidated or disrespected if you say to them '... you are going to **need this...**', so I would rather make it as an offer not as an order" **TM/3/40**.

In contrast to the above, the ‘keeping quiet’ as a means of coping further appeared to be a passive-aggressive means of coping with difficult interpersonal relationships – as illustrated by the following excerpts:

“I try not to say anything to the surgeons ... after the case I take off my gown and gloves and go straight to my line manager - tell them what happened and I then write a little note and then give that to her, and it is taken up further from there” **TB/4/68**.
“He reported them afterwards. I didn’t say anything ... to them ... they were called in by the matron, so I just decided that I don’t need to go and hammer on the same thing” **TT/3/56, 60**.

In both of the above situations the participants concerned had elected to keep the peace, to keep quiet and not to confront their doctor and nursing colleagues respectively thus avoiding further confrontation and/or unpleasantness on the one hand, but abdicating responsibility for resolving the conflict on the other.

4.9.2 Prayer and professionalism

A number of participants confided that they used prayer to get themselves through the day:

“If I knew I was going to be working with him ... I had to sort of try and calm myself down ... I prayed a lot” **TF/13, 14/225-229**.

“I ... come from a religion where I am very religious and I often just pray in my mind that ... everything must go well ...; a certain kind of calmness that comes over me – I must thank God for that ... I just try and be calm ... [and] ... I try not to say anything to the surgeons to upset them further” **TB/4/58, 68**.

“I just pray and hope that the morning or afternoon goes by and ... it is not going to be as unpleasant as I expected it to be” **TB/8/118**.

For Srs F and I respectively, maintaining a professional stance with both nursing and medical colleagues was additionally used as a protective mechanism:

“There is definitely that ... guarded thing ... on my part ... it actually makes it ... [workplace relationships] ... more comfortable in some respects ... and ... it makes the possibility of the things that I would experience with my nursing colleagues ... less able to happen ... because ... you have kept things more at arms length so it can't become personal and ... they can't become personal with certain issues and things like that ... like any things ... [issues that] ... they've got with ... your tone of voice, or your attitude or something like that. If things are more at arm's length away or more professional I don't think it affects people as personally and it doesn't bother you as much ... because it is not as personal” **TF/22/322-328**.

“It is like a challenge ... they always want to challenge you! Like you always got to defend yourself, you have always got to ... [be on your guard/ be professional]” **TI/13/297**.

Prayer seemingly distanced the participant from the unpleasantness of the situation and thus made it seem more manageable. Similarly maintaining a strict professional demeanour appeared to serve to keep the perpetrator (s) at arm's length (distancing) and to enable the participant to avoid 'being hurt'.

4.9.3 Avoidance and withdrawal

For several participants avoiding and withdrawing from the perpetrators and /or working in certain theatres were used as defense strategies to circumnavigate situations where workplace violence was more likely to be experienced:

“I try to avoid that theatre if I possibly can” **TT/8/114**.

“I don’t scrub for him at the table, I don’t go anywhere near him – if he talks to me I talk to him and that is about it” **TI/6/141**.

“I ... try and avoid the situation – you know, like I try and stay away from any further confrontation with her” **TI/14/301**.

“You sort of draw away from that person ... stay away, don’t want to talk to them ... keep quiet or just ignore them ... or gossip or something like that!” **TFG/31/621**.

While none of the participants indicated that they would actually call in sick if allocated to work with certain surgeons, a number of participants indicated that this is exactly how they felt when they saw with whom and where they were allocated to work at times.

Notwithstanding this, it was noted by the researcher in one of the participant’s accounts that there had recently been a day in theatre where nine staff members had called in sick.

4.9.4 Intellectualization, rationalization, minimization

The utilization of intellectualization, rationalization and minimization as defense strategies and coping mechanisms against workplace violence were apparent across all of the participants’ accounts:

“I do ... sometimes take it quite personally ... but most times I just brush it off and say ‘...well tomorrow will be a better day” **TM/5/51**. (Minimization of incident).

“I will just chew over it, and I wrestle with it ... and go through in my mind - scenarios ... if it should happen again how I would respond ... I sort of ... rehearse beforehand how I am going to be towards them and ... try and be as relaxed and easy as possible” **TF/17/271-273**. (Intellectualization).

“I thought that Sr I felt insecure ... and that was why she reacted the way she did ... she reacted aggressively, because she was so insecure ... she was so unsure of herself that she didn’t trust herself so she couldn’t trust her team. Because ... she ... felt that she couldn’t rely on Sr W ... [when in fact it was] ... because she couldn’t rely on herself actually” **TFG/20/378**. (Rationalisation of incident of verbal abuse).

4.9.5 Over-compensation and humour – the ‘court jester’

Similarly the use of over-compensatory behaviours and humour was employed by a number of participants as a means of coping with workplace violence:

“I have explained myself and I have ... apologized. I have said you know ‘...if I do come across as rude, please I am sorry, tell me and we will sort it out immediately. Don’t walk around feeling hard done by or anything like that...’. I said ‘I am no harm to anybody, I won’t hurt anybody else ... sometimes I may be a bit louder than what I should be and please forgive me” **TI/12/262**.

“I don’t like to see people at each other ... I don’t like confrontation ...and I don’t like upsetting other people ... I just ... try to make sure that other people are comfortable all the time ... I tend to overcompensate so that person feels completely comfortable” **TFG/20/380**.

“I try and lighten the situation ... humour ... I humour him – I am like a jester ... you know you are like an entertainer in the theatre ... to keep things calm you play music and you talk about happy things and you laugh and joke” **TI/7/163-165**.

“I always used to say ... ‘... here is the tray ... “Pick and Pay” ... I am sorry ... I don’t know ... I don’t know what it is ... please help me ...’. I said ‘... it is “Pick and Pay” today...’ They are fine with that” **TFG/21/400-402**.

4.9.6 Venting to colleagues, support networks, crying and comfort eating

It was found that being able to vent one’s emotions and feelings that arose in response to an incident of workplace violence to colleagues who had experienced similar difficulties was a source of relief. It was felt that these colleagues were able to shed perspective on the matter at hand and/or were able to identify with what the participant was feeling. For one participant, venting her annoyance and frustration at the situation in front of a surgeon who was prone to verbally abusing the staff, e.g. by swearing, served as a unique

defence mechanism. She stated that she deliberately swore in front of - but not at - him so that the communication conveyed to him was that she was not going to be intimidated by his swearing and offensive behaviours. A number of participants indicated that their fellow nursing colleagues were a source of support for them when they were confronted by stressful and difficult situations:

“Which ever friend I see walking past I just ask them to pray for me as well ... and I try and get my confidence just by speaking to my friends and asking them to give me a bit ... of guidance as well” **TB/10/144.**

“I ... say straight out to the nurses ‘this man irritates the hell out of me, I wish that he would just not come here’ ... we all talk amongst ourselves” **TT/10/138-140.**

“I don’t particularly enjoy working there but I know how to handle him so I am able to ... survive that situation for that day ... I give back to him **exactly** what he gives back to me ... when he swears at me, I don’t swear back at him **but** I will swear in front of him ... so he knows that that doesn’t bother me, I am not going to be frightened” **TFG/23/418-420.**

While the presence of an informal, nurse colleague support network in the workplace was evidenced in participants’ accounts, it was further evident that support networks outside of the workplace were less than satisfactory. This is illustrated by the following excerpts from the transcripts of Srs T and F respectively:

“When people upset me at work, I try talk to him ... [my husband] ... but he is one of those people that ... he feels that he doesn’t want to hear it. Because he feels as if I want him to do something about it. And ... I say to him I don’t want you to do anything – because there is nothing you can do, I just want you to listen to me; I just need to get this feeling off me, and just be relaxed ... I need someone to talk to ... [but] ... I end up either talking to my friend ... or I will just talk to one of the staff” **TT/16/226.**

“I talk about it a lot to my poor husband who just can’t take it any more. He tells me ‘time out’ ... so I am only allowed a certain amount of time now. We have made an agreement that ... I am allowed 30 minutes and that’s it – to talk to him about it ... because he can’t handle it” TF/17/267-269.

Not having a support network outside of the workplace that they could rely on for support and understanding in respect of being able to air their grievances and/or to be debriefed about an incident of workplace violence was found to be problematic for the participants concerned.

Additional coping mechanisms were evidenced in the account of Sr I:

“I normally cry ... I go to the bathroom ... if it is really bad ... I cry. I don’t like anyone to see me cry” TI/17/383.

“Comfort eating works well!” TI/17/387.

4.9.7 Altruism, ethical conduct, and honesty

A number of participants were conscious of their professional and ethical responsibilities towards their patients and colleagues. When confronted with stressful situations such as in incident of workplace violence, it was felt that remembering and adhering to these responsibilities added a different perspective to the matter at hand and enable the participant to rise above the current situation and carry on, i.e. there was a sense of purpose:

“If at all possible ... I ... would go and speak to that person, I have to clear the air ... I can't carry baggage. I just ... have to deal with it ... and get on with it ... get on with life. I can't leave things hanging and harbouring ... so if at all possible I will go and speak to them ... and I will make a first approach, and I will apologise whether I feel that I did wrong or not. ... I can't work in situations that have got bad vibes and people have got animosity towards you – it is not a ... a good work environment then” **TF/20, 21/306-310.**

“I have actually spoken to my husband about it and he said to me next time you take your gloves off and you walk out! ... **but** ... what always gets to me is the fact that it is not the patient – it is the doctor! So if I take my gloves off and I walk out the patient is the one who is going to get it at the end of the day which is not fair. So ... I keep quiet ... I do not have to have any type of conversation with him. I give him what he wants and other than that he must leave me alone” **TT/6/92**

“I am there for the patient and to help the staff” **TI/6/141.**

Acknowledging one's competencies and limitations and being honest about these was a further mechanism used by a number of participants to ward off potential verbal abuse and awkward situations.

“I always say to them ... ‘... I have never done this before I don't know what I am doing ...’ - I will be honest with them ... and they tend to ... appreciate that. Instead of going in there with this act now that you know exactly what is going on ... and that I am the expert on this and then you fall short – and then they... and then they get angry” **TFG/21/395.**

CHAPTER FIVE: INTERPRETATIVE ANALYSIS

5.1 Introduction

In this study the term 'workplace' referred to the operating theatre setting within a private hospital and 'workplace experience' referred to both the material and non-material aspects of being an employee within this organisation, e.g. the experience of the nurse in respect of the organisational climate in respect of her physical working conditions, supervisory and professional support received, and psychosocial climate. The focus on the hospital environment was chosen because hospitals are the largest employers of nursing personnel, and the theatre setting was chosen because it is a recognized high stress environment for nursing personnel (Jackson et al., 2002). The operating theatre context took the (anaesthetized) patient out of the equation to some extent, and exposed seams and ruptures of relationships within the medical 'teams' in highly specialized institutional (and clinical medical and nursing) routines of patient care. Most literature has hitherto focused on patient-nurse violence (e.g. Jackson et al., 2002) and on nurse-patient violence (e.g. Van Der Walt, 2002).

In this study, five broad research questions were explored with the focus group and with each of the study's individual participants by means of thematically semi-structured interviews. The participants were not asked the research questions; but an initial trigger question and prompts (see Chapter Three and Appendix One) were used to explore the following five broader research questions:

1. What are the direct (personally experienced) and indirect (witnessed) experiences of operating theatre nursing personnel in respect of workplace violence?
2. What meanings are given by operating theatre nursing personnel to experiences of workplace violence?
3. How do operating theatre nursing personnel understand workplace violence?
4. How do operating theatre nursing personnel manage experiences of workplace violence?
5. How could workplace violence in the operating theatre be effectively contained and managed?

While the thematic findings described in Chapter Four have addressed the first four of these research questions in detail, this chapter interpretively considers the thematic findings along several dimensions related to the research questions and the previously reviewed literature (in Chapter Two). Firstly, the workplace violence experiences of theatre nurses are itemized and the different forms of workplace violence as perpetrated by hospital management, doctors and fellow nurses are discussed. Secondly, the meanings given by nurses to their experiences of workplace violence are examined at intrapersonal, interpersonal and institutional levels, with a view to informing interventions that encompass these elements (see Chapter Six). Thirdly, the discussion focuses on the participants' understandings of workplace violence relative to the coping strategies of the participants. In conclusion, Chapter Six addresses the last research question in terms of how workplace violence in the operating theatre could be addressed, managed and ameliorated.

5.2 Direct (personally experienced) and indirect (witnessed) experiences of operating theatre nursing personnel of workplace violence.

This area of questioning examined both the material and non-material aspects of the nursing workplace experience in respect of the participants' personal experiences and witnessing of workplace violence in the operating theatre. The participants' personal experiences and witnessing of workplace violence – as perpetrated by both doctors and fellow nurses - were examined. The findings showed that a range of workplace violence incidents had occurred and were continuing to occur. Direct (personally experienced) and indirect (witnessed) incidents evident from the participants' accounts ranged from verbal abuse, intimidation, bullying, humiliation, physical assault to sexual harassment.

The above findings in the study are similar to those of Jackson et al. (2002) who noted that workplace violence encompasses incidents of physical aggression and assault, harassment, sexual harassment, bullying, and intimidation. They further described workplace violence as being inclusive of the following: verbal abuse (rudeness, use of abusive and /or aggressive language, the use of obscenities and offensive language, distasteful jokes) and humiliation.

It was noteworthy that the bias in the reviewed literature, and assumed in this phenomenological study, was that nurse-participants were not themselves perpetrators of such workplace violence events. Research (including this study) has described abuses visited upon nurses by “others”, i.e. doctors and fellow nurses; and has largely avoided the more difficult and sensitive topics of nurses' reflecting on their own relationship skills, and whether they had ever abused a colleague in “violent” ways, for whatever

reason. This study found some hints of exasperation and impatience (see section 4.5.1 Expectations, standards and performance pressure), but no confessions of abuse /violence. This nurse-complicity in abusive workplace relationships might be usefully explored in future studies.

In this study it was noted that nursing colleagues were found to be perpetrators of more passive and/ or petty forms of verbal abuse and bullying while the abuse meted out by doctors, notwithstanding the documented incidents of physical and sexual assault, was found to be more aggressive and pervasive in nature. As noted in Chapter Four it was apparent that specific surgeons were predominantly responsible for the verbal abuse and that this had impacted significantly on the working environment of the staff – such that no staff member was comfortable to work in those theatres with those surgeons, and actively avoided working in particular theatres because of the verbal abuse that they were subject to.

In accounting for the differences found between the types of workplace perpetrated by doctors and nurses, it was noted that the incidents of verbal abuse delivered by nursing colleagues related mostly to raised and angry tones of voice, e.g. shouting at a nurse colleague when stressed, anxious or insecure about a case. It was further noted that being short staffed and /or having to work with inadequately trained staff heightened the stress and pressure experienced by the theatre nurse. While some of the verbal abuse from doctors may have been precipitated by tension experienced during a difficult case or due to frustrations over perceived sub-standard service or equipment, the position of this

study is that the bulk of these tensions and frustrations are created through the doctors' unrealistic expectations of service delivery. Furthermore the consistent intense, personal and vitriolic attacks by certain surgeons on nursing staff cannot be explained away under the guise of the doctor being tense or frustrated about an aspect of the case. A more likely explanation for these types of attacks may be found in the dynamic of skewed interpersonal relationships, e.g. where the perpetrator bears a lack of respect for his nursing colleagues as health care professionals, as women and regards them as social inferiors. Where doctors are regarded by hospital management as customers, this study is of the position that this additionally fosters unrealistic expectations of service delivery and entitlement in doctors, and that management in turn reinforces these notions to the detriment their nursing staff. This finding is similar to that found by King (2005a).

With respect to incidents of physical / sexual assault Fisher (2005) argues that an incident of workplace violence is almost always pre-meditated, and that it is usually preceded by warning signs which follow a clear and detectable pattern, e.g. a pattern of verbal threatening, intimidation and/or flirtation that escalates over a period of time and which then culminates in an incident of workplace violence. In this study, while there is evidence for premeditated assault - as evident in the account of Sr I who had experienced both a physical assault (chloromycetin in the eye) and sexual harassment (feeling her breasts in the operating theatre) from two different doctors, there had been no warning signs. However, there seemed to be reason to suspect pre-meditation as the doctor/s had purposefully ordered the ointment and sent staff out on errands before the incidents.

5.3 Meanings given by operating theatre personnel to their experiences of workplace violence

A variety of meanings, possible reasons and explanations were given by the participants in accounting for their doctor and nursing colleagues' behaviours. Predominant types of attribution were categorized at three levels: intrapersonal, interpersonal and institutional.

5.3.1 Intrapersonal level

At the intrapersonal (individual) level, a number of the participants were of the opinion that their workplace experiences were mediated by their nursing colleagues' personalities and attitudes, and were to a certain extent understanding and forgiving of incidents of workplace violence (e.g. verbal abuse) which were felt to have been triggered by tensions and stresses due to a colleague's circumstances, e.g. where the colleague was experiencing social and or other home problems. In contrast to the above the participants also attributed their experiences of workplace violence to the temperament of their doctor colleagues (i.e. to the individual's character). It appeared that there was a degree of reductionism and essentialism in this regard and that the changing of these behaviours was perceived as an exercise in futility. The participants noted that certain surgical disciplines attracted more composed and calm personalities while others appeared to be populated by the more vitriolic, temperamental ('Prima Donna') and perfectionist types of personalities.

Interestingly, a number of participants' subjective meaning constructions regarding the occurrence of and their experiences of workplace violence were around victim- and /or

self-blaming. That is, the reasons for the occurrence of the violence were located internally and did not take the context of an incident into account, e.g. where the nurse colleague was felt to have brought an incident upon herself because she had 'an attitude'. This finding corroborates those of Van Wyk (2003) who noted that with regard to humiliations to self-esteem resulting from process trauma, workplace violence had its own dynamics which, while leading to a belief about a loss of safety in the workplace, further gave rise to issues of anger and blame as employees searched for the reasons and causes for the incident of workplace violence. By blaming their colleagues or themselves for an incident, certain participants appear to have created a 'safety net' for themselves in that by attributing the blame for the incident onto the victim or onto themselves, the participants are able to 'manage' and create the illusion of having control over the situation. Further explanations given by the participants regarding the behaviour of their doctor colleagues related to perceptions of how their behaviours were thought to be camouflage for feeling insecure and/or inadequate. Nurse-on-nurse episodes of workplace violence (mostly verbal abuse) were similarly attributed to the individual's feelings of insecurity and inadequacy due to concerns regarding performance and competency.

While acknowledging the participants' meaning constructions and the difficulty of working with a 'frustrated artist' surgeon, it was noted by the researcher that in certain instances, the behaviour of 'a problem surgeon' appeared to be perpetuated by certain nursing personnel (see more on this below).

5.3.2 Interpersonal level

At the interpersonal level, a number of the participants attributed their experiences of workplace violence to the territorial attitudes and behaviours of certain nursing colleagues. It was felt that territoriality not only increased levels of tension and stress in the theatre between personnel, but also served to increase a surgeon's insecurity when having to work with a 'new' scrub sister and predisposed the 'new' scrub sister to being on the receiving end of verbal abuse. While the act of being territorial is not dissimilar from bullying on the one hand, on the other it could be seen as an attempt by the perpetrator to carve out an autonomous existence for the self within the theatre, i.e. to be recognized as an expert in a particular sub-discipline, and to be acknowledged and needed.

Notwithstanding possible autonomy seeking territorial behaviours by one's colleagues, on clarification with the participants it was felt that such behaviours by nursing personnel contributed to surgeon insecurity because they created unrealistic expectations and further conveyed the message that only certain people were competent scrub sisters. It could thus be argued that territoriality by theatre nurses might be regarded as pandering to and feeding surgeons' insecurities because when confronted with a 'new face' (theatre nurse) at the operating table it was inevitable that the surgeon would be tense due to concerns about competency, and tensions in the theatre would be heightened.

Most of the participants additionally attributed the behaviour of certain of their medical colleagues to the fact that they had been 'spoilt' over the years by the nursing personnel.

It was felt that they had placed these doctors 'on pedestals' and as a consequence were having to bear the brunt of this in terms of their doctor colleagues' expectations of entitlement and belief that they were the one's who were in control of the health care team. Nursing personnel who were perceived to be not observing of this demi-god status of their doctor colleagues were then more likely to be 'put in their place' (i.e. to experience verbal abuse) by their doctor colleagues and were regarded as 'cheeky'.

The above finding suggests that gender distribution and traditional role expectations significantly impact on the workplace experience of the theatre nursing personnel. This finding is similar to that of McKoy and Smith (2001) who argued that gender distribution and the experience of workplace violence are linked to the structural variables of patriarchy and to the traditional role socialization of women. McKoy and Smith (2001) argued that traditional role socialization did not foster the development of egalitarian work ethics, mutual respect or power sharing in the workplace e.g. between the nursing profession and the allied health professions, e.g. medicine.

In addition to the above, it was noted by several participants that the female nursing staff employed in the operating theatre were treated differentially by their male doctor colleagues. It was felt that this differential treatment was in terms of hierarchy, status and race and furthermore that it underpinned certain incidents of workplace violence. From a feminist perspective Rajab (2007) argues that the differential treatment of women, e.g. in terms of status, class and even race, ensures that male privilege and power are protected:

“Divide and rule. Treat some women like queens and others like deviant children and then you would have created a situation where they could never get together against you” (p. 7).

The researcher posits that while the above serves to protect male privilege and power in the operating theatre, it has the further effect of dividing the staff in respect of issues on which they should be united, e.g. in respect of challenging unacceptable behaviour and verbal abuse in the theatre. The position of this researcher is that the spoiling of surgeons through over-compensatory deference, unnecessarily going the extra, ‘extra mile’ (e.g. allowing the surgeon to extend a non-emergency operating list and expecting the staff just to stay on after the end of their shifts to finish the list to cover for the exigencies of the service), feeds into doctor’s notions of entitlement.

In sum all of the participants felt that the lack of respect for nurses as health professionals and as women by their predominantly male doctor colleagues underpinned the majority of workplace violence incidents. Interestingly the participants noted that male nurse experiences in the theatre were significantly different to that of female nurses and that where two particular surgeons were concerned the behaviours were attributed to misogyny. This finding is similar to that reported by King (2005a) who noted that male registered nurses’ experiences of workplace violence differed from that of their female colleagues. In that study it was found that the male nurse’s experience of verbal abuse from the patients, the public and doctors was less than that experienced by their female colleagues. In this study, as in King (2005a), the participants attributed the above difference in treatment to gender.

5.3.3 Institutional Level

The majority of participants felt that workplace violence incidents and heightened tensions were fueled by unrealistic expectations of service delivery, performance pressures (having to cover for the 'exigencies of the service') and through having to maintain standards in a situation where they were short staffed and/or were presented with team members who were inadequately trained. This finding complements the research of Jackson et al. (2002) who argue that violence in nursing does not occur in isolation and that organisations have a central role in the perpetuation of workplace violence. Jackson et al. (2002) note that workplace environments perpetuate existing cultures of oppression through managerial budgeting and staffing decisions that contribute towards sub-optimal working conditions that in turn increase their nursing personnel's exposure to workplace violence, e.g. in situations where hospitals are short staffed and where personnel are expected to work with increased workloads (Nabb, 2000 as cited by Jackson et al., 2002).

A number of participants further attributed the occurrence of tensions between nurses to their colleagues ignoring each other's basic needs, e.g. in terms of relieving a colleague for tea or lunch, and /or to not coming in timeously to take over a slate at the end of a shift and so forth. While the participants realized that being short staffed meant that often there were no colleagues to provide for tea and/or lunch relief, the fact that the theatre management appeared to be unable and/or unwilling to set limits on the number of cases booked by surgeons per slate, and were tolerant of surgeons regularly over booking their slates which ran into lunch time and over the end of a shift, meant that their basic needs

were ignored. Most of the participants additionally felt that they were just expected to shoulder the workload and 'get on with it', i.e. to provide for the exigencies of the service.

All of the participants were familiar with the phrase 'to cover for the exigencies of the service' and stated that it was in their contracts. While it was understood that 'exigencies of the service' meant staying on to cater for emergency cases and situations, most of the participants were of the opinion that it was abused by management and was increasingly being taken to mean that the staff must stay on to finish slates that had overrun their allocated time, work through their lunch times and cater for non-emergency cases on weekends e.g. doing joint replacement surgery on a Saturday and/or Sunday. Weekend work was regarded by the participants as being for 'emergency work' and where cold cases (non-emergencies) were booked this often meant that when an emergency came in, a second team of personnel would have to be called out to open up a second theatre.

According to The Constitution of the Republic of South Africa, Act 108 of 1996, and 'The Bill of Rights' as enshrined in Section Two of the Act, everyone has the right to fair labour practices. The above findings suggest that the rights of those nursing personnel who have experienced and who continue to experience process types of workplace violence have been infringed upon.

Another explanation given by the participants for the occurrence of workplace violence pertained to management's perceived inaction with regard to complaints about doctor

colleagues. This inaction was perceived to be related to fiscal considerations and concerns by the management. In essence the participants felt that management were predisposed to put 'profits before people' and were therefore less likely to take serious and effective action against the perpetrator of an incident, and especially with regard to workplace violence incidents of the process type, e.g. overbooking of operating slates. Inaction in these situations was equated with management condoning the situation.

The above finding is similar to that of King (2005a) whose participants were of the opinion that nothing was done about these incidents because of management's attitude that the doctors were the customers and that the nurses were just (expendable) employees who must provide a service and go the 'extra mile'. Ironically, as Pieterse (2006) notes theatre nurses are the unrecognised driving force behind a health care organisation's profit making.

Further attribution for management's inaction with regard to certain incidents of workplace violence, e.g. specific surgeons' penchants for verbally abusing and intimidating the staff, pertained to that of management having vested and social interests in maintaining relationships with them. It was felt that certain senior nursing personnel in management positions were unable and/or unwilling to support their staff and take action with regard to complaints regarding workplace violence incidents because they had crossed professional boundaries e.g. by having become these surgeons' patients and/or by engaging in social relationships with these doctors outside of the workplace. This finding is similar to that pertaining to the 'differential treatment of staff' as discussed above.

As the feminist perspective articulated by Rajab (2007) has argued, it is the differential treatment of women, e.g. in terms of status that serves to divide the nursing personnel on issues on which they should be united.

5.4 Understandings of workplace violence

5.4.1 Perceptions of workplace violence

It was noted that there was a tension between explanations / understandings of workplace violence that were more dynamic and severe, and those that were more so ordinary and unremarkable that they were hardly worth talking about. For the majority of participants workplace violence was understood primarily to refer to dramatic physical and /or verbal abuse. Aside from the physical assault perpetrated upon Sr I, physical abuse additionally related to surgeons throwing instruments, bloodied swabs and /or human tissue around the theatre and/or at the theatre nurse. Verbal abuse related mostly to doctors and /or nursing colleagues swearing, shouting and /or being rude.

When confronted by verbal abuse from doctors and fellow nurses most of the participants reported that they felt unhappy with the situation, but that they felt unable to do anything about it because if they reported it to management either nothing would be done about it, or they would not be believed and would be branded as 'trouble makers'. This finding is similar to that found by King (2005a), and in this study it is clearly illustrated in the incident involving sexual harassment with Sr I (as documented previously). When Sr I had indicated to the doctor concerned that she was reporting the incident, he reportedly

had said that she would not be believed, that she would be branded a trouble maker and that she must remember what had happened to a colleague at another local hospital who had tried to report a doctor for a similar offense. He had further stated that she must remember that 'he was a customer'. This communication from the doctor concerned further contributed to Sr I's anxious state and caused her to doubt whether she should report the incident or not.

From the participants narratives it was further clear that incidents of workplace violence in the theatre were under reported. In the clarification interview with Sr I it was reported that since she had laid a grievance against the doctor concerned, a number of female nurses and doctors had confided in her that they too had similar experiences with the doctor concerned but that they had not reported the incident out of embarrassment. The above findings are congruent with those of Jackson et al. (2002) who have argued that incidents of nursing workplace violence are under reported and also with the findings of McKoy and Smith (2001) who additionally noted in their study the following reasons for nurses failing to report such incidents:

- peer pressure not to report such incidents
- ambiguities inherent in defining violence
- fear of job loss
- perceptions that workplace violence is 'just part of the job'
- fear of being blamed in respect of somehow having caused the incident
- perceptions that if one reported the incident then this would be viewed by the employer as having occurred due to negligence or poor job performance

- the belief that the reporting of such incidents are futile because nothing gets done about them, i.e. there is no personal benefit to reporting such incidents
- intrapersonal conflict relating to the nurse's perception of her professional role (putting the patient first) versus the role of being a victim.

This researcher notes that the findings mentioned above are similar to those found by King (2005a) and that additional research has evidenced that the above findings correlate with increased incidences of absenteeism, sick leave, drug and alcohol abuse, burnout and high staff turnover rates (Jackson et al., 2002). As Lehane (2005) has argued, persistent workplace violence, e.g. bullying of an individual, not only gradually erodes their self confidence, but further results in the individual experiencing physical symptoms such as stomach complaints, ulcers, an inability to concentrate, headaches, tearfulness, insomnia and may furthermore exacerbate any health conditions that may already be present, e.g. depression. Van Wyk (2003) has similarly argued that the long drawn out nature of such workplace trauma is traumatic and furthermore that it potentially causes adjustment disorders and other conditions like anxiety states and depression - conditions which are highly incapacitating and which predispose to absenteeism. As Hutton (2006) and Lehane (2005) have noted in their respective articles, the financial implications of absenteeism are self evident and should alert management to the fact there may well be problems in the workplace that need attention and remediation.

In contrast to the above, subtle, unremarkable, invisible 'part of the job' types of violence, e.g. repeatedly being asked to stay on after a shift to finish a slate and the cancelling of lunch and/or tea breaks, was less easily recognized as being forms of workplace violence. It was apparent from the participants' accounts of their workplace

experiences in general that these more insidious forms of workplace violence were considered to be distasteful but unavoidable parts of the job. Interestingly staff who endeavoured to take their lunch break and who insisted on going off duty on time were regarded by their colleagues as somehow being 'less' dedicated and/or professional.

5.4.2 The blaming triangle

The attributing of 'blame' in the form of accusing colleagues of 'not being real nurses' (internal attribution), and the perception by a number of the participants that they were blamed by management for an occurrence of workplace violence is interesting because it is congruent with Van Wyk's (2003) findings. In his article he argues that process type workplace violence gives rise to anger and blame as employees endeavour to make sense of their situation. The above findings augment Lanza's (1992) observation of an organisational 'blaming triangle' (Lanza, 1992 as cited by McKoy & Smith, 2001). In a blaming triangle the victim(s) of workplace incidents blame themselves or authority figures for the incident, colleagues blame the perpetrator of the incident and the organisation in turn blames the workers.

In the theatre situation and in the context of process workplace violence, e.g. having to work short staffed, the 'blaming triangle' (see Diagram 5.4.2) might be conceptualized as follows: the nurses blame themselves, each other and brand colleagues as 'not being real nurses' because 'real' nurses don't complain about not getting their lunch, tea or having to sacrifice their personal lives for the good of the patient, and further blame management for short staffing the unit (intrapersonal, interpersonal and institutional levels of

attribution for workplace violence respectively). The nurses also blame the surgeons for over booking their slates and for being 'selfish' (interpersonal level of attribution). The doctors blame the nurses and accuse them of being incompetent, lazy and inefficient, and blame the organisation for not meeting service delivery expectations (interpersonal and institutional levels of attribution respectively). The organisation blames and/ or brands the nurses in terms of their being not cost effective, lazy and not customer orientated (intrapersonal and institutional levels of attribution respectively).

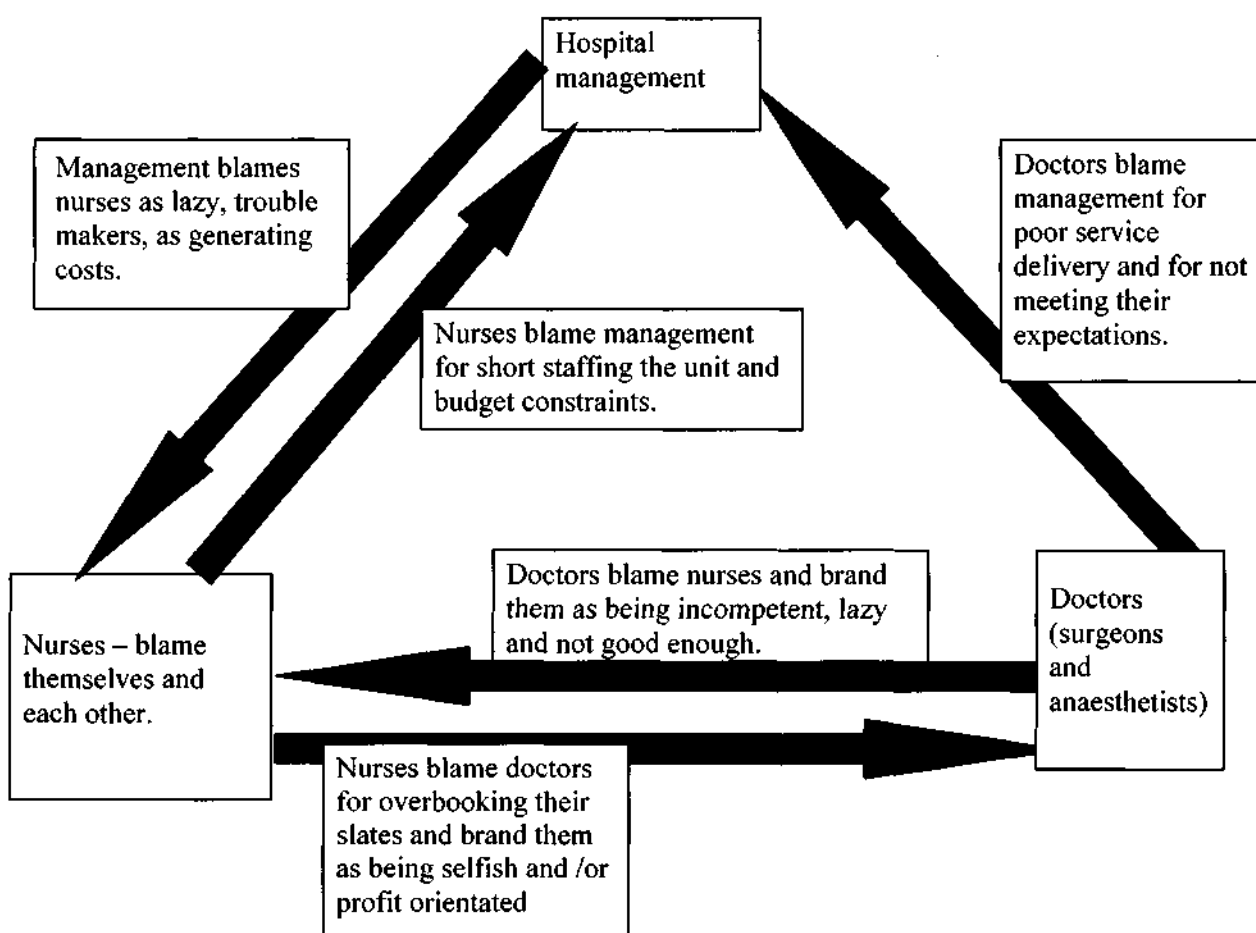


Diagram 5.4.2: The blaming triangle

In examining the above 'blaming triangle' it is apparent that there are multiple levels of attribution that occur regarding situations of workplace violence. It is clear that any actions taken by management in respect of effectively managing workplace violence need to take into account the different levels of attribution discussed previously. As mentioned in Chapter Two, the use of cognitive behavioural models alone in remediating the above situation would be problematic because the assumptions underpinning the use of these models mean that any interventions so devised would be focused on individuals - at the intrapersonal level - and not on a group of employees, i.e. at the interpersonal and institutional levels. As Naidoo and Wills (2000) have argued, the theories of behaviour change are additionally flawed in that they are underpinned by assumptions that disregard the individual's context, e.g. complex workplace violence situations, socially determined behaviours such as responses to workplace violence and external forces which impact on the situation. As mentioned previously in Chapter Two, the forces referred to are those pertaining to socio-structural (e.g. race and patriarchy), socio-economic, environmental and organisational conditions – forces which create and maintain barriers to behaviour change and which create barriers to the empowerment of nurses in respect of their being able to effectively manage and contain workplace violence.

Notwithstanding the dynamics of a 'blaming triangle', the different levels of attribution and the flaws of cognitive behavioural models, it was evident on closer analyses of the transcripts that the participants' thinking about workplace violence did significantly impact on their physiological and psychological state and influence their subsequent behaviour (see below). In the focus group session, and particularly in the transcripts of

Srs B and F, where negative internal attributions had been made in the wake of a verbally abusive incident with a particular doctor, this in turn generated anxiety related symptoms such as tachycardia, feeling nervous and experiencing difficulty sleeping the night before having to work with him. Their physiological responses to the stressful situation appeared to exacerbate their anxiety, and since they were unable to fight or flight from the situation, this created further anxiety and stress.

The above finding suggests that theatre nurses may experience workplace violence in terms of a cognitive-behavioural triad. A cognitive-behavioural triad may be conceptualized as follows: an antecedent event occurs, e.g. an unconditioned stimulus such as verbal abuse. This is subjectively experienced in terms of the individual's beliefs about the event and the self, e.g. a cognitive distortion such as 'I am useless; I will never meet this surgeon's expectations'. The experience and associated beliefs subsequently impact on the individual's behaviour (affect and actions) and are manifest through the individual being tense, anxious and /or clumsy. In this situation, the perpetrator of the verbal abuse becomes the conditioned stimulus, i.e. the individual now associates their inner tensions and anxieties to their having to work with the perpetrator, and any further negative appraisals of the individual's actions or incidents of verbal abuse (e.g. as a consequence of being anxious and clumsy) in turn feeds back into the individual's negative beliefs about the self and perpetuates their anxiety state.

The presence of a cognitive-behavioural triad suggests that despite the reservations mentioned about using cognitive behavioural models of behaviour change, intervention and remediation measures might employ the use of a behaviour change model as part of a multi-tiered strategy to contain and manage workplace violence at the intrapersonal level.

5.5 Coping strategies

A range of coping mechanisms and defensive strategies were employed by the participants to cope with and manage their experiences and witnessing of workplace violence incidents. It was noted that there were tensions between coping mechanisms and defensive strategies that were more pathological / ineffective and those that contributed to the resilience of the theatre nurses in the face of workplace violence.

From a clinical psychological perspective certain of the coping mechanisms and defensive strategies could be regarded as problematic, pathological and /or ineffective, e.g. avoidance and withdrawal from certain situations, minimizing incidents of workplace, keeping the peace/ keeping quiet and being stoical, comfort eating, crying and over-compensatory behaviour. The researcher posits that these coping mechanisms and strategies are problematic because they do not permit the individual to satisfactorily address or resolve problematic work situations and thus perpetuate the situation.

The above situation, in the absence of any intervention has been conceptualized by the researcher along cognitive-behavioural lines. Firstly, the incident of workplace violence, e.g. verbal abuse (unconditioned stimulus) results in stress, tension, anxiety and in a

physiological response. Secondly, the workplace and/or working with a particular surgeon and/or nursing colleague now becomes a conditioned stimulus and leads to further anxiety type symptoms. Thirdly this leads to further verbal abuse due to surgeon frustration and/or intolerance. Fourthly, this leads to increased stress, anxiety, to cognitive distortions, anxiety and depression disorders and burnout. Final outcomes of the above may be poor work performance, territorial behaviours and perpetuation of workplace violence through taking one's frustrations out on others, and / or the resignation of the nurse concerned (see Diagram 5.5.2).

In contrast to the above, certain of the coping mechanisms and defensive strategies appear to be forms of adaptive defense mechanisms, e.g. venting to colleagues, seeking out support networks and rationalisation to an extent. The researcher posits that these defense mechanisms and strategies have endowed the theatre nurses with a degree of resilience that has enabled them to stay on in their profession of choice. This is because these defense mechanisms and strategies appear to be a means by which the theatre nurse is able to achieve catharsis regarding any anger, frustration and anxiety as subjectively experienced in the face of workplace difficulties on the one hand, and a means by which she is able to maintain a healthy perspective on the situation at hand on the other. The above is illustrated in Sr T's account when she recalled an incident of verbal abuse - she stated that the realisation that the case would soon be over and that the doctor would then leave the theatre enabled her to continue at her post.

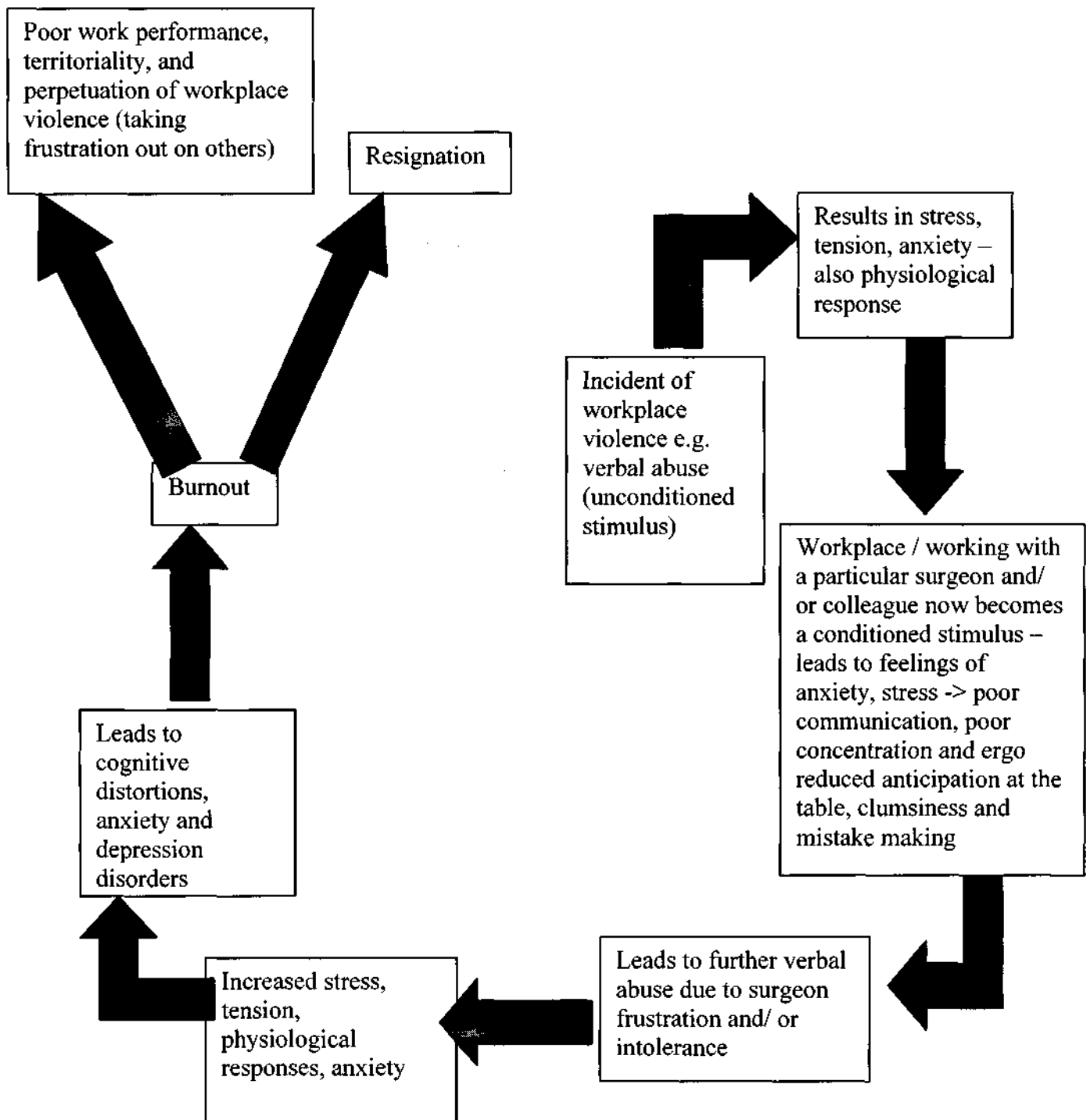


Diagram 5.5.2: The cycle of workplace violence: effects and outcome

The above finding is similar to the findings of Colavecchio (1982, as cited by Booyens, 1985) and Callaghan (2003) who argued that while nurses complained about their work environment and working conditions, it was not 'the patient' or 'nursing' that was driving them out of the profession, but other aspects of the job which made them unhappy. The above finding demonstrates that theatre nurses, even in the face of workplace violence, continue to hold their patients and their responsibility towards caring for their patients in high regard. This professional attitude and altruism appears to have encouraged a number of this study's participants to 'rise above' and cope with a situation of workplace unpleasantness.

Notwithstanding the above and in view of the particular finding that most of the participants in this study did not have access to a satisfactory support network (see Chapter Four), the researcher posits that an awareness of the phenomenon and occurrence of workplace violence in theatre needs to be fostered. It is additionally vital that the importance of and need for support networks and for intervention in the above situation be discussed. As mentioned above, potential sequelae for theatre nurses in the absence of intervention with regard to workplace violence in theatre are burnout, resignation or the perpetuation of the cycle of workplace violence due to frustration, territoriality and/or poor work performance. It is clear that workplace violence interventions needed to be multi-tiered. While there is a place for the cognitive behavioural model aimed at intervening effectively at the intrapersonal (individual) level, interventions need to incorporate interpersonal and institutional programmes as well.

CHAPTER SIX: CONTAINING AND MANAGING WORKPLACE

VIOLENCE

6.1 Introduction

This chapter addresses the last research question in terms of how workplace violence in the operating theatre could be contained, managed and ameliorated. Firstly, the participants expectations regarding the containing and managing of workplace violence and literature pertaining to workplace violence prevention programmes is mentioned. Secondly, recommendations regarding the containment and management of workplace violence are made for hospital management and the nursing profession. Thirdly, recommendations for further research are made, and finally, additional considerations regarding the strengths and specific methodological critiques of the study and conclusions drawn from the study are presented.

6.2 Participant expectations and workplace violence prevention programmes

In this study all of the participants emphasized the need for management to be proactive and supportive of the staff with regard to incidents of workplace violence, and to visibly demonstrate a valuing of their staff. This finding is similar to that of McKoy and Smith (2001) who noted in their study on workplace violence in the United States that there is a general expectation among employees that employers provide a safe and peaceful work environment. Further analyses of the transcripts (see Chapter Five) suggested that the theatre and hospital management structures played a pivotal role with regard to the handling of workplace violence incidents. While the participants wanted management to

be more proactive and supportive there was a general perception that management generally did not support the nursing personnel when they complained about the behaviour, e.g. verbal abuse of certain doctors, and that most of the participants were hesitant to report matters to the management because they felt that they would be blamed and/or chastised for the incident. In addition to this, the majority of participants felt that workplace violence incidents and heightened tensions were fueled by unrealistic expectations of service delivery, performance pressures and through having to maintain standards in a situation where they were short staffed and/or were presented with team members who were inadequately trained.

As discussed previously, the findings in this South African study complement the research findings of Jackson et al. (2002) in their study on workplace violence in developed contexts. While Jackson et al. (2002) have argued that violence in nursing does not occur in isolation and that organisations have a central role in the perpetuation of workplace violence the organisational dynamics in their study were not apparent. In this study the organisation concerned is a private healthcare institution and thus might present with different dynamics to those surveyed by Jackson et al. (2002), i.e. public hospital organisational dynamics versus private hospital organisational dynamics. In the South African managed healthcare (private hospital) context, it appears that health and the provision of healthcare are commodities to be traded and the organisation is run primarily as a business. The researcher is of the position however, that notwithstanding the complexities of organisational dynamics, that the organisation in this study should play a central role in eliminating, containing and managing workplace violence. McKoy

and Smith (2001) have argued that 'prevention and avoidance' are among the most important strategies that employers can implement in order to avoid the occurrence of violence in the workplace.

Forster et al. (2005) in their Australian study have identified a number of key components that workplace violence prevention programmes should include: risk assessment of workplace violence, staff education and training and a focus on management practices, e.g. in terms of policies about workplace violence and in terms of intervention strategies to be implemented to manage and/or contain incidents of workplace violence.

Notwithstanding Forster et al.'s (2005) key components, King (2005b) has argued, from within South Africa's healthcare system, that the planning and implementation of strategies to prevent and manage workplace violence need to be conducted on a number of levels: intrapersonal, interpersonal, and organisational. It was noted that any workplace violence prevention programme needed to secure the 'buy-in' and commitment of all participants and stakeholders and that different levels of programmes needed to be implemented simultaneously (King, 2005b). King (2005b) proposed that individuals would engage in life skills training programmes, while management disseminated and implemented policies on workplace violence, and that focus / support groups could additionally be used to foster awareness of and /or stimulate consciousness raising pertaining to workplace violence. She noted that these could in turn be used to provide feedback on the incidence and prevalence of workplace violence, and on the efficacy or not of containment measures.

In a theoretical discussion regarding organisational change Nutbeam and Harris (1999) argue that any plan intended to effect an organisational change of some sort, e.g. a plan to eliminate workplace violence, needs to incorporate and recognise that organisational change moves through various stages. Firstly, there is an *awareness raising stage* that is used to conscientise role players regarding the occurrence of workplace violence and of the need and benefits to changing the status quo. Awareness raising further identifies cost-benefit considerations to key role players / hospital management, e.g. by pointing out the benefits of reduced staff turnover, reduced absenteeism, and the promotion of quality nursing care through caring for the carer, and /or provides information regarding legislative – labour relations considerations.

Secondly, there is an *adoption phase* in which key role players and hospital management decide whether or not to implement an organisational change and plan for the adoption of new policies by which the change is to be effected, e.g. policies regarding workplace violence. This stage is additionally the point at which it is determined what training, material and resources, e.g. personnel are needed, and when gate-keepers, e.g. senior nursing personnel are consulted with regard to the drafting and implementing of the policies.

Thirdly, there is an *implementation phase* where the devised programme or change decided on above is actually implemented. Here education materials and life skill courses, e.g. conflict resolution courses and education to personnel about workplace violence and grievance procedures, are implemented. At this stage access to counselling

services could be enabled. Nutbeam and Harris (1999) note that a final stage in the organisational change cycle, the *institutionalisation phase*, requires key role players and management to commit to the long term maintenance of programmes implemented and that this is enabled through the ongoing monitoring and evaluation of implemented programmes.

6.3 Recommendations for hospital management

The recommendations are interpretively based on several substantive sources. Firstly, from literature reviewed. Secondly, from suggestions by the participants and from the interpretation of the participants' subjective experiences by the researcher (see Chapters Four and Five). Thirdly, from the researcher's own research studies in the field and experience in theatre nursing. There are several broad goals of the recommendations listed below. Firstly, to foster awareness and/ or the raising of individual, group and organisational consciousness of workplace violence. Secondly, to identify possible solutions to this problem. Thirdly, to secure commitment from individuals and management to work towards the containing and managing of workplace violence on a number of levels (intrapersonal, interpersonal and institutional) simultaneously.

At the Institutional level, hospital management should:

- Visibly demonstrate their support and valuing of their nursing personnel. This support and valuing should be clearly evident to the doctors utilizing the hospital's facilities. In essence management should 'put their people before profit'.

- Adopt policies that promote transparency regarding the management of workplace violence and which ensure that feedback is given to the parties concerned regarding the outcome of investigations into incidents of workplace violence.
- Ensure that all nurses and particularly theatre nurses are educated regarding grievance procedures and assured of management's support in the face of workplace violence and / or discriminatory practices.
- Be committed towards maintaining professional boundaries with all personnel – that is with doctor / customers as well as with nursing personnel.
- Implement programmes that educate nursing personnel about workplace violence and which promote assertiveness training, anger management and conflict resolution.
- Provide a support structure for theatre nurses to assist with the containment and management of workplace violence, e.g. support groups, psychological services for debriefing and psychoeducation regarding workplace violence.
- Specifically for theatre management - given the findings regarding the stress to the staff caused by the over-booking and over-running of slates - management should consider setting limits on the number of cold cases permitted to be attended to per slate and enforce these strictly, i.e. no last minute cold case additions; 'after hours' and 'weekend work' should be for emergency cases only.

6.4 Recommendations for the nursing profession

At an institutional level, the nursing profession, e.g. those involved in nurse training programmes at universities, colleges and hospitals and individual nurses themselves should:

- Ensure that nursing curricula deliver the appropriate life skills training, e.g. assertiveness and conflict resolution training, anger and stress management courses.
- Engage in a marketing campaign to promote the profession. Stereotype of the nursing profession by the media and others should be challenged since this negatively affects not only public perception but also the perceptions of the allied health professions e.g. doctors.

At the interpersonal level, the nursing profession should:

- Unite and demonstrate a visible solidarity – both within the workplace and without. This may be achieved through joining an appropriate union that efficiently and adequately represents the interests of nurses in the workplace; by taking an active part in consultative forums and by attending the relevant professional body meetings.
- Be supportive of each other and not condone workplace violence in any form, e.g. the verbal abuse of a colleague by another, demeaning jokes, gossip, slander and innuendo. Silence both condones and perpetuates abuse, and there is nothing professional about being a doormat.

At the intrapersonal level:

- Take part in ‘life skills’ and communication training, e.g. assertiveness training, education re the grievance procedure process and conflict resolution skills. Proficiency in these skills is intended to boost self esteem and perceptions of self efficacy/ agency which in turn impacts on the individual’s behaviour when it comes to following through on a planned behaviour, e.g. actually being assertive and setting boundaries.

- Be cognizant of / become educated regarding matters pertaining to basic conditions of service and the labour law, and be informed about their rights both in the workplace and constitutionally, e.g. be informed about grievance procedures, when the procedure may be employed, how it is initiated and the course that follows until resolution of the matter at hand has been achieved.

6.5 Recommendations for further research

The following recommendations for further research have additionally been drawn from the findings:

Given that in this study a shortage of nursing personnel has been cited as a precipitating factor with regard to workplace violence and given that the current systems of determining unit staffing do not appear to be satisfactory, research should be initiated into mandatory minimum staffing ratios particularly with regard to the theatre context. This is necessary because taking an operating slate at face value does not take into account the amount of preparatory work and non-nursing duties, e.g. charging, that are done by operating theatre nurses.

In reflecting on this study's process trauma findings and given Van Wyk's (2003) link between process trauma and adjustment disorder, anxiety states and depression, research should be initiated into identifying the extent of process trauma / violence in the theatre, and into how this could be ameliorated.

6.6 Additional considerations, specific methodological critiques and strengths

The broad limitations of this study are associated with the small scale of the study and to the researcher using a purposive sampling technique in the selecting of participants to take part in the study. While the above is consistent with IPA, this means that the reader must decide if the study is transferable to other similar contexts and must be aware that the sample used will not necessarily be representative of the population being investigated.

An additional limitation was the presence of the researcher and the need to record the interviews, since not all of the participants were at ease with having their interviews recorded. Babbie and Mouton (1991) argue that this means that some of the study's participants' responses may have been less than spontaneous. Babbie and Mouton (1991) have further argued that because the interview situation is 'unknown' to most participants it is not uncommon for participants to experience the interview as a test, or a 'spying operation' on the behalf of management. While these fears were dealt with in terms of the study's ethical considerations, (see Chapter Three), they may have had an effect on the responses of the participants.

Specific methodological critiques and concerns of the study relate to the conceptual and practical limitations of IPA. Willig (2001) notes that these concerns relate to the role of language in IPA, and to the suitability of IPA in respect of working with participants' accounts and explanations of their experiences. The study grappled with these concerns in the following way:

The role of language: Willig (2001) argues that while language is the medium through which participants convey and communicate their subjective experiences to the researcher, it must be remembered that language both describes and constructs reality and/ or a particular experience. She further notes that there are many of ways of talking about an experience in that the words that are chosen to reflect or describe a particular event or experience are laden with meaning. Given that IPA works with text and “relies on the representational validity of language” (p. 63), Willig (2001) notes that critics of IPA posit that transcript text offers the researcher an account of “how an individual talks about a particular experience within a particular context ... [rather] ... than about the experience itself”. To address these concerns the researcher used a thematically semi-structured interview format in which the label ‘workplace violence’ was not used and in which participants were invited to talk about their current workplace experiences using their own words (see Chapter Three). The researcher took care not to construct workplace realities for the participants or to define workplace violence for the participants. In this way the narratives obtained from each participant elucidated their experiences of the phenomenon itself.

Suitability of accounts and explanations: IPA works with texts and relies on participants to describe and to articulate their experiences in a manner that gives full expression to their thoughts, feelings and perceptions (Willig, 2001). Willig (2001) argues that where participants are not used to verbalizing their thoughts, perceptions and feelings that this may detract from the suitability of the participant’s account for IPA because they are

unable to communicate the subtleties of their subjective experiences and of the meanings attached to these.

This concern was addressed in the following ways. Firstly, in terms of the study's ethical considerations particularly with regard to assurances pertaining to anonymity and confidentiality (see Chapter Three). Secondly, through emphasizing the voluntary nature of participation in the study and the fact that participants could withdraw from the study at any time. Thirdly, by limiting the participants to those who were English speaking. The participant demographics further evidence that each of the participants in this study held tertiary education qualifications. The researcher posits that all of the above measures have facilitated the participants being able to communicate the subtleties of their subjective experiences and the meanings attached to these and thus that the participant accounts derived in this study are suited to IPA.

The strengths of this study are as follows. First, the researcher does have inside experience in terms of previous professional qualifications and experience in the nursing profession and particularly in the operating theatre as a theatre nurse. This enabled the researcher to establish rapport with the theatre nurses in this study which in turn facilitated more spontaneous responses to the interview situation. Second, this insider experience and perspective enabled the researcher to understand and interpret the participants' experiences. Third, the researcher has previously published a research study in the field (see King, 2005a) and finally, the credibility of the study has been established through the use of clarification interviews, member checking and peer review.

6.7 Conclusion

In this study the participants' lived experiences of workplace violence in the operating theatre indicated that workplace violence had impacted and was impacting on their everyday work experience. A range of workplace violence experiences as precipitated and perpetuated by doctors, fellow nurses and hospital management was noted. These included verbal abuse, bullying, intimidation, process violence, physical assault and sexual harassment. Differences between the types of workplace violence perpetrated by doctors, nurses and hospital management were found. The participants articulated a range of subjective meanings and explanations for their colleagues' behaviours (intrapersonal, interpersonal and institutional) - all of which were found to have impacted on their psychological wellbeing. A variety of defense mechanisms and coping strategies were identified and discussed.

Following McKoy and Smith (2001), the researcher identified a number of factors that made the nursing workplace and/or the healthcare environment more susceptible to the occurrence of workplace violence, e.g. low staffing, a reduction in trained staff, and the profit-motives of private hospitals in the healthcare industry (managed healthcare). These were found to have impacted on each of the participants in this study in respect of their experiences of workplace violence. In sum, the study has provided a clear, department specific picture about the experiences of theatre nurses in respect of workplace violence. A number of interventions to facilitate and retain the services of theatre nurses in the operating theatre have been suggested.

7. REFERENCES

Airhihenbuwa, C.O. and Obregon, R. (2000). A critical assessment of theories/ models used in health communication for HIV/AIDS. Journal of Health Communication, 5, p. 5 -15.

Awases, M., Gbary, A., Nyoni, J. and Chatora, R. (2004). Migration of health professionals in six countries: a synthesis report. Brazzaville, South Africa: World Health Organisation Regional Office for Africa (Division of Health Systems and Services Development).

Babbie, C. and Mouton, J. (1991).The practice of social research. Oxford: Oxford University Press.

Beharie, S. (2006). Nurse sues RK Khan Hospital. The Sunday Tribune News, 2 July, p. 7.

Booyens, S.W. (1985). Opmerkings oor 'n ondersoek na die tekort aan verpleegpersoneel in Transvaalse provinsiale hospitale, 1983. Curationis, 8 (1), p. 16.

Callaghan, M. (2003). Nursing morale: what is it like and why? Journal of Advanced Nursing, 42 (1), p. 82 -89.

Crotty, M. (1996). Phenomenology and nursing research. Melbourne, Australia: Churchill Livingstone.

Denscombe, M. (1998). The good research guide. Buckingham: Open University Press.

Dudley, L. (2007). A time for strong medicine – the nurses' strike action highlights the human resource crisis within the public health system. The Mercury, 12 June, p. 11.

Fisher, A. (2005). How to prevent violence at work. Fortune, 151 (4), p. 42.

Forster, J.A., Petty, M.T., Schleiger, C. and Walters, H.C. (2005). Know workplace violence: developing programs for managing the risk of aggression in the health care setting. The Medical Journal of Australia, 183 (7), p. 357-61.

Geyer, N. (2004). Re - marketing the nursing profession. Nursing Update, 28 (3), p. 34 -37.

Hoel, H. and Brennan, W. (2005). Tackle the 'vampire' bullies. Occupational Health, 57 (6), p. 11.

Holloway, I. and Wheeler, S. (1996). Qualitative research for nurses. Oxford: Blackwell Scientific.

- Hosken, G. (2007). Pregnant nurse recovering. The Pretoria News, 05 November, p. 1. Retrieved November 12, 2007 from the World Wide Web: <http://www.themercury.co.za/?fSectionId=&fArticleId=vn20071105110321591C896501>
- Hutton, S.A. (2006). Workplace incivility: state of the science. The Journal of Nursing Administration, 36 (1), p. 22-27.
- Jackson, D., Clare, J., and Mannix, J. (2002). Who would want to be a nurse? Journal of Nursing Management, 10 (1), p. 13 – 20.
- Janiszewski Goodin, H. (2003). Integrative literature reviews and meta- analyses – the nursing shortage in the United States of America: an integrative review of the literature. Journal of Advanced Nursing, 43 (4), p. 335. Retrieved March 22, 2004 from the World Wide Web: <http://www.blackwell-synergy.com/servlet/useragent?searchbutton.x=1>
- King, L. (2005a). Hospital workplace experiences of registered nurses that have contributed to their resignation in the Durban metropolitan area. Curationis, 29 (4), p. 70 - 81.
- King, L. (2005b). The identification and elimination of workplace violence, an empowerment project. Unpublished Masters Coursework, Department of Nursing, University of KwaZulu-Natal, Durban.
- Kgosimore, D.L. (2004). Employing violence. Nursing Update, 28 (1), p. 17 - 20.
- Krefting, L. (1991). Rigor in qualitative research: the assessment of trustworthiness. The American Journal of Occupational Therapy, 45 (3), p. 214 - 222.
- Kvale, S. (1996). Interviews. Thousand Oaks: Sage Publications.
- Kwok, R.P., Law, Y.K., Li, K.E., Ng, Y.C., Cheung, M.H., Fung, V.K., Kwok, K.T., Tong, J.M., Yen, P.F. and Leung, W.C. (2006). Prevalence of workplace violence against nurses in Hong Kong. Hong Kong Medical Journal, 12 (1), p. 6-9.
- Lehane, M. (2005). Stand up to bullies. Nursing Standard, 19 (38), p. 28 - 29.
- Massachusetts Nurses Association (MNA). (2005a). Groundbreaking survey on workplace violence released. Massachusetts Nurse: The Newsletter of the Massachusetts Nurses Association, 76 (6), p. 10.
- Massachusetts Nurses Association (MNA). (2005b). Workplace violence prevention bill heads to Ways and Means Committee. Massachusetts Nurse: The Newsletter of the Massachusetts Nurses Association, 76 (7), p. 1 and 12.

Massachusetts Nurses Association (MNA). (2005c). Workplace violence prevention and intervention: being assaulted is NOT part of the job no matter where you work. Massachusetts Nurse: The Newsletter of the Massachusetts Nurses Association, 76 (3), p. 12.

McKoy, Y. and Smith, M.H. (2001). Legal considerations of workplace violence in healthcare environments. Nursing Forum, 36 (1), p. 5 - 14.

McPhaul, K.M. and Lipscomb, J.A. (2004). Workplace violence in health care: recognised but not regulated. Online Journal of Issues in Nursing, 9 (3), p. 168- 185. Retrieved April 6, 2006 from ACADEMIC SEARCH PREMIER Database: <http://search.epnet.com/login.aspx?direct=true&db=aph&an=16508468>

Minkler, M. and Wallerstein, N. (1997). Improving health through community organization and community building. In K. Glantz, I.M. Lewis and B.K. Rimer (Eds.), Health behaviour and health education: theory, research and people (p. 241 – 269). San Francisco: Jossey-Bass Publishers.

Naidoo, J. and Wills, J. (2000). Health promotion: foundations for practice, (2nd edition). Baillière and Tindall: Edinburgh.

Nutbeam, D. and Harris, E. (1999). Theory in a nutshell – a guide to health promotion theory. McGraw-Hill: London.

Paterson, B., Leadbetter, D., and Miller, G. (2005). Beyond zero tolerance: a varied approach to workplace violence. British Journal of Nursing, 14 (15), p. 810-815.

Pieterse, V. (2006). What is my value to you? South African Theatre Sister, 31 (1), p. 31 – 34.

Polit, D.F. and Hungler, B.P. (1997). Essentials of nursing research methods, appraisal, and utilization. 4th edition. Philadelphia, New York: Lippincott.

Rajab, D. (2007). Understanding our male counterparts. The Mercury, 13 August, p. 7.

Smith, J.A., Jarman, M. and Osborn, M. (1999). Doing interpretative phenomenological analysis. In M. Murray and K. Chamberlain (Eds.), Qualitative health psychology theories and methods (p. 218 – 239). London: Sage Publications.

The Constitution of the Republic of South Africa - Act 108 of 1996, as adopted on 08 May, 1996 and amended on 11 October, 1996 by the Constitutional Assembly.

The Basic Conditions of Employment Act – Act 75 of 1997 as amended by the Basic Conditions of Employment Amendment Act in 2002 by the Constitutional Assembly.

Willig, C. (2001). Introducing qualitative research in psychology: adventures in theory and method. Buckingham: Open University Press.

Van Der Walt, H. (2002). Too close for comfort: emotional ties between nurses and patients. In L. Swartz, K. Gibson and T. Gelman (Eds.), Reflective practice psychodynamic ideas in the community (p. 73 – 82). Pretoria: Human Sciences Research Council.

Van Wyk, G. (2003). Trauma in the workplace – the new way of managing trauma ... turning a bad experience into good. TraumaClinic, September, p. 3-11.

7.1 Additional Readings:

Brink, H.I. (1996). Fundamentals of research methodology for health care professionals. Kenwyn, South Africa: Juta.

Brink, H. (1991). Quantitative vs qualitative research. Nursing RSA, 6 (1), p. 14-18.

Burns, N. and Grove, S. (1995). Understanding nursing research. Philadelphia: W.B. Saunders.

Creswell, J. (1998). Qualitative inquiry and research design - choosing among five traditions. London: Sage Publications.

Crotty, M. (1998). The foundations of social research. London: Sage Publications.

Wilson, H. S. (1985). The craft of qualitative analysis: from observations to exploration. In H. S. Wilson (Ed.), Qualitative research in nursing. (p. 396 – 427). California: Addison-Wesley.

Wilson, H. S. (1989). The craft of qualitative analysis. In H. S. Wilson (Ed.), Research in nursing (p. 452-499). Redwood City, CA: Addison-Wesley.

8. APPENDICES

8.1 Appendix One: Focus group and interview schedule

Setting the scene:

Ensure private venue for interview.

Establish rapport, greet participant (s), thank participant (s) for agreeing to be interviewed. Discuss the study and briefly summarize the research study objectives, discuss the matter of confidentiality, remind the participants that participation is voluntary and that they may end their participation at any time. (Obtain written consent). Prior to turning on the tape recorder, allow participant (s) to choose a pseudonym that will be used throughout the interview and in the study.

This is a semi-structured interview. The research questions (in bold print) have been included on this document as a guide for the researcher, and the prompts are intended to elicit information from the participants in respect of exploring each research question/ area. Please note that the participant will **not** be asked the research questions.

It is important to start with some 'less sensitive' questions so that the participant (s) does not feel threatened or uncomfortable. These questions would take the form of 'verifying' questions e.g.

- How long have you worked at hospital x?
- What is your area of specialty?

Thereafter the primary '**trigger**' question – 'how would you describe your current interpersonal relationships in the operating theatre?' will be asked, followed by a 'prompt/s' if appropriate. If the interview appears to stall, the researcher will employ the use of a prompt/s.

1. How do operating theatre nursing personnel understand workplace violence?

PROMPTS:

- How would you describe your current interpersonal relationships in the operating theatre?
- Please describe a typical day in the operating theatre where things seemed to go wrong for you.
- Is there anything about that day, e.g. in terms of your interactions with other theatre personnel that stands out for you?
- What is the 'grievance procedure' and when is it used?

2. What are the direct and indirect experiences of operating theatre nursing personnel in respect of workplace violence?

PROMPT:

- Are there specific items or incidents that come to mind in respect of workplace incidents that have affected you personally, e.g. a situation in which you felt less than pleased with the events or outcome?
- Have you witnessed the occurrence of workplace bullying, intimidation and/or verbal abuse?
- Have any of your colleagues experienced incidents of workplace unhappiness?
- How do management address negative workplace incidents?

3. What meanings are given by operating theatre nursing personnel to experiences of workplace violence?

PROMPT:

- What effect did the witnessing of the incident have on you?
- What effect do these incidents have on the work climate?
- When X [*an incident or experience of workplace violence*] happens, what are your thoughts about the situation or events that unfold afterwards?
- What does X mean for you?

4. How do operating theatre nursing personnel manage experiences of workplace violence?

PROMPT:

- When X [*a disclosed incident or experience of workplace violence*] happens to you / has happened how do you react to the situation?
- When X happens, what are your thoughts about the situation or events that unfold afterwards?

5. How could workplace violence in the operating theatre be effectively contained and managed?

PROMPT:

- How should negative workplace incidents be handled?
- Is there a department policy in place to deal with negative workplace incidents?

Thank participant again for their time and participation. Ask if there is anything else that they would like to add to the interview, schedule a follow up interview to clarify and check information obtained in this interview.

8.2 Appendix two: ethical clearance documentation: see overleaf.



RESEARCH OFFICE (GOVAN MBEKI CENTRE)
WESTVILLE CAMPUS
TELEPHONE NO.: 031 - 2603587
EMAIL: ximbap@ukzn.ac.za

13 SEPTEMBER 2006

MS. LA KING (202519964)
PSYCHOLOGY

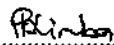
Dear Ms. King

ETHICAL CLEARANCE APPROVAL NUMBER: HSS/08462A

I wish to confirm that ethical clearance has been granted for the following project:

"Exploring the experience of workplace violence on nursing personnel in a private hospital in the Durban Metropolitan Area"

Yours faithfully


.....
MS. PHUMELELE XIMBA
RESEARCH OFFICE

PS: The following general condition is applicable to all projects that have been granted ethical clearance:

THE RELEVANT AUTHORITIES SHOULD BE CONTACTED IN ORDER TO OBTAIN THE NECESSARY APPROVAL SHOULD THE RESEARCH INVOLVE UTILIZATION OF SPACE AND/OR FACILITIES AT OTHER INSTITUTIONS/ORGANISATIONS. WHERE QUESTIONNAIRES ARE USED IN THE PROJECT, THE RESEARCHER SHOULD ENSURE THAT THE QUESTIONNAIRE INCLUDES A SECTION AT THE END WHICH SHOULD BE COMPLETED BY THE PARTICIPANT (PRIOR TO THE COMPLETION OF THE QUESTIONNAIRE) INDICATING THAT HE/SHE WAS INFORMED OF THE NATURE AND PURPOSE OF THE PROJECT AND THAT THE INFORMATION GIVEN WILL BE KEPT CONFIDENTIAL.

cc. Faculty Officer (Post-Graduate Office)
cc. Supervisor (Ms. J. Wilbraham)



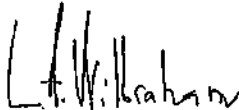
15 September 2006


ETHICAL CLEARANCE


Ms Lisa King is a registered Masters (Clinical Psychology) student in the Psychology School, Howard College, University of KwaZulu-Natal.

This letter is to certify that the research study for her Masters dissertation has been approved by the Higher Degrees Committee of the Faculty of Humanities, Social Science and Development; and full ethical clearance granted by the University of KwaZulu-Natal Ethics Committee. Ethical clearance has been granted for the research project entitled:

"Exploring the experience of workplace violence on nursing personnel in a private hospital in the Durban Metropolitan Area."


Dr L.A. Wilbraham
Research Supervisor


Professor I. Petersen
Head: School of Psychology


Professor S. Collings
Coordinator: Masters (Clinical Psychology) Programme

School of Psychology

Postal Address: Durban, 4041, South Africa

Telephone: +27 (0)31 260 7423

Facsimile: +27 (0)31 260 2618

Email: chellyih@ukzn.ac.za

Website: www.ukzn.ac.za

Founding Campuses:

Edgewood

Howard College

Medical School

Pietermaritzburg

Westville

8.3 Appendix three: Letter requesting permission for the study to the Department Of Health:

18-06- 2006

Mr. G. Tromp

Department of Health - Natalia

Private Bag X 9051
Pietermaritzburg
3200

Dear Sir

Request for permission to conduct a research project in a private hospital in the Durban Metropolitan Area.

My name is Lisa King. I am a postgraduate student at the University of KwaZulu -Natal and I am studying for a Master's degree in Clinical Psychology. My dissertation is being undertaken as partial fulfilment of the requirements for this degree.

The title of the research project is:

Exploring the experience of workplace violence on nursing personnel in a private hospital in the Durban Metropolitan Area (DMA).

Ethical clearance has been obtained from the University of Kwazulu-Natal's School of Psychology and the Humanities' Faculty Ethics Committee.

The purpose of this study is to explore and describe the workplace experiences of theatre nurses currently employed in a specific context (an operating theatre) in a hospital in the DMA. This study aims to create awareness – at middle and senior management levels of the experiences that contribute towards the high turnover of nursing personnel in this area of practice, as too of those experiences that have resulted in nurses leaving the nursing profession. If these experiences are accurately identified it is envisioned that the current trend (chronic shortage and high turnover of nursing personnel), might be effectively reduced.

I intend to conduct a focus group in which the above topic will be broadly discussed. The focus group will be comprised of 4-8 registered nurses who work in theatre. With permission from hospital management, the focus group would be conducted during on-duty time / over a lunch time for approximately forty minutes. Lunch and refreshments will be provided.

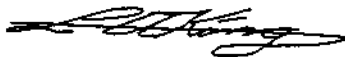
Thereafter I intend to conduct two semi- structured interviews with selected participants – either at the hospital or at a private venue at a date and time of their choice. The initial interview will be approximately 40 minutes long, and will be recorded so that an accurate transcript of the interview can be made. The second interview is intended for follow up and clarification of material obtained in the initial interview. All recordings and transcripts are confidential. Only the researcher and the research supervisor will have access to the recordings. Once data analysis is complete all recordings will be destroyed. Specific means by which the confidentiality and anonymity of the hospital and that of individual participants are assured are: by means of the use of pseudonyms (at no stage will personal details be recorded on any of the research documentation) and anonymity will be assured by suitably modifying any potentially recognizable workplace incidents described so that they cannot be identified. All participants have to meet the inclusion criteria of the study, and these criteria are that they must:

- be qualified (registered) nurses
- be currently working in the operating theatre department
- not be in a line management or team leader position
- be English speaking
- be willing to meet with the researcher
- have experience of the phenomenon of workplace violence

No costs would be incurred by participating organisation or their personnel, and participating personnel would be asked to participate at a time that is convenient to both themselves and their employing body. Participation is voluntary and participants may withdraw from the study at any time should they wish to do so. The anticipated benefit would be primarily in terms of the results obtained – and how these could be applied by middle and senior hospital management to the recruitment and retention of nursing personnel in the operating theatre. Given the Department of Health's commitment to quality improvement in all spheres of health care delivery, the results of this research would be of interest to all those who employ nursing personnel in their health care services.

Thanking you in anticipation.

Yours sincerely



Lisa King

Researcher's contact details:

Ms. L. King
Tel: (031) 260 2618

Research Supervisor's contact details:

Prof. L. Wilbraham
Tel: (031) 260 2615

University of KwaZulu-Natal
School of Psychology
Howard College Campus
Durban
4001

8.4 Appendix four: Letters granting permission for the study from the Department Of Health: see overleaf.



DEPARTMENT OF HEALTH
Private Bag X9051
PITERMARITZBURG
3200
Tel.: 033-3953003
Fax: 033-345 3527
Email.: Padmini.Naidoo@kznhealth.gov.za
www.kznhealth.gov.za

Reference : 049/06
Enquiries : Mrs P Naidoo
Telephone : (033) 395 3003

21 September 2006

Ms Lisa King
12 Rouken Glen
381 Musgrave Road
Durban
4001

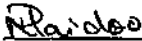
Dear Ms King

ACKNOWLEDGEMENT OF RESEARCH PROPOSAL

This is to inform you that we have received your research proposal on: **Exploring the experience of workplace violence on nursing personnel in a private hospital in the Durban Metropolitan Area (DMA)** on 21 September 2006.

Please be advised that your proposal is being reviewed and you will be notified of the outcome in due course.

Thank you


Mrs. P Naidoo

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope



DEPARTMENT OF HEALTH
Private Bag X9051
PIETERMARITZBURG
3200
Tel.:033-3952382
Fax: 033-394 3782
www.kznhealth.gov.za

Reference : 049/06
Enquiries : Mrs M Badenhorst
Telephone : (033) 395 2382
Fax No: (033) 394 3782

08 January 2007

To : Ms Lisa King
12 Rouken Glen
381 Musgrave Road
DURBAN
4001

Dear Ms King

RESEARCH PROPOSAL APPROVAL

TITLE

EXPLORING THE EXPERIENCE OF WORKPLACE VIOLENCE ON NURSING PERSONNEL IN A PRIVATE HOSPITAL IN THE DURBAN METROPOLITAN AREA (DMA).

Thank you for submitting the above protocol for review by Kwa-Zulu Natal Department of Health. The protocol is hereby approved.

Kindly make necessary arrangements with site before commencing with the study. Please provide this office with six monthly, interim and final reports arising from this study. Your final reports are to be posted to **HEALTH RESEARCH AND KNOWLEDGE MANAGEMENT Private Bag X 9051, PIETERMARITZBURG, 3200** and e-mail an electronic copy to sophy.skhosana@kznhealth.gov.za.

Sincerely

**Mrs. M Badenhorst
General Manager**

uMnyango Wezempilo . Departement van Gesondheid

Fighting Disease, Fighting Poverty, Giving Hope

8.5 Appendix five: Letter requesting permission for the study to health care institution:

10 -01- 2007

Chief Nursing Services Manager

XXX Hospital
XXX Road / P.O. Box XXX
Durban
4001

Dear Mrs. X

Request for permission to conduct a research project at XXX Hospital

My name is Lisa King. I am a postgraduate student at the University of KwaZulu -Natal and I am studying for a Master's degree in Clinical Psychology. My dissertation is being undertaken as partial fulfilment of the requirements for this degree.

The title of the research project is:

Exploring the experience of workplace violence on nursing personnel in a private hospital in the Durban Metropolitan Area (DMA).

The purpose of this study is to explore and describe the workplace experiences of nurses currently employed in a specific context (an operating theatre) in a hospital in the DMA.

Permission to conduct the research has been obtained from the Department of Health and ethical clearance has been obtained from the University of Kwazulu-Natal's School of Psychology and the Humanities' Faculty Ethics Committee.

This study aims to create awareness – at middle and senior management levels of the experiences that contribute towards the high turnover of nursing personnel in the Durban Metropolitan Area, as too of those that result in nurses leaving the nursing profession. If these experiences are accurately identified it is envisioned that the current trend (chronic shortage and high turnover of nursing personnel), might be effectively reduced.

I intend to conduct a focus group in which the above topic will be broadly discussed. The focus group will be comprised of 4-8 registered nurses who work in theatre. With permission from hospital management, the focus group would be conducted during on-duty time / over a lunch time for approximately forty minutes. Lunch and refreshments will be provided.

Thereafter I intend to conduct two semi- structured interviews with selected participants – either at the hospital or at a private venue at a date and time of their choice. The initial interview will be approximately 40 minutes long, and will be recorded so that an accurate

transcript of the interview can be made. The second interview is intended for follow up and clarification of material obtained in the initial interview. All recordings and transcripts are confidential. Only the researcher and the research supervisor will have access to the recordings. Once data analysis is complete all recordings will be destroyed. Specific means by which the confidentiality and anonymity of the hospital and that of individual participants are assured are: by means of the use of pseudonyms (at no stage will personal details be recorded on any of the research documentation) and anonymity will be assured by suitably modifying any potentially recognizable workplace incidents.

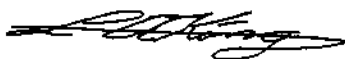
All participants have to meet the inclusion criteria of the study, and these criteria are that they must:

- be qualified (registered) nurses
- be currently working in the operating theatre department
- not be in a line management or team leader position
- be English speaking
- be willing to meet with the researcher
- have experience of the phenomenon of workplace violence

No costs would be incurred by XXX hospital, and participating staff members would be asked to participate at a time that is convenient to both the hospital and the staff member concerned. Input required from XXX hospital would be in the form of permission to conduct the research on hospital premises with willing participants. Participation is voluntary and participants may withdraw from the study at any time should they wish to do so. The benefit to XXX hospital would be primarily in terms of the results obtained – and how these could be applied by middle and senior hospital management to the recruitment and retention of nursing personnel in the operating theatre. Given the hospital's commitment to quality excellence in all spheres of health care delivery, the results of this research might be of interest to XXX hospital as a whole.

Please would you consider my doing this research at XXX hospital. Thanking you in anticipation.

Yours sincerely



Lisa King

Researcher's contact details:

Ms. L. King
Tel: (031) 260 2618

Research Supervisor's contact details:

Prof. L. Wilbraham
Tel: (031) 260 2615

University of KwaZulu-Natal
School of Psychology
Howard College Campus
Durban
4001

8.6 Appendix six: Letter granting permission for the study from participating institution:

[Redacted]

Group

[Redacted]

28 February 2007

Ms L King
University of KwaZulu-Natal
School of Psychology
Howard College Campus
Durban

Dear Lisa

Research project: [Redacted]

With reference to your request to conduct research for a study on workplace violence, I am pleased to inform you that the hospital is willing to grant you access to theatre staff.

It is understood that the participation by nursing personnel is entirely voluntary, and that staff interviews and focus groups will take place at a time convenient to the workplace requirements.

The Cardiac Intensive Care unit manages a meeting room that should suit your purposes ideally as it is close to the theatres and of a suitable size. Please contact the Unit Manager, Sr [Redacted] on extension [Redacted] to make bookings for the use of the room.

If there is any further assistance you require, please do contact me.

Yours sincerely,

[Redacted Signature]

[Redacted Name]

Theatre Manager

[Redacted]

8.7 Appendix seven: covering letter to participants advising them about the study and inviting them to participate and consent form:

Researcher's contact details:

Ms. L. King

Tel: (031) 260 2618

University of KwaZulu-Natal

School of Psychology

Howard College Campus

Durban

Research Supervisor's contact details:

Prof. L. Wilbraham

Tel: (031) 260 2615

4001

Dear Colleague

REQUEST FOR YOUR PARTICIPATION IN A RESEARCH STUDY:

My name is Lisa King. I am a postgraduate student at the University of KwaZulu -Natal and I am studying for a Master's degree in Clinical Psychology. My dissertation is being undertaken as partial fulfilment of the requirements for this degree.

The title of the research project is:

Exploring the experience of workplace violence on nursing personnel in a private hospital in the Durban Metropolitan Area (DMA).

You have been identified as fulfilling the following criteria for this study – in that you are:

- a qualified (registered) nurse
- are currently working in the operating theatre department
- are not in a line management or team leader position
- are English speaking
- are willing to meet with the researcher
- have experience of the phenomenon of workplace violence

The purpose of this study is to explore and describe the workplace experiences of theatre nurses currently employed in a specific context (an operating theatre) in a private hospital in the DMA.

I intend to conduct a focus group in which the above topic will be broadly discussed. The focus group will be comprised of 4-6 nursing colleagues who work with you in theatre. With permission from hospital management, the focus group will be conducted during on-duty time / over a lunch time for approximately forty minutes. Lunch and refreshments will be provided.

Thereafter I intend to conduct two semi- structured interviews with selected participants - in a private venue, and at a date and time of your choice. The initial interview will be approximately 40 minutes long, and will be recorded so that an accurate transcript of the interview can be made. The second interview is intended for follow up and clarification of material obtained in the initial interview. All recordings and transcripts are confidential. Only the researcher and the research supervisor will have access to the recordings. Once data analysis is complete all recordings will be destroyed - participants may request to have their tape returned to them if they so wish. Your confidentiality is further assured by the use of a pseudonym that may be chosen by you, throughout the interview. At no stage will your personal details be recorded on any of the research documentation e.g. your name, identity number, or staff number. Participant anonymity will be assured by suitably modifying any potentially recognizable workplace incidents described so that they cannot be identified.

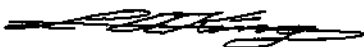
Please note that participation is voluntary, and that by participating in this study and signing the consent form overleaf you indicate that you consent to take part in the study. Provision has been made for free, professional counselling at the School of Psychology clinic - should this be required at any stage throughout the research process. The contact details for the Clinic Director are as follows: Prof. S. Collings, tel: (031) 260 2618.

This research is being conducted with the permission of the Department of Health and has been approved by the University of Kwazulu-Natal's School of Psychology and the Humanities faculty Ethics Committee. Permission to conduct the study has additionally been obtained from the Chief Nursing Services Manager at your institution, however please note that the researcher is not affiliated to your organisation. A copy of the dissertation will be given to the Department of Health and to hospital management.

Should any participant wish to contact me about the outcome of the research once the results have been collated, I would be happy to discuss the project with them and have recorded my contact details above.

Thanking you in anticipation,

Yours sincerely,



Lisa King

RESEARCH STUDY CONSENT FORM

I, _____ hereby consent to take part in this research study
(Name in block capitals please)

conducted by Lisa King. I understand the nature and content of the study, that free professional counselling is available to me at the Psychology clinic at the University of KwaZulu-Natal, that my participation is entirely voluntary, and that I might withdraw from the study at any time.

I further consent to the tape recording of the focus group interview and individual interview (s) by the researcher, and understand that the recordings are confidential and will not be accessed by any other person aside from the research supervisor for the project.

(Signature of participant)

(Date)

(Witness – Lisa King)

8.8 Appendix eight: workplace violence poster – calling for participants for the focus group:

WORKPLACE VIOLENCE

Interested?

A recent phenomenological study across both private and public hospitals in the Durban Metropolitan Area (DMA) described and documented a variety of hospital workplace experiences that had contributed to the resignation of registered nurses in the DMA. The experience of workplace violence was found to be common to the majority of participants in this study.

What are your experiences and understandings of workplace violence?

If you are:

- a qualified (registered) nurse
- are currently working in the operating theatre department
- are not in a line management or team leader position
- are English speaking
- are willing to meet with the researcher
- have experience of the phenomenon of workplace violence

Please come and join me in an interactive focus group to discuss workplace violence.

WHERE: Cardiac ICU Conference Room

WHEN: 07 March 2007

TIME: 12h00 – 13h00

NB: A LIGHT LUNCH AND REFRESHMENTS WILL BE PROVIDED

NAMES

*** Max. 10 persons**

THANK YOU FOR YOUR PARTICIPATION