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**Understanding the Management of Intra/Inter Professional Aggression: A Critical Nursing
Ethnography**

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**Understanding the Management of Intra/Inter Professional Aggression:
A Critical Nursing Ethnography**

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Thesis submitted to the
Faculty of Graduate and Postdoctoral Studies
In partial fulfillment of the requirements
For the PhD degree in Nursing

School of Nursing
Faculty of Health Sciences
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Abstract

As the link between a healthy workforce and better patient outcomes is becoming more evident, creating healthy and safe workplaces for health care providers is now a concern for many employers. While a safe work environment includes being exempt from aggression, workplace aggression continues to be identified as a serious problem by health care professionals. Notwithstanding the importance and obligation of addressing all types of workplace aggression and all groups of perpetrators, dealing with instances of intra/inter professional aggression is essential since this type of aggression is often insidious and can be more disturbing to the victim than any other type of aggression. While nurse managers were identified as playing a central role in the management of workplace aggression, it is not clear how they deal with instances of intra/inter professional aggression given their current work environment and working conditions. The purpose of this study is to broaden the understanding of how nurse managers respond to intra/inter professional workplace aggression. Based on a theoretical framework developed from the work of Girard, Foucault and Weber, this study focuses on aspects of the social/cultural work environment influencing nurse managers' responses to intra/inter professional aggression as well as strategies deployed by nurse managers to deal with such aggression. Using principles from critical nursing ethnography, the research was conducted in both a university affiliated psychiatric hospital and a community hospital located in a large metropolitan city in Ontario. Data collection included 23 semi-structured interviews, collection of mute evidence and observations. The major study findings are that 1) aggression management is a non linear process involving managing perceptions, emotions and the actual aggressive act, which are all influenced by omnipresent and insidious power relations; 2) aggression management is not solely the responsibility of managers but must involve several actors including the aggressive individual, peers, human resources department and unions; and 3) each individual needs to play an active role in aggression management and be held responsible and accountable for his/her actions.

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CHAPTER 1 PROBLEM STATEMENT

As the link between a healthy workforce and better patient outcomes is becoming more evident, creating healthy and safe workplaces for health care providers is now a concern for many employers (Shamian & El-Jardali, 2007). A safe work environment encompasses many characteristics including being exempt from aggression. Still, the issue of workplace aggression in the context of health care is not new nor is it an isolated problem linked to only a few individuals. Rather it is an insidious and complex problem “rooted in social, economic, organizational and cultural factors” (International Labour Office [ILO], International Council of Nurses [ICN], World Health Organisation [WHO], & Public Services International [PSI], 2002, p. 9).

The importance of addressing workplace aggression and of promoting safe work environments is recognized at provincial, national and international levels, as seen by the development of several position statements and guidelines (Canadian Nurses Association [CNA], Canadian Federation of Nurses Unions, 2008; International Labour Office [ILO] et al., 2002; Registered Nurses’ Association of Ontario [RNAO], 2008, 2009). However, these appear to only have limited effect on resolving the issue since workplace aggression continues to be identified as a serious problem by health care professionals and stakeholders (Quality Worklife Quality Healthcare Collaborative [QWQHC], 2007; Shields & Wilkins, 2006). Whereas managers were identified as playing central roles in the management of workplace aggression (Alexandre, Fraser, & Hoeth, 2004; Umiker, 1997), there is little evidence available pertaining to managers’ specific actions taken to respond to workplace aggression that occurred on their units, as well as how factors in the work environment can play a role in the management of aggressive acts.

Research Problem

The issue of workplace aggression is not limited to acute care settings, even if the majority of studies on the topic were conducted in hospital settings. Many health care professionals, mostly staff nurses, from several different types of units did complete quantitative questionnaires in an attempt to better understand the scope of the problem. As a result, intensive care units, general medicine wards, psychiatric wards and emergency departments were all identified as high risk areas for verbal abuse (Öztunç, 2006). However, there is still no agreement on whether emergency departments and intensive care units are actually more at risk for workplace aggression than general wards such as medicine (Landy, 2005).

Workplace aggression is also known to be a significant problem in psychiatric facilities (Barlow, Grenyer & Ilkiw-Lavalle, 2000; Privitera, Weisman, Cerulli, Tu & Groman, 2005). Research into workplace aggression suggests that staff, rather than patients, were more often the victim of both verbal and physical aggression from patients (Daffern, Ogloff and Howells, 2003). As well, aggressive incidents were more likely to be preceded by interpersonal or hospital related antecedents, such as staff refusing a request, and managed by physical interventions such as restraint and medications rather than verbal such as counselling (Shepherd & Lavender, 1999).

Workplace aggression is not without consequences as it includes direct costs (illness, injury, disability, death, absenteeism, staff turnover); indirect costs (reduced work performance, lower quality of service); and intangible costs (damage to the image of the organization, decreased staff motivation and morale, diminished loyalty to the organization) (Di Martino, 2005; Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002). As well, the ramifications of workplace aggression are not only felt by employees and employers but can

also affect spouses, children and families in general (Courcy & Savoie, 2003). As for the financial cost associated with workplace aggression, Henry and Ginn (2002), citing the work of Jossi (1999), have stated that “combined with other costs such as lawsuits, lost productivity, higher insurance cost and workers’ compensation claims, the bottom line figure for workplace violence is an estimated \$36 billion U.S. annually” (p. 481). Consequently, the management of workplace aggression remains a priority for action in health care, as seen in provincial and federal reports which identify the development of workplace aggression prevention programs as organizational priority action strategies for decision-makers and managers to improve quality of worklife for health care professionals as well as quality of care and patient outcomes (Quality Worklife Quality Healthcare Collaborative [QWQHC], 2007; Registered Nurses’ Association of Ontario [RNAO], 2008).

Patients/family and intra/inter professional aggression are identified as the most prevalent types of aggression and are most often examined in the health care literature. Whereas patients are generally described as the main source of physical aggression, hospital staff is often, if not more frequently, cited as an important source of non-physical aggression (Hesketh et al. 2003). Notwithstanding the importance and obligation of addressing all types of workplace aggression and all groups of perpetrators, managing instances of intra/inter professional aggression is imperative since intra staff aggression is found to be more disturbing to the victim than any other type of aggression (Farrell 2001, Farrell 1999). Despite these troubling findings, no studies were found in the literature addressing the management of intra/inter professional aggression within health care milieus.

The ongoing restructuring of the Canadian health care system that began in the 1990’s is also contributing to the increased frequency of workplace aggression. In effect, widespread restructuring and downsizing is having a profound effect on work environments and working

conditions, often resulting in layoffs, salary freeze or salary cut, heavier workloads, faster pace of work, longer hours of work and increased stress (Di Martino, 2003). These may potentially lead to aggressive acts driven by insecurity, frustration and a sense of helplessness (Di Martino, 2003).

A closer look at nursing managers' work environments shows that restructuring is also having a profound effect on their working conditions. For example, downsizing is used by many health care organizations as a mean of cutting cost (Doran et al, 2004). As a result, several chief nursing officers and middle manager positions are abolished, leaving limited power to influence change for those remaining and leading to an under-representation of nursing in institutional hierarchies (Patrick & Spence Laschinger, 2006). Additionally, remaining managers become responsible for several units thus managing more staff (Norrish & Rundall, 2001). A Canadian report indicates that on average first-line managers have approximately 70 direct reports with some exceeding 100 reports (Laschinger & Wong, 2007). As a result, the role of nursing managers changed considerably to include less of a clinical focus and more of a management focus, necessitating additional knowledge and skills (Shirey, 2006; Thorpe & Loo, 2003). While no study exploring the relationship between managers' span of control and their management of workplace aggression was found in the literature, a Canadian study found that as work unit size increases, the relationships between managers and staff becomes less positive (Doran et al., 2004).

The high demands placed on remaining nursing managers considerably increases their work stress (Lindholm, 2006; Shirey, 2006) and levels of burnout (Spence Laschinger, Almost, Purdy, & Kim, 2004). Numerous nurse managers are now reporting experiencing psychological distress (Bourbonnais et al., 2001) and low self-rated health (Lindholm, Dejin-Karlsson, Östergren, & Udén, 2003). Several nurse managers are also reporting facing

organizational mistreatment (Harlos & Axelrod, 2005), feeling isolated (Delmas, Mayrand Leclerc, & Pronost, 2006), stuck between “a rock and a hard place” (Mayrand Leclerc, Lavoie-Tremblay, & Viens, 2006) with ambiguous and sometimes conflicting roles and responsibilities (Westerberg & Armelius, 2000).

Given the call for managers to improve and create safe work environments and seeing that tolerating low intensity deviant behaviours may in fact be conducive to more serious types of aggressive behaviours, there is a need to understand how nurse managers respond to intra/inter professional aggression. As well, while factors in the work environment of health care workers are identified as influencing the incidence of workplace aggression (Courcy & Savoie, 2004; Engel, 2004; Lewis, 2006; Salin, 2003), it is not clear how these organizational factors may play a role in the management of intra/inter professional aggression. Finally, there is a need to identify how nurse managers are supported when having to manage intra/inter professional aggression.

Research Objectives

1. To understand the management of intra/inter professional aggression from the nurse managers' perspective;
2. To identify organizational factors that can facilitate or impede the management of intra/inter professional aggression;
3. To explore how nurse managers are supported when having to manage intra/inter professional aggression.

Research Questions

The analysis will serve to answer the following questions:

1. What are the strategies deployed by nurse managers to deal with intra/inter professional aggression?
 - a. What are the specific actions taken by nurse managers, when managing intra/inter professional aggression on their units?
 - b. How do the type of perpetrator and the type of aggression play a role in the choice of action taken?
2. Which aspects of organizational/unit culture, structures and systems influence the management of intra/inter professional aggression by nurse managers?

- a. How do factors in the organizational environment play a role in the management of intra/inter professional aggression?
- b. How can nurse managers be supported when having to manage intra/inter professional aggression?

Epistemological Stance

This research project sits in a postmodern approach within the critical theory paradigm. Postmodernists believe that reality has a “plural nature” with multiple positions from which it can be viewed (Cheek, 2000). As such, any representation of reality can only be partial and the “truth” is open to challenges (Cheek, 2000). This study attempts to explore why certain health care practices in relation to the management of intra/inter professional aggression are shaped the way they are, and why particular players and practices are commonly put forward while others are omitted. The uses of a postmodern view provides the basis for conceptualising intra/inter professional aggression in a new and different way; and to think about the issue in a reflexive manner to unmask hidden complex political and ideological agendas (Cheek, 2000).

From an ontological perspective, researchers who position their work in a critical theory paradigm believe that reality is shaped over time by social, political, cultural, economic, ethnic and gender factors (Guba & Lincoln, 1994). From an epistemological perspective, researchers who sit in a critical theory paradigm believe that both researcher and object of research are interactively linked, while also believing that researchers’ values inevitably influence the study and study findings (Guba & Lincoln, 1994). As a result, critical researchers must reflect on their own subjectivity as a way to achieve greater objectivity (Foley & Valenzuela, 2005), and must explicitly expose their assumptions so that there are no confusion about where they stand (Kincheloe & McLaren, 2005).

Accordingly, a researcher's beliefs about the nature of reality and the nature of knowledge impact his/her choice of research methodology. The methodology used by critical researchers involves a dialogue between researchers and study participants to uncover and make visible the subtleties of oppression and power relations which are socially and historically constituted (Carspecken, 1996).

I have worked in the field of occupational health nursing for almost 15 years. As part of my work in the hospital sector, I had the opportunity to observe the effects of an unhealthy work environment on employees. I saw nurses burn out and leave the profession. I also witnessed how workload, role ambiguity and competition can lead to conflict and aggression. These observations combined with the experience I acquired working in health care institutions have stimulated my interest in exploring the issue of workplace aggression and more specifically intra and inter professional aggression. Instinctively, I perceived a relationship between power, power games and aggression. My readings of Michel Foucault's work, particularly *Discipline & Punish* and *The Subject and Power*, allowed me to better understand how power is insidious and everywhere and the need to question "normal" organizational dynamics. As a result, it is increasingly important that my research address the issue of power using a critical perspective and a willingness to challenge *status quo*. My reflections are leading me to position myself as adhering to many of the guiding principles and beliefs found within a critical theory paradigm. For example, I believe that there are multiple realities shaped by social, political, cultural and economic factors. These realities are co created by both researcher (me) and participants amidst a naturalistic environment. I am also aware that my qualitative interpretation and critical theorizing are influenced by these basic beliefs and are shaping my understanding of the issue.

CHAPTER 2 LITERATURE REVIEW

The literature search covered publications in English and French, from the early 1960 to 2010; and included books, reports and journal articles. Bibliographic databases searched for journal articles included Cumulative Index to Nursing and Allied Health Literature (CINAHL), Current Content, EMBASE, Medline, PsycINFO and Web of Science. Additional search strategies included the identification of relevant references from each article retrieved. Key words used for the search included but were not limited to: abuse of power, aggression management, bullying, emotional abuse, harassment, human aggression, nurse manager, mobbing, occupational violence, violence against nurses, workplace aggression; workplace violence. The literature review chapter is divided into three sections, all of which pertain to health care milieus:

- 1) Workplace aggression and violence;
- 2) Management of aggression;
- 3) Summary of literature review

More specifically, section one looks at the need for a clear definition, the issue of under-reporting and the perpetrators of workplace aggression. Section two focuses on the management of aggression including the importance of taking into account individual, interpersonal and organizational determinants of workplace aggression, a brief overview of conflict management strategies; and a review of issues specific to the work environment and working conditions of nurse managers such as role ambiguity, role overload, role conflict, limited support and limited training. Section three summarizes the literature review and introduces the Workplace Aggression Management Framework.

Workplace Aggression and Violence

Workplace aggression and violence in the context of health care is of increasing importance as more and more health care professionals are reporting these incidents both formally and informally. However, there is a common belief that it is the very nature of the work performed by health care professionals that is putting them at risk for experiencing workplace aggression and violence (Erickson & Williams-Evans, 2000; Ferns & Chojnacka, 2005; Henry & Ginn, 2002). While this statement may be partially true in relation to health care professionals often rationalizing that patients' aggressive behaviours are related to their medical condition; it also reinforces the notion that aggression and violence in caring milieus are part of the job and inevitable.

Statistics related to workplace aggression and violence confirm the need for action. For example, a Canadian study of 260 employees (response rate 52%) found that out of 13 occupations studied, nurses were the second highest for risk of violence and aggression, right next to police officers who were first (LeBlanc & Kelloway, 2002).

Findings from the Canadian component of a large international study involving Canada, the United States, England, Scotland and Germany found that of the 8780 registered nurses from Alberta and British Columbia that took part in the study (response rate 51%), 46% of respondents experienced one or more types of violence in the last five shifts (Duncan et al., 2001). Types of violence included emotional abuse (38%), threat of assault (19%), physical assault (18%), verbal sexual harassment (7.6%) and sexual assault (0.6%). Yet, 70% of these nurses chose not to report the abuse (Duncan et al., 2001). As well, other findings from the same study found that while patients were the main source of physical assaults, hospital staff (physicians and nursing co-workers) were the main source of non-physical violence (e.g. emotional abuse and verbal sexual harassment), especially in critical care areas

(not including emergency departments) (Hesketh et al., 2003). More specifically in critical care settings, physicians were responsible for 31.2% of all instances of emotional abuse while nursing co-workers committed 25.5%. Physicians were also responsible for 43.7% of all cases of verbal sexual harassment while nursing co-workers for 9.9%. As well, of all critical care nurses sampled (n=1439), 14% reported being emotionally abused by a co-worker in the last five shifts (compared to 7.7% of nurses from all other specialties combined), and 2.2% of critical care nurses reported being sexually harassed by a co-worker (compared to 0.8% of the rest of the nurses) (Hesketh et al., 2003).

A third Canadian study of about 19 000 regulated nurses (registered nurses, licensed practical nurses and registered psychiatric nurses) across the country (response rate 80%) found that while 29% of all nurses reported physical assault by a patient in the last year, 44% reported emotional abuse by patients, followed by visitors (16%), nurse co-workers (12%) and physicians (8%) (Shields & Wilkins, 2006). Furthermore, males were found to be more likely than females to experience physical assault (44% compared to 28% respectively) and twice as likely to report such assault, and nurses younger than 45 were more likely to report emotional abuse from a patient (47%) compared to 38% of nurses 55 or older (Shields & Wilkins., 2006). In the United States, the Bureau of Labour Statistics reported a rate of 15 injuries from assaults and violent acts per 10,000 workers for those employed in social services and a rate of 25 injuries per 10,000 for nursing and personal care facility workers. These figures compare to an overall injury rate of 2 per 10,000 workers in private sector industries (Occupational Safety and Health Administration [OSHA], 2004).

The issue of workplace aggression in psychiatric wards is well documented (Daffern, Ogloff & Howells, 2003; Privitera et al., 2005). In effect, psychiatric settings are identified as prominent sites for aggression directed towards staff and other patients (Barlow, Grenyer

& Ilkiw-Lavalle, 2000). In psychiatric units, most violent incidents tend to be perpetrated by patients (Chen, Hwu, Kung, Chiu & Wang, 2008), while most common victims tend to be staff members (Barlow, Grenyer & Ilkiw-Lavalle, 2000).

The incidence of aggressive acts as well as its management is based on the interaction between: patient (e.g. psychopathology, gender), environment/setting (e.g. size of ward, crowding), interaction/situation (e.g. aversive stimulation, provocation), and staff (e.g. level of education, training in aggression management, attitudes) (Abderhalden, Needham, Friedli, Poelmans & Dassen, 2002). In fact, the attitudes and behaviours of staff may be the most important factors affecting patients' aggressive behaviour (Abderhalden et al. 2002). A study exploring differences between patient and staff perceptions of aggression in mental health settings found that staff often perceived patients' illness as the cause of aggression, while patients perceived illness, interpersonal and environmental factors as being equally responsible for their aggression (Ilkiw-Lavalle & Grenyer, 2003). As a result, staff believed that change in medication was indicated to deal with the issue, while patients suggested improving staff-patient communication and flexible unit rules to reduce aggression (Ilkiw-Lavalle & Grenyer, 2003). As such, strategies identified by staff to respond to acts of patient aggression often included physical interventions such as restraints, medication and seclusion, while strategies identified by patients included counselling (Shepherd & Lavender, 1999).

A cyclical model of violence by psychiatric in-patients suggests that nurses' reaction following an act of aggression may in fact contribute to the risk of further aggression (Whittington & Wykes, 1994). In effect, since experiencing assault may lead to increased stress, such stress may in turn affect nurses' behaviour toward patients. Coping strategies may include such behaviours as becoming "confrontive" by over controlling or verbalizing hostility towards patients; or "escape-avoiding" patients by spending as little time as possible

in direct communication with them, thus increasing the risk of further aggression (Whittington & Wykes, 1994). Conversely, the issue of intra/inter professional aggression does not appear to be reported nor addressed in the psychiatric literature.

More and more incidents of workplace aggression are now spreading to general wards (Beck, 2008; O'Connell et al., 2000). As a result, several studies explored the issue of workplace aggression towards health care staff in relation to their area of practice. Findings from several studies that compared critical care units such as emergency departments (ED) and intensive care units (ICU) to ward units found that certain types of critical care units appear to have a slightly higher rate of aggression. For example, a study of 2 407 Australian nurses (response rate 38%) found that 76.1% of ED nurses, 68.9% of ICU nurses and 63.8% of operating room/day surgery nurses experienced verbal abuse compared to 72% of medical setting nurses and 64.1% of surgical setting nurses (Farrell, Bobrowski, & Bobrowski, 2006). The percentage of nurses experiencing physical abuse was also slightly higher in critical care units with 57.5% of ED nurses and 47.1% ICU nurses reporting physical abuse compared to 44% of medical settings nurses and 35.5% of surgical setting nurses (Farrell et al., 2006). While 74.3% of survey respondents identified patients/clients as the most common perpetrators of verbal abuse, patient/client visitors were identified by 35.3% of survey respondents, nurse colleagues by 28.7%, doctors by 27.1% and nurse managers/supervisors by 15.8% (Farrell et al. 2006).

A different study of 86 nurses (response rate 68.8%) working in a Florida medical center focussing specifically on verbal abuse and physical assault by patients found 100% of ED nurses and 85.2% of ICU nurses reported verbal assaults by patients and family in the last year compared to 80.6% of "floor" nurses (May & Grubbs, 2002). Instances of physical assaults were also higher in critical care units where 82.1% of ED nurses and 77.8% of ICU

nurses reported physical assault compared to 63.3% of “floor” nurses (May & Grubbs, 2002). A UK study of 375 health care professionals (response rate 33%) focussing on physical assault, threatening behaviour and verbal aggression from patients/visitors towards hospital staff found 75% of ED health care professionals experiencing verbal aggression from patients/visitors compared to 38.8% of medical and 25.5% of surgical health care professionals. However, physical assault was more widespread on medical/surgical wards than ED, with 42.4% of medical and 36% of surgical health care professionals experiencing physical assaults compared to 30.8% of ED health care professionals (Winstanley & Whittington, 2004). These results indicate that physicians and nurses are identified as being responsible for several acts of non-physical aggression, and that psychological aggression appears slightly more widespread on critical care units while physical aggression is equally found on both critical care and ward units. Seeing that intra staff aggression is found to be more disturbing to the victim than patient assault or aggression from other health care professionals (Farrell, 1997, 1999, 2001), there is a need to examine the issue of “worker on worker” aggression and to explore how these forms of aggression are managed by nurse managers.

Notwithstanding the large amount of data pertaining to the issue, workplace aggression is said to be under-reported (International Council of Nurses [ICN], 1999). Several reasons are cited to explain the under-reporting of workplace aggression.

Issue of Under-Reporting

A number of justifications as to why workplace aggression continues to be under-reported are found in the literature. They include but are not limited to: aggression being perceived as an integral “part of the job”; reporting being considered as not worthwhile because, most likely, nothing will be done about it; the fear that the victim will be

reprimanded, or accused of negligence or inadequate performance, thus provoking the attack; reporting mechanisms that are both cumbersome and time-consuming; and nurses perceiving a conflict of interest between reporting workplace aggression and being a professional caregiver (Erickson & Williams-Evans, 2000; Ferns & Chojnacka, 2005; Gates & Kroeger, 2002; Hesketh et al., 2003; McKoy & Smith, 2001; O'Connell et al., 2000). These numerous justifications suggest a form of vicious circle which results in a no win situation for everyone.

It is said that under-reporting may also be encouraged by senior decision-makers because, if the actual number of incidents were known, “administrators would have to respond to pressures to determine why there were so many assaults [and] they would be forced to take remedial action to prevent further incidents of aggression” (Rippon, 2000, p.454). On the other hand, senior managers may not be aware of the real extent of the issue because of lack of reporting from front-line staff and front-line and middle-managers. While in the context of understanding attitudes towards a patient safety culture, a study of 15 California hospitals by Singer et al. (2003) serves to parallel this last point. The study found a marked discordance between the attitudes and experiences of non-clinician senior managers and front-line workers; where non-clinician senior managers often provided answers that were consistent with a culture of safety while front-line workers gave more problematic responses (Singer et al., 2003). The findings suggest a tendency for front-line workers and middle managers to gloss over patient care problems when briefing senior managers, which in turn make it hard for executives to understand the true state of their organization (Singer et al., 2003). As such, under-reporting may in fact play down the seriousness of the issue of workplace aggression to senior management.

It is estimated that only one-fifth of cases of workplace aggression are officially reported (International Council of Nurses [ICN], 1999), which serves to confirm the notion of a *conspiracy of silence* around the reporting workplace aggression. In fact, silence only gets broken when serious incidents occurs, and can be attributed to the fact that workplace injuries requiring medical attention or involving lost time from work are required by law to be declared to Provincial Workplace Compensation Boards (Rippon, 2000).

Conversely, some authors suggest that ignoring or tolerating low intensity deviant behaviours may in fact create work environments that are conducive to more serious types of aggressive behaviours (Andersson & Pearson, 1999). As a result, there is a need for organizations to implement better reporting systems and to encourage staff to report all episodes of workplace aggression. Monitoring incidents of workplace aggression may be the first step in identifying trends which may guide future interventions and educational needs (Clements, DeRanieri, Clark, Manno, & Kuhn, 2005).

Savard (2004) argues that before employees can feel comfortable reporting incidents of workplace aggression, the organization (including the administration) must itself break from the conspiracy of silence by taking a clear stand on the issue. She suggests, as a first step, the need for a clear policy pertaining to workplace aggression and stresses that management must show congruence between what is stated and what is being done (Savard, 2004). Another important reason often cited for the under-reporting of workplace aggression relates to the lack of a clear definition of the concept.

Definition of Workplace Aggression and Violence

The definition of what constitutes workplace aggression and violence is still debated to this day. In some instances the terms aggression and violence are used interchangeably; whereas in other instances a clear distinction is made. Current reviews of the terminology

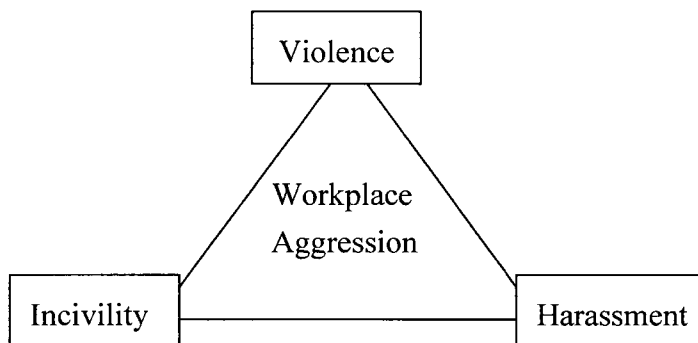
suggest that both terms appear to have different meanings whether they are used in English or in French. When used in English, it appears that *aggression* has a broader meaning than violence (Jauvin, 2003); with few authors viewing *violence* as only the physical expression of aggression (Griffin & Lopez, 2005; Mason & Chandley, 1999; Newman & Baron, 1998). As well, some view the term *violence* as relating more to the area of criminology and criminal justice, and the term *aggression* relating to health care (Chappell & Di Martino, 1998). Conversely, when used in French, it is the term “*violence*” that has a broad meaning; while the term “*aggression*” has more of a legal or technical connotation (Jauvin, 2003).

Other challenges associated with defining workplace aggression and violence resides in the fact that aggression and violence are often perceived as *emotive topics with particular stigma* (Rippon, 2000); and as *internal personal constructs with subjective aspects* where the perception of what constitutes violence can vary between groups and cultural settings (O’Connell et al., 2000). A theoretical paper by Waddington, Badger and Bull (2005) reinforces these views and identifies three main reasons as to why the concept of workplace violence is so difficult to define. First, violence can be exhibited in a number of different contexts; in some contexts violence may be acceptable whereas in others it will not be tolerated. Second, participants of a violent episode can give different meanings to their own and others’ actions (i.e., objective actions versus subjective responses to these actions). Third, the relationship between the apparent severity of an act of violence and the impact the act has on the victim is often unclear and very complex. For example, verbal aggression could ultimately be more debilitating than physical attack (Waddington et al., 2005). This last point is also paralleled by Engel (2004) who states that “there is no correlation between the extent of physical injury and the degree of psychological injury. People do not have to be physically injured to suffer psychological trauma from a violent episode” (p. 45).

While definitions of workplace aggression and violence may greatly vary in the literature, some factors appear to be consistent and include: intent on the part of the aggressor, a cognitive process and the behaviour resulting in a physical, psychological or emotional harm (Rippon, 2000). However, explicitly including “intent” as part of the definition may create challenges in health care because health care professionals are likely to be the victims of unintentional aggression from patients who are confused, demented or hypoxic (Ferns & Chojnacka, 2005) or in physical pain or distress (Ferns, 2006); thus making their cognitive process impaired as a result. As well, while factors found in the work environment of employees may potentially elicit aggressive or violent behaviour (International Labour Office [ILO] et al., 2002), and while common workplace practices such as the measure of time and workload, and mandatory overtime are associated with institutional violence (St-Pierre & Holmes, 2008), one would be hard pressed to prove any explicit intention to hurt on the part of the employer (O’Leary-Kelly, Griffin, & Glew, 1996). Currently, there is still no agreement on a clear definition of what constitutes workplace aggression and workplace violence. As such, definitions and typologies vary considerably from study to study or are completely omitted, resulting in ambiguity and greatly reducing the ability to make inter-study comparisons.

A plethora of definitions and typologies are found in the literature and is summarized in Appendix A. To provide a better understanding and an appreciation for the scope of the concept, an overview of common forms of workplace aggression is warranted. The concept of workplace aggression is broad and encompasses three sub concepts: incivility, harassment and violence. **Workplace incivility** is defined as low-intensity aggression and includes behaviours such as waiting uninvited impatiently by someone engaged in a conversation, or leaving the supply cart empty and not telling anyone (Andersson & Pearson, 1999).

Workplace violence, defined as high-intensity physically aggressive behaviour (Andersson & Pearson, 1999), including actions such as biting, scratching, spitting and punching. For its part, **workplace harassment**, defined as an act of aggression repeated over time includes bullying, mobbing and abuse of power (Courcy, 2004). Figure 2.1 provides a visual representation of forms of workplace aggression.



Source: Figure Developed Based on the Three Sub-Concepts Suggested by Andersson & Pearson (1999)

Figure 2.1: Forms of Workplace Aggression

For this study, the proposed definition of workplace aggression is based on the definitions provided by Courcy (2004) and Engel (2004), and will read as follow:

Any act violating an organization's current recognized and accepted norms which is known or ought to have known to cause harm to an employee while at work or on duty; including perceived or actual threat to one's life, safety, health, integrity or dignity.

The typology used to classify episodes of workplace aggression is the typology suggested by Courcy (2004) based on the work of Damant, Dompierre and Jauvin (1997). The typology is from the perspective of the victim and includes four categories: physical, psychological (including verbal, harassment, mobbing, bullying and abuse of power), sexual and financial (Courcy, 2004). Next, potential perpetrators of workplace aggression will be explored.

Potential Perpetrators of Workplace Aggression

Five distinct groups of potential perpetrators of workplace aggression towards nurses and other health care professionals are repeatedly identified in the literature. These include: 1) patient and/or their relatives; 2) physicians; 3) nursing peers; 4) managers; and 5) other health care workers (Baumann et al., 2001; Fédération des infirmières et infirmiers du Québec [FIIQ], 1995; Jackson, Clare, & Mannix, 2002; O'Connell et al., 2000).

Patients and Relatives

Patients and their relatives are often identified as a source of aggression towards health care professionals (Erickson & Williams-Evans, 2000; Farrell, 1999; Hesketh et al., 2003; Jackson et al., 2002; O'Connell et al., 2000; Shields & Wilkins, 2006). Physical assault is known to be mostly perpetrated by patients (Findorff, McGovern, Wall, Gerberich, & Alexander, 2004; Gerberich et al., 2004; Hesketh et al., 2003) or their relatives (AbuAlRub, Khalifa, & Habbib, 2007; Celik, Celik, Agirbas, & Ugurluoglu, 2007) with the most frequent types of aggression including being grabbed, punched, pushed, pinched, scratched, kicked, hit with an object, spat on or bitten (O'Connell et al., 2000).

While aggression from patients is especially common in “high risk” areas such as psychiatry and emergency departments; it can also occur in other areas such as medical surgical units (Hesketh et al. 2003). Working in a nursing home, long term care or rehabilitation facility is also known to increase the risk of physical violence and aggression (Gerberich et al., 2004; Shields & Wilkins, 2006).

Physicians

Verbal abuse appears to be the most common type of aggression perpetrated by physicians and includes: abusive anger, ignoring, condescension (Manderino & Berkey, 1997), as well as judging, criticizing, accusing and blaming (Oweis & Diabat, 2005). While

mentalities regarding nurse-physician relationships and the role of nurses have changed tremendously over the years, there is still an inherent conception that the nurse's role includes executing physician's orders, resulting in nurses' expertise being devaluated and hierarchal rapports maintained (Fédération des infirmières et infirmiers du Québec, 1995). Nurses report being concerned about the tolerance of administrators towards physicians' disruptive behaviours as well as the lack of support from executive physicians in dealing with such behaviours (Rosenstein, 2002).

Nursing Peers

Nurse to nurse aggression is also referred to as horizontal violence, inter-personal conflict, intra-staff aggression and bullying. Most often, nurse to nurse aggression is psychological rather than physical and is often covert rather than overt. Examples of types of aggression include: rudeness, abusive language, humiliation in front of others, others failing to speak up for someone in his/her defence, denied access to opportunities, others stealing credit for someone's work, being refused help to perform necessary tasks, excessive scrutiny of one's work, other spreading malicious rumours about someone and unjustified criticism (Farrell, 1999; McKenna, Smith, Poole, & Coverdale, 2003).

The literature suggests many explanations for the prevalence of nurse to nurse aggression. A common theory is that horizontal violence is the product of nursing being an *oppressed discipline* where nursing is part of a strict hierarchy and nurses are made to feel inferior. As a result, nurses become hostile and aggressive towards their peers or subordinates because they can't fight back their oppressor (Farrell, 2001; Leiper, 2005; Longo & Sherman, 2007; Thomas, 2003).

However, others have criticized this view as falling short of an adequate reason to explain horizontal violence and have presented other explanations such as: *disenfranchising*

work practices (where a nurse might annoy her peers if she regularly fails to fully complete her tasks during her shift); *low self-esteem or potency* (where nurses may feel that they or their work are undervalued compared to other groups); *generational and hierarchical abuse* (where more senior nurses believe that they have “earned the right” to abuse others including more junior nurses or students); *clique formation* (where a subgroup marginalize those who are not part of the clique); *aggression breeding aggression* (where aggression is seen as part of the job and staff may mimic aggressive behaviours); *actor-observer effects* (where nurses view their own negative behaviour as related to factors outside of their control, making them unaccountable for their behaviour); and *easy targets* (where new nurses and students become the aim of aggressors because they lack the personal and professional resources to challenge such practices) (Farrell, 2001; Leiper, 2005; McKenna et al. 2003; Randle, 2003).

Prevalence of nurse to nurse aggression is also associated with unit of work. Acute care areas are identified as units where nurse to nurse aggression is high. The reason is probably related to the proximity or interdependence of co-workers which may exacerbate interpersonal conflicts (Hesketh et al. 2003).

Managers

Managers are identified in the literature as perpetrators of workplace aggression, such as bullying, intimidation, and hostility (Farrell et al., 2006; Findorff et al. 2004; Jackson et al., 2002; Merecz, Rymaszewska, Moscicka, Kiejna, & Jarosz-Nowak, 2006; O’Connell et al., 2000). Managers within the field of health care are identified by nurses as unsupportive when an act of workplace aggression is reported (Arnetz & Arnetz, 2001; Clements et al. 2005; Farrell, 2001; Henderson, 2003; Jackson et al., 2002), consequently influencing nurses’ decisions to further report such incidents. Nursing managers are also perceived as lacking appropriate concern and as failing to acknowledge the emotions resulting from a

distressing incident of aggression (Crabbe, Alexander, Klein, Walker, & Sinclair, 2004; Farrell, 1997).

Other Health Care Workers

While not explicitly identified in the literature, “other health care workers” are also emerging as potential perpetrators of workplace aggression; and as such could eventually form a fifth group. Unfortunately, only limited information is available about “other health care workers” as perpetrators of workplace aggression because data pertaining to that group is often found aggregated under the “other” category. However, because of the ongoing shift towards multidisciplinary work and interprofessional collaboration, specific data for this category may soon become available. For example, an article by Farrel et al. (2006) explicitly identified allied health personnel and ancillary staff as perpetrators of aggression towards nurses.

Focus of Current Study: Intra/Inter Professional Aggression

While examining the literature for potential perpetrators of workplace aggression, it became apparent that the reasons for the aggressive behaviour, as well as the specific forms of aggression differed to some extent for each group. Notwithstanding the importance and obligation of managers to address all forms of workplace aggression and all groups of perpetrators, the current study focuses specifically on the management of intra/inter professional aggression such as nurse on nurse aggression (intra professional) and physician on nurse or orderly on nurse aggression (inter professional).

Two small scale studies conducted in Québec confirm the need to focus on intra/inter professional aggression. The first study explored health care employees’ perceptions of psychological harassment between peers. A total of 113 questionnaires were returned for a 38% response rate. The results showed that of the 79% of respondents who were nurses, 77%

reported being the victim of psychological harassment by a peer (Racine, 2006). The second study explored the issue of workplace violence against Québec nurses. A total of 181 registered nurses with l'Ordre des infirmières et infirmiers du Québec [OIIQ] returned a mail-in questionnaire for a response rate 63%. The results found that 66% of respondents experienced violence (including physical, psychological or sexual) by a peer compared to 59,6% by a supervisor and 59,1% by a physician (Lemelin, 2004).

Management of Workplace Aggression

The literature pertaining to workplace aggression can be grouped under three main level of analysis: 1) micro or individual determinants; 2) meso or interpersonal determinants; and 3) macro or organizational determinants (Jauvin, 2003). Accordingly, the management of workplace aggression should also include strategies that take into account these three determinants. Each will now be reviewed.

Individual Determinants of Aggression

A number of individual determinants are linked to aggression. These include: personality traits (e.g. type A), anxiety, fear, irritability, emotional susceptibility, perceived locus of control, shame, attitudes (e.g. prejudice), low self-monitoring abilities (e.g. less aware or concerned with other's responses), hostile attributional bias (e.g. individuals who interpret other's behaviour as hostile and as a result feel the need to retaliate) and gender (Baron, Newman, & Geddes, 1999; Baron & Neuman, 1998; Baron & Richardson, 1994; Hershcovis et al., 2007). Additionally, as part of their theoretical paper, Martinko and Zellars (1998) identified several traits that are linked to a predisposition to aggression such as: *negative affectivity* (i.e. the propensity to experience distress, helplessness, inadequacy and vulnerability even to mild frustration"), *emotional susceptibility* (i.e. the exhibition of more aggressive behaviours compared to others), *impulsivity* (impetuous), *pessimistic attribution*

style (i.e., the attribution of success to external causes and failure to internal causes) and *gender* (where males and females use different types of aggressive behaviours). They explained that if the cause of the negative outcome is perceived to be internal, individuals were more likely to accept blame and exhibit a non-violent response. However, when the cause of the negative outcome is perceived to be external, controllable and intentional (not related to mitigating circumstances) such as a supervisor's deciding to downsize even when the company is doing well, individuals were more likely to express anger and aggression towards others (Martinko & Zellars, 1998).

Social influences such as upbringing, family background, values, experiences and motives are also identified as potential contributing factors (Van Fleet & Griffin, 2006). Furthermore, heredity and hormones (e.g. levels of dopamine and serotonin) are identified as biological bases for human aggressive behaviour while mental illness, drugs, alcohol, sex and erotica are known to influence aggressive responses (Baron & Richardson, 1994; Elliot & Jarrett, 1994; Geen, 2001; Van Fleet & Griffin, 2006).

A theoretical model is now available to understand and address disruptive behaviour in health care organization (Piper, 2006). The model depicts human behaviour as having three components: personality (or characteristic pattern of behaviour and thoughts of the person); motivation (or the impetus for a person to work and fulfill a role in the organization); and soul (defined as the spiritual principle embodied in human beings) (Piper, 2006). According to the model, human conflict could originate from the incongruence between an individual's personality, motivation or soul and the organization's mission, vision, culture or soul (Piper, 2006). Piper's 2006 model parallels Lewin (1951) model of personal conduct where one's behaviour can be explained by his/her interaction with the environment.

Interpersonal Determinants of Aggression

Attributes of workplace relationships and the manner in which people interact with one another are strong determinants of workplace aggression (Courcy & Chamberland, 2004). As such, poor leadership (verbal hostility, over control and authoritarian management styles) and perception of interpersonal injustice (lack of respect and honesty by the supervisor towards employees) are identified as predictors of supervisor targeted aggression (Hershcovis et al., 2007). As well jealousy and envy, lack of solidarity, poor communication and lack of support are all identified as contributing to incidences of workplace aggression (Jauvin, 2003).

While it cannot be described as people interacting together, the interaction between an individual and “the organization” for which he/she is employed can also elicit episodes of workplace aggression (O’Leary-Kelly et al., 1996; Van Fleet & Griffin, 2006). A framework by Van Fleet & Griffin (2006) depicting potential interactions between the individual and the organization serves to illustrate such an interaction (figure 2.2). The vertical axis of the framework represents the individual’s predisposition to engage in dysfunctional behaviour while the horizontal axis corresponds to the organizational tendency to elicit dysfunctional behaviour. Each axis is broken down as a dichotomous (high/low) propensity to dysfunctional behaviour, thus yielding four situations. According to the framework, a person with a high predisposition for dysfunctional behaviour would have the highest incidence of such behaviour when working for an organization that has a high tendency to elicit dysfunctional behaviour.

Individual predispositions to engage in dysfunctional behaviour	High	1 Moderate incidence of dysfunctional behaviour	2 Highest incidence of dysfunctional behaviour
	Low	4 Lowest incidence of dysfunctional behaviour	3 Moderate incidence of dysfunctional behaviour
		Low	High
Organizational tendency to elicit dysfunctional behaviour			

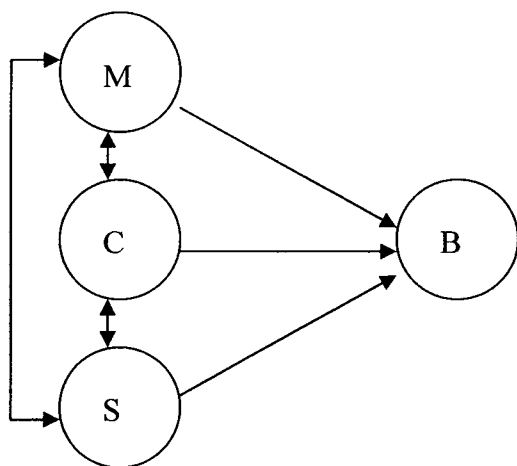
Source: Figure Developed Based on the Article by Van Fleet & Griffin, 2006

Figure 2.2: Framework to Illustrate Interactions between Individual and the Organization in Eliciting Dysfunctional Work Behaviours (Including Aggression)

Organizational Determinants of Aggression

While individuals always have the propensity to elicit workplace aggression, many scholars now realize the role played by organizational factors in contributing to or detracting from such episodes (Hoogervorst, van der Flier, & Koopman, 2004; Van Fleet & Griffin, 2006). The *popcorn metaphor* by Folger & Skarlicki (1998) illustrates well the need to focus on the organizational determinants when dealing with workplace aggression. In the metaphor, *organizational factors* are viewed as the “hot oil” and *employees* as the “individual kernels” (Folger & Skarlicki, 1998). As such, the “hot oil” (organizational factors) can precipitate the “individual kernels” (employees) to explode (become aggressive). Therefore, one would be “more likely able to predict the occurrence of aggression by paying attention to organizational conditions (i.e. the pressure created by the heating oil) than trying to predict which person (i.e. kernel) will explode” (Martinko, Douglas, & Harvey, 2006, p. 117).

Organizational factors that are linked to workplace aggression include but are not limited to: organizational culture, values and vision of leaders, compensation and rewards structures, incentive systems, management practices, rigid rules and procedures, social pressures to conform and role/job ambiguity (Hoogervorst et al. 2004; Litzky, Eddleston, & Kidder, 2006; Martinko et al. 2006; Van Fleet & Griffin, 2006). A conceptual model by Hoogervorst, van der Flier and Koopman (2004) proposes that employees' behaviour is influenced by the organizational or behavioural context which includes three facets: organizational culture, organizational structures and systems, and management practices (figure 2.3). As a result, to change employees' behaviour, one should focus on changing the conditions that influence such behaviour (i.e., the behavioural context) rather than focusing on changing individual behaviours alone.



Source: Hoogervorst, van der Flier and Koopman, 2004, p. 289

Figure 2.3: Management Practices (M), Organizational Culture (C), and Organizational Structures and Systems (S) as Determinants of Employees' Behaviours (B)

The role of organizational culture and organizational structures and systems as they relate to workplace aggression in the health care sector is further explored.

Organizational Culture

Organizational culture is said to have its theoretical foundation in symbolic interaction (Mead, 1934) and social construction (Berger & Luckmann, 1966); and refers to “the deep structure of organization, which is rooted in the values, beliefs, and assumptions held by organizational members” (Denison, 1996, p. 624). For many, organizational culture is synonymous with social beliefs, roles, norms, values, assumptions, symbols, ceremonies and rituals (Schein, 1990; Tregunno, 2005); and can be described using two approaches: behavioural and cognitive (Hoogervorst et al., 2004). The behavioural approach sees organizational culture as “something the organization **is**” and focuses on the *manifestation of culture* such as rites and ceremonies. In contrast, the cognitive approach views organizational culture as “something the organization **has**” and focuses on the *content of culture* such as basic values and beliefs which arise from group members responding to their environment.

While individuals come and go, organizational culture is rooted in history and as such is considered relatively stable as it “perpetuates and reproduces itself through the socialization of new members entering the group” (Schein, 1990, p. 115). As such, organizational culture is “a characteristic of the organization, not of individuals” (Hofstede 1998, p. 479 as cited in Tregunno, 2005 p. 69).

In addition, organizational culture is viewed as a learned dynamic process. It is the product of: the stability of the group, the length of time the group has existed, the intensity of the group’s experience, the way learning has taken place (positive vs. negative) and the strength and clarity of the leaders’ assumptions (Schein, 1990). Furthermore, organizational culture is said to communicate how things ought to be and to define the unwritten rules of the game (Hoogervorst et al., 2004).

According to Schein (1990), organizational culture manifests itself at three levels: 1) observable artefacts (e.g. dress code, manner in which people address each other, vision and mission statements, etc.); 2) values (e.g. norms, ideologies, philosophies); and 3) underlying assumptions (which will determine perceptions, feelings and behaviours). Consequently, because organizational culture is “abstract”, it is not clear whether it can be measured with survey instruments alone (Schein, 1990). For that reason, many argue that the study of organizational culture would benefit from qualitative research in order to explore and understand untold, unconscious and implicit underlying values and assumptions (Denison, 1996; Tregunno, 2005). Glisson and James (2002) describe culture as “the way things are done in an organizational unit” and consequently, is the property of the organization. Culture is said to affect managerial policies and practices (such as structure) (Glisson & James, 2002).

The literature is rich with articles linking organizational culture to workplace aggression, psychological harassment and bullying. An article by Vézina and Dussault (2005) describe three cultural elements which allow psychological harassment to thrive. The first element is the *trivialization and/or negation that psychological harassment is happening*. According to Vézina and Dussault (2005), comments such as “what’s happening here is not any worse than other places, it’s only a reflection of our society” are in fact defence mechanisms aimed to justify inaction. The normalization of psychological harassment can also lead to the transgression of well established rules and/or the non-reporting of harassment for fear of retaliation. The second element is the *tolerance of workplace incivility* such as the lack of respect towards others, teasing about sexual orientation or nationality, or criticism of the work being done. It is the ambiguous nature of the intention that makes workplace incivility difficult to qualify as aggression or violence.

However, tolerating incivility at work can in fact be conducive to increasingly serious types of aggressive behaviour (Vézina & Dussault, 2005). Finally, the *perception of being discriminated against or treated unfairly* can lead to frustration and even aggression and violence. If inequity, injustice and favouritism become part of the norm, it becomes extremely difficult to correct such situations (Vézina et Dussault, 2005). Furthermore, a culture of blame can promote the risk of aggressive episodes (Lau et al., 2004), while a supportive culture (depicted by organizational support) can serve to buffer the damaging consequences of workplace aggression (Schat & Kelloway, 2003).

Bullying cultures in the context of health care and nursing are frequently reported. Stevens (2002) argues that while bullying appears to be integral to the nursing culture, the nursing profession is in fact reluctant to address the issue. As such, health care organizations that employ nurses are seemingly unable to acknowledge the problem or effectively address it (Stevens, 2002). The views of Stevens (2002) are paralleled by Hutchinson et al. (2006) who state that bullying in nursing is so predominant and part of the organizational culture that it is almost invisible (Hutchinson, Vickers, Jackson, & Wilkes, 2006). As well, with many health care organizations endorsing effectiveness and efficiency as a way of doing business, bullying is acknowledged by some nurse managers as “an acceptable way of getting the work done by staff” (Lewis, 2006, p. 55).

The development of a “human-centered workplace culture” based on safety, dignity, non-discrimination, tolerance, equal opportunity and cooperation is identified as an intervention to address workplace aggression (International Labour Office [ILO] et al., 2002, p.17). The creation of a human-oriented, safe environment is also promoted as a process optimization strategy for health institutions (Viens, Hamelin Brabant, Lavoie-Tremblay, & Brabant, 2007). For example, authors have adapted the concept of safety climate to develop

and test among 198 American nurses (response rate 29%) the concept of *perceived violence climate* (Spector, Coulter, Stockwell, & Matz, 2007). The authors found a relationship between perceived violence climate and nurses' experiencing both physical violence and verbal aggression as well as violence resulting in injuries and perceptions of workplace danger (Spector et al., 2007). The same study found perception of violence climate explaining variance in psychological strain where employees who perceived a poor violence climate might experience psychological strain, regardless of whether they were actually assaulted (Spector et al., 2007).

The culture of an organization also plays a role in dictating its structures and systems. The role of organizational structures and systems, their potential relationship to workplace aggression, and their imminent contribution to the management of such aggression by nursing managers is now reviewed.

Organizational Structures and Systems

Organizational structures and systems are often viewed as the core elements of organizations and refer to the "formal system of control that embodies knowledge and principles for governance" (Hoogervorst et al., 2004, p. 296). Because they are embedded in communication, organizational structures and systems should be consistent, legible and coherent; and should align with organizational mission, vision, values and goals (Hoogervorst et al., 2004).

Tobin (2001) supports the belief that the structures and practices of an organization influence the behaviour of its members; and views organizational structures as composed of three primary characteristics: *complexity* (i.e. degree of division of labour, job titles, and hierarchical levels including horizontal and vertical levels); *formalization* (i.e. organizational rules, procedures and guidelines); and *centralization* (i.e. location, division and amount of

decision-making power throughout an organization). To remain competitive or to cut cost, organizations may decide to change their structure and/or processes which may disagree with the beliefs of individuals within that organization. As such, conflicting expectations may lead to frustration which may ultimately lead to aggression and/or violence (Tobin, 2001).

Specific structures and processes found in the work environment and associated with bullying are identified and classified into three groups: *enabling structure* (or necessary antecedents); *motivating structures* (or incentives) and *precipitating processes* (or triggering circumstances) (Salin, 2003). According to Salin (2003), enabling structures provide the “fertile soil” for bullying and include such conditions as: perceived power imbalance between victim and perpetrator (e.g. employee bullied by his/her supervisor); perceived low cost (or minor consequences) to the perpetrator (effect/danger ratio); and dissatisfaction and frustration at work (e.g. poor climate, lack of control over own job, role conflict and ambiguity).

For their part, motivating structures are described as circumstances that can make harassment at work rewarding (or a way to rationalize the need to bully). Examples include: high internal competition and politicized climate; certain forms of reward systems (promotion of employees who are known to bully others); and expected benefits (e.g. performance-based evaluation and remuneration).

Finally, precipitating processes are the actual triggers for bullying and typically relate to changes in “status quo” such as restructuring and downsizing; changes in management and/or the composition of working groups; and other organizational changes such as flatter and decentralized structures. The elimination of layers and positions often leads to increased workload, decreased job security, increased stress, reduced promotion opportunity and increased competition which can ultimately lead to lower thresholds for aggression and

violence (Salin, 2003). For example, the impact of decisions related to budget and staffing made at the strategic level has resulted in an increase in nurses' exposure to workplace aggression and violence because violent outbursts are linked to low staffing levels and/or increased workloads (Nabb, 2000; Priest, 2006). While these three groups of structures and processes are described in the context of bullying, one can argue that they can easily apply to the broader category of workplace aggression.

Policies are statements of expectation; and set the boundaries in which one is to act in a particular situation (Paige, 2003). They are part of the structure of any organization. However, while policies specifically addressing prohibited behaviours help reduce incidences of workplace aggression (Nachreiner et al., 2005), policies alone often fail to be effective when dealing with certain forms of workplace aggression such as bullying (especially when managers are the bullies) (Lewis, 2006). As well, the mere existence of a policy against aggression does not address the issue of under-reporting as the decision to report such instances is influenced by the organizational culture and by management practices. In fact, organizations may be perceived as tolerating acts of aggression if their policy against aggression is not monitored and there are no consequences for those infringing it (Umiker, 1997; Salin, 2003).

Conversely, an article by Hodge & Marshall (2007) suggests that the notion of a "zero tolerance" policy implies intolerance and may in fact infringe patient's right to express frustration or displeasure with unsatisfactory services. The authors suggest considering the aggressive behaviour within the context of the patient's clinical presentation and underlying disease process to rule out any organic medical condition before enforcing the aggression management policy (Hodge & Marshall, 2007). They also propose that in instances where the aggressive behaviour is not linked to a medical condition, there should be a basic

understanding as to why the behaviour arose and how it could have been diffused so that the “zero tolerance” policy be applied in appropriate circumstances only (Hodge & Marshall, 2007). Similarly, an article by Middleby-Clements & Grenyer (2007) comparing health staff attitudes following two different training programs on aggression minimization found that staff who received training emphasizing a zero tolerance approach to aggression became less tolerant toward aggression and developed rigid or inflexible attitudes toward aggression management compared to staff who received another type of training, thus suggesting problems with training focussing on a zero tolerance approach to aggression management.

Other organizational factors identified include: poor work climate (Courcy & Savoie, 2004); increased workforce diversity including a wide range of knowledge, skills, abilities, experiences and education levels ranging from high school to more than eight years of university (Piper, 2006); normative behaviour (i.e. aggression seen as part of the job) and norm violations (e.g. use of part-time workers when only full term permanent employees used to be employed), layoffs, downsizing, budget cuts, pay cuts/freezes, change in management, restructuring and reengineering (Neuman & Baron, 1998; Umiker, 1997).

Whereas the perception of organizational justice is linked to workplace aggression (Beugré, 2005; Dupré & Barling, 2006; Folger & Skarlicki, 1998; Greenberg & Barling, 1999; Hershcovis et al., 2007; Inness, Barling, & Turner, 2005; Jawahar, 2002; Skarlicki & Folger, 1997; VanYperen, Hagedoorn, Zweers, & Postma, 2000), procedural justice, which is interested in the “perceived fairness of the process by which outcomes are determined” (Cohen-Charash & Spector, 2001, p. 280), is important when evaluating the perception of fairness in the application of policies and procedures. As such, the perception of procedural justice is often based on six criteria (sometimes referred to as the Leventhal’s criteria): 1) are the procedures applied consistently across people and time (*consistency criteria*); 2) do the

parties have personal self-interests in the allocation process (*bias-suppression criteria*); 3) is accurate information collected and used in the decision making process (*accuracy criteria*); 4) are mechanisms in place to correct flawed or inaccurate decisions (*correctability criteria*); 5) are the opinions of various groups affected by the decision taken into account (*representativeness criteria*); and 6) did the decision making process follow fundamental moral and ethical values of the perceiver (*ethicality criteria*) (Cohen-Charash & Spector, 2001; Colquitt, Conlon, Wesson, Porter, & Ng, 2001).

For her part, Engel (2004) argues that workplace aggression is in part due to a failure of the system. She identifies several organizational factors which can contribute to the problem including: a corporate culture supporting and fostering abusive behaviour because “toughness is good” and linked to success, power and money; patriarchy as the dominating culture with power resting with an elite group who surrounds itself with people of similar values and conduct; executives who ignore the problem because they are either offenders themselves, believe aggression is part of the job, are too far removed from the situation, or are insensitive to their staff’s reality; downsizing and restructuring which create worried, angry and stressed people; and the perception of unfair treatment such as unfair labour practices, inattention to employee’s complaints and management teams who are unskilled to deal with human resources problems (Engel, 2004). A number of environmental factors are also linked to workplace aggression. They include but are not limited to: hot temperatures or extreme cold, poor lighting, poor air quality, high humidity, high noise levels and crowding (Baron et al., 1999; International Labour Office [ILO] et al., 2002). These factors are known to render the physical environment uncomfortable and unpleasant thus making people irritable and impatient.

The literature specific to the management of workplace aggression appear to mainly focus on the suggestion of broad strategies to maintain a safe working environment and prevent workplace aggression. For example, a conceptual paper by Olson et al. (2006) suggests several strategies for the management of aggression in organizations including: 1) training employees to be empathetic; 2) promoting effective communication, 3) building trust; 4) providing empowerment; 5) placing more emphasis on managing minor aggression; and 6) ensuring that newer employees are able to shape their behaviours and interpretations according to expectations by creating and maintaining organizational culture that builds on cohesiveness, loyalty and organizational commitment. These strategies are in fact primary prevention strategies, or strategies that will hopefully prevent workplace aggression from happening. For the current study, the management of workplace aggression is not limited to primary prevention strategies but also includes the exploration of strategies used at the secondary prevention level (i.e. during the aggressive incident) and tertiary prevention level (i.e. post aggressive incident).

Nursing Managers and the Conflict Management Literature

Arguably, nursing managers are identified as “the glue that holds the hospital together” (Parsons & Stonestreet, 2003, p. 120). They play a pivotal role in shaping organizational culture, managing instances of workplace aggression and influencing the climate of the working environment of nurses as well as the quality of care delivered (Alexander et al., 2004; Farrell, 1997; Johansson, Pörn, Theorell, & Gustafsson, 2006; Kane-Urrabazo, 2006). The role of nursing managers is found to include four to five main managerial functions: planning, organizing, motivating and controlling (La Monica Rigolosi, 2005), or planning, organizing, staffing, directing and controlling (Marquis and Huston, 2006). More specifically, managing staff problems such as workplace violence is identified as a role of

nursing managers under the management of human resources (Sullivam & Decker, 2009). As well, conflict management is identified as an important directing function of nursing managers (Marquis and Huston, 2006). While conflict and aggression are two very different concepts, horizontal violence, emotional abuse and bullying (which are forms of workplace aggression) are used as surrogate terms for conflict in the literature (Almost, 2006).

Several conflict resolution strategies are identified in the management literature and include: avoiding (ignoring the conflict), accommodating/smoothing/obliging (one side neglects his/her own concerns to satisfy the other side's concerns), competing/coercing/dominating (one party strongly defends its own stance while believing it to be the right one), negotiating/compromising (each side relinquish something to produce a decision acceptable to both by taking a middle position), and collaborating/integrating/problem solving (both sides work together to find a mutually satisfying resolution) (Hibberd & Smith, 2006; Kelly-Heidenthal, 2004; Yoder-Wise, 2007). Since there is a paucity of workplace aggression management strategies in the literature describing specific actions taken by nurse managers to respond and deal with aggressive act(s), there is a need to explore whether some conflict management strategies are used in the context of workplace aggression management.

While nurse managers are identified as having a responsibility in managing workplace aggression, several factors that are now integral to the work environment of nurse managers are also linked to aggression. This reality substantiates allegations that nurse managers too have suffered many negative consequences as a result of ongoing health care restructuring (Mayrand Leclerc et al. 2006). I posit that the work environment of nurse managers plays a role in how they manage workplace aggression. The work environment of nurse managers is now examined.

Work Environment of Nurse Managers

The work environment and roles of nurse managers changed considerably in the last 20 years. Many of the changes resulted in a challenging work environment and working conditions for nurse managers, as described below. These difficult working conditions can also impact nurse managers' ability to positively manage instances of workplace aggression.

Role Ambiguity and Role Overload

A study by Thorpe and Loo (2003) of 26 Canadian nurse managers shows that as a result of having less nurse managers, remaining ones saw an increased in their responsibilities; including having to manage more than one unit or clinic and having to take on roles previously assumed by directors thus in some instances creating role ambiguity. The resulting increase in workload then makes it difficult for nurse managers to be visible on the unit (Thorpe & Loo, 2003), even when knowing how important their presence is for maintaining good working relationship with staff. A 2004 Canadian study by Doran et al., exploring the impact of manager's span of control on leadership and performance found that the 40 participating managers had an average span of control of 77 employees. Span of control was defined as the number of people supervised by the manager (Doran et al., 2004). The study also found a link between the size of the work unit and the relationships between manager and staff, where as work unit size increased, the relationships between manager and staff became less positive (Doran et al., 2004).

Additionally, nurse managers noted a loss in both their credibility and their trust in the organization as a result of ongoing health care restructuring; and found that strategies that used to work well in the past were no longer effective (Ingersoll, Cook, Fogel, Applegate, & Frank, 1999). Nurse managers are also frequently finding themselves caught between demands from clients, superiors and subordinates while not always possessing the necessary

authority or powers to deal with the issues (Westerberg & Armelius, 2000). The result of experiencing such demands can lead to *role conflict* (arising from various and sometimes incompatible demands or expectations from others); *role overload* (arising from too many expectations and demands); and/or *role ambiguity* (from a lack of individual control and skill discretion) which can ultimately bring about job-related stress (Westerberg & Armelius, 2000).

Role Conflict

The endless emphasis on efficiency and productivity is also affecting nurse managers since such organizational values are often conflicting with their personal values of respect for people, human dignity, equity and caring (Hendel & Steinman, 2002). Nurse managers often feel at a lost on how to create and maintain healthy work environments for their employees while ensuring quality patient care amidst budgetary constraints and the shortage of health care personnel (Thorpe & Loo, 2003). In their study of 71 Israeli middle nurse managers, Hendel & Steinman (2002) found that there was frequent dichotomy between nurse managers' professional and personal values, and the values set by the organization. These dichotomies led to ethical conflicts for nurse managers who often find themselves forced to compromise their moral integrity to comply with institutional demands. When such ethical conflicts occurred, nurse managers often experienced frustration, anger, dissatisfaction and even confrontation with the values conveyed by their peers (Hendel & Steinman, 2002).

Limited Support

A qualitative study of 20 Australian nurse managers by Paliadelis, Cruickshank, & Sheridan (2007) found that nurse managers perceived a lack of respect and support from their organization, especially from non-nursing colleagues; and felt excluded from the wider decision making process. While not specific to nurse managers, a study of 225 health care

professionals (response rate 26%) conducted in Ontario demonstrated the importance of organizational support when experiencing workplace aggression and violence. In effect, the study found that two forms of organizational support: instrumental support (support received from co-workers, supervisors and management following the experience of aggression) and informational support (training received on how to deal with aggressive or threatening events at work) moderated the effects of physical violence, vicariously experienced violence and psychological aggression on emotional well-being (e.g. self-confidence, depressive symptoms), somatic health (e.g. sleep disturbance, gastrointestinal symptoms), and job-related affect (how often the job made respondents feel a certain way) (Schat & Kelloway, 2003).

Limited Training

The limited initial training in management and continuing professional development of nurse manager can also have an impact on their job performance. Nurse managers who struggle to do their job because of limited training can see their self-esteem, confidence and job satisfaction affected which can ultimately affect their intent to remain in their job (Gould, Kelley, Goldstone, & Maidwell, 2001). Despite the ever increasing complexity of the tasks expected of them, nurse managers' training needs are mostly overlooked (Gould et al., 2001). Nurse managers who were promoted on the basis of their clinical expertise and were solely schooled in patient care but who assume leadership roles frequently encounter situations for which they are ill prepared when dealing with resource limitations, increasing complexity of care and diversity of personnel (Hynes, Kissoon, Hamielec, Greene, & Simone, 2006; Orovioigoicoechea, 1996). These managers may also be lacking skills and/or experience to complete their work properly (Thorpe & Loo, 2003). As a result, they may circumvent their managerial responsibilities and "take refuge" in their clinical roles (Paliadelis et al., 2007). A

study of 99 clinical nurse managers employed in the U.K. found them perceiving themselves as clinically competent but lacking confidence when dealing with issues such as human resources, budgets, having to represent senior colleagues and with information technology (Gould et al., 2001). Lack of training is also identified as a factor linked to workplace aggression (Jauvin, 2003).

“Part of the Job”

As part of their duties, nurse managers must manage employees. As such, employees’ can become potential perpetrators of workplace aggression. There is a paucity of nursing studies examining employees as potential perpetrators of workplace aggression. However, while not in nursing, a few studies investigated the issue of supervisor-targeted aggression and identified perceived job insecurity, perceived organizational justice and surveillance of employees as predictors of supervisory workplace aggression and violence (Dupré & Barling, 2006; Greenberg & Barling, 1999; Inness et al., 2005).

The requirement for nurse managers to provide feedback and conduct performance reviews also has the potential to bring about instances of workplace aggression, especially when the feedback is perceived negatively by the recipient. A study by Geddes and Baron (1997) examining the concerns and experiences of 151 managers (response rate 100%) when providing negative feedback to subordinates found that 98% of the managers surveyed encountered some form of aggression by employees in response to the negative feedback they provided. Of the respondents, 104 (69%) reported that employees were verbally abusive following negative feedback, and 47 managers (31%) reported physical abuse. Eighty nine percent of managers reported that passive forms of aggression following negative feedback were more common than active form of aggression. The most prevalent forms of passive aggression were “refusing to perform assigned duties”, “increased level of absenteeism”, and

“performing at a lower level of productivity” (respectively reported by 32%, 31% and 45% of managers) (Geddes & Baron, 1997, p. 443). No framework specific to the actual management of aggression was found in the literature. As such, a theoretical framework was developed based on the current literature review.

Summary of Literature Review

The review of the literature identified a number of key factors which appear to play a role in the proliferation of aggressive acts. As such, strategies to manage intra/inter professional aggression need to be multi-faceted to address the complexity of the issue. Based on the literature, the Workplace Aggression Management (WAM) framework was developed to depict the interrelation of six elements that are known to play a role in workplace aggression (figure 2.4). I therefore posit that these elements should be taken into consideration when managing intra/inter professional aggression.

The WAM framework hypothesizes that the management of workplace aggression is a function of the relationships between victim, perpetrator, type of aggression, social environment, physical environment, and management practices. More specifically, the victim is the person who is, or was intended to be harmed. In this study, the victim is always a health care provider. The perpetrator is the person who caused harm, or intended to cause harm to the victim. In this study, the perpetrator is also always a health care provider. The type of aggression includes four categories: 1) *physical* (using body parts or objects to harm); 2) *psychological* including verbal (inflicting harm using words), harassment (aggression repeated over time), mobbing (aggressive behaviour used by a group over one individual, bullying (aggressive behaviour used by one individual over another individual or a group), and abuse of power (behaviour exceeding the legitimate power of individuals as granted by the organization); 3) *sexual* (forcing of undesired sexual talks or acts by one person to

another; and/or 4) *financial* (where the victim suffers a loss of income as a result of the aggression) (Courcy, 2004). As well, aggression can be *direct* (harm is delivered directly to the victim) or *indirect* (harm is delivered through the action of other agents, or on persons or objects valued by the victim); and *active* (harm is delivered by a behaviour) or *passive* (harm is done by withholding some action) (Buss, 1961). The social environment refers to the social context of the unit such as a description of the unit culture and structures/processes. It is expected that the context of the unit will be influenced by the organizational context. The physical environment includes a description of the unit where the aggressive act took place.

The early management of acts of aggression is critical since ignoring or tolerating low intensity deviant behaviours may in fact lead to more serious types of aggressive behaviours (Anderson & Pearson, 1999). As well, the risk of workplace aggression is minimized when individuals believe that the organization will take action against acts of workplace aggression (Dupré & Barling, 2006). As such, it is important to view the management of intra/inter professional aggression as a continuum of activities around the specific act(s) including: pre-aggression (pre-event), aggression (event), and post-aggression (post-event) (Runyan, 2000). The proposed framework guides the current study as it explores how nurse managers respond to and deal with intra/inter professional aggression. The study findings are expected to refine the proposed framework.

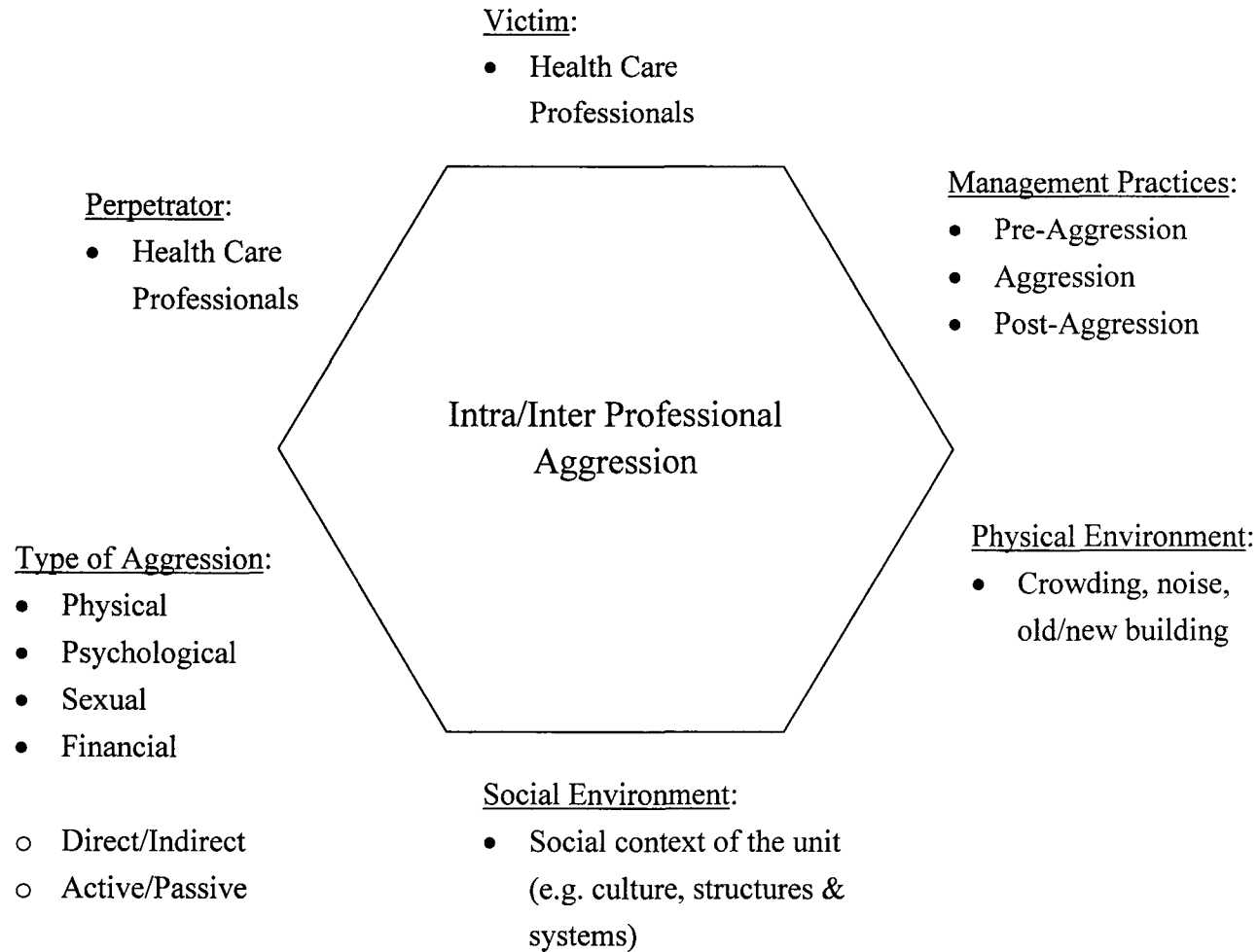


Figure 2.4: Workplace Aggression Management (WAM) Framework Applied to Intra/Inter Professional Aggression

CHAPTER 3 THEORETICAL FRAMEWORK

The last section of chapter one briefly introduced the epistemological assumptions guiding this research project. In line with a critical perspective, Girard's mimetic mechanism, Weber's conceptualization of professional closure and Foucault's theory of power as they relate to violence are now further explored.

René Girard, Violence and the Mimetic Mechanism

René Girard, French historian, literary critic and philosopher, wrote several books about human culture. Based on the analysis of biblical text and mythology, Girard has put forward hypotheses regarding the functioning of the mimetic mechanism which provides the basis for the understanding of human violence. According to Girard (2004), the mimetic mechanism can be summarized as a sequence of phenomenon starting with mimetic desire, followed by mimetic rivalry resulting in a mimetic or (sacrificial) crisis, and ending with the demise of a scapegoat. Each phenomenon will be described in an attempt to explain how the mimetic mechanism can serve to explain the issue of intra/inter professional aggression.

Mimetic Desire

According to Girard, human desire is more than just a person choosing to desire an object in a completely independent way. Instead, he believes that human desire originates from a triple relation between subject, object and model where a person (subject) wants to imitate another person (model) by wanting the same object owned by the model (Girard, 1972).

Girard explains that once the subject's basic needs are met, he/she still intensely desires something else without exactly knowing what that is. According to Girard, what the subject in fact desires is a "sense of being" from which he/she feels deprived but perceives the model

as possessing. As such, the subject perceives that if he/she had in his/her possession what the model has, such as specific clothes, a car, a house, etc, then he/she will “be”. The subject thus waits for the model to tell him what he/she needs to desire in order to gain that “sense of being” (Girard, 1972); resulting in the model becoming a “mediator” of desire, where desire does not come spontaneously to the subject but is instead “acquired” from the model (Girard, 1961).

Conversely, the subject is embarrassed to want to mold himself to the model because in doing so, he/she reveals his/her lack of “being” and recognizes his/her own insufficiency (Girard, 1972). In order to avoid this uncomfortable position, the subject therefore attributes the model’s status/importance to what he/she owns, as this is what differentiates the subject from the model. The object is then nothing more than a proxy of the subject’s desire for the prestige he/she believes the ownership of the object will provide (Cottet, 2000). On the other hand, if the subject comes to own the object, the object is suddenly reduced to its actual tangible properties; and the subject often experiences deception and disenchantment as he/she realizes that owning the object has not changed him/her (Girard, 1961).

The model does not play a passive role in the mimetic triangle. On the contrary, he/she needs to arouse competition by exposing to others his/her good fortune, as an object for which nobody competes for has no interest or value and does not arouse desire (Cottet, 2000). The value of the object increases proportionally to the resistance encountered when trying to acquire the object, creating a chain reaction where each individual component of the chain: the prestige of the model, the resistance put up by the model, the value of the object, and the strength of the desire for the object; represents a tree hiding the forest of the mimetic game (Orsini, 1982). It is the fact that the model still desires the object that renders the object even more desirable to the subject, and makes desires *concurrent* between both the subject

and model (Girard, 1961). However, by needing to feel the others' desire, the model also arouses competition and causes rivalry to emerge. Rivalry then increases the model's prestige and reinforces the bond between object and model by forcing the model to overtly declare his/her right or desire for the object, this rendering the subject incapable of giving up the inaccessible object (Williams, 1996). While neither subject nor model admit to being rivals, mimetic desire always automatically generate jealousy, envy and conflict, where violence and desire are intimately linked (Girard, 1972; 1986).

According to Girard, mimetic desire is a function of culture. As such, the distance that separates the subject from the model serves to determine the potential for rivalry (Girard, 1961). Here distance does not refer to the physical space between people, but rather corresponds to the spiritual, social and intellectual distance that separate individuals (Williams, 1996). More specifically, Girard (1961) refers to "external mediation" to describe a sufficient distance between subject and model to eliminate the possibility that both come to possess the same object (e.g. people from different social classes); and to "internal mediation" to indicate a distance that is close enough to allow subject and model to own the same object.

Mimetic Rivalry

As the rivalry intensifies between subject and model, the role of the model becomes more prominent and the object becomes less important (Girard, 1961). Desire becomes "metaphysical" where the subject no longer wants "to have", nor "to be" him/herself, but wants to become the other (Orsini, 1982). Both parties become locked in a battle for the prestige and/or recognition attributed to possessing the object (Kirwan, 2005). Two fundamental elements of mimetic rivalry are now in place: 1) the differences between subject and model are lost; and 2) the role of the object is now non-existent, only the rivalry between

subject and model is left (Cottet, 2000). Mimetic rivalry often leads to mimetic crisis.

Mimetic Crisis

While social order is based on difference (where everyone has his/her place and function), mimetic desire jeopardizes social order because it eliminates differences. As competition and rivalry arising from mimetic desire escalate to conflict and violence, a mimetic crisis erupts that threatens to destroy the person, the group, or even society as a whole (Girard 2004).

For example, Girard explains that mimetic crisis can be fueled by the erosion of social classes. Because the economy plays such a central role in our current society, and because all social classes are now bombarded by the same publicity, people from lower social classes now believe that they are entitled to the same objects as people from higher classes, even if they have less buying power (Girard, 2004). Nowadays, as a result of the decreased distance between models and subjects, there are more models to desire objects from, leading to increased competition and rivalry between people and groups (Girard, 2004). As the subject imitates more and more the model, the rivals become increasingly identical. It is the erosion of differences between the subject and the model that creates what Girard terms the crisis of “indifferentiation” (Girard, 2004), and where “hierarchical safeguards which were in place to channel and control mimetic unrest become less effective” (Kirwan, 2005; p. 43).

Granstedt (1985) cautions that the techno-economic transformations of our era are bound to fail as well as bring about international rivalry and tension as we have less and less rules and cultural prohibitions, leading to a worldwide crisis of indifferenciation and violence. As a result, and unless the mimetic game around production and consumption is stopped, Granstedt (1985) envisions a kind of global anarchy (internal to each society but also across society as they conduct business together), combined with powerless fascism

(where the power of the state brutally and desperately attempt to keep the wheel turning regardless of the fatal flaws), and political lynching as a quest to find someone liable/responsible for the demise (a scapegoat).

Scapegoat Mechanism

Girard believes that the only way to halt mimetic crisis and save people and/or groups from auto destruction is to channel mimetic rivalry and its by-product violence towards a designated victim or scapegoat which will serve to bring back social order and peace (even if only ephemeral) (Girard 2004, Williams, 1996). According to Girard, the scapegoat mechanism, which can be compared to a form of collective persecution, always has the same backdrop: the loss of social differences and coherence (Orsini, 1982); and can be understood as a mechanism of social differentiation (Atlan, 1988). As part of his work, Girard (1982) identified a typology of four stereotypes of persecution which serve to construct the scapegoat mechanism:

- 1) Societal/cultural crisis (or the loss of differences);
- 2) Stereotypical accusation;
- 3) Choice of victim; and
- 4) Violence itself.

Societal/Cultural Crisis

The process by which differences are lost was discussed in detail in previous sections. As culture erodes and social crisis arises, individuals feel powerless and disconcerted, and confusion and uprising threaten peace and order. Yet, rather than blame themselves for the crisis, individuals prefer to blame either society as a whole or specific people/groups that appear different, thus threatening (Girard, 1982). Attributing blame to others is less menacing for individuals, who as a result do not have to take responsibility and ownership of

the problem.

Stereotypical Accusation

Ultimately, individuals convince themselves that a minority of people or even a single person is responsible for the crisis. As such, individuals become persecutors who are on the lookout for “accessible causes that will appease its appetite for violence”, for “they dream of purging the community of the impure elements that corrupt it, the traitors who undermine it” (Girard, 1986, p.16).

Choice of Victim

While the choice of victim can be random, it is not always the case. Persecutors can choose their victims on the basis that they belong to a class that is susceptible to persecution rather than because of the crimes they committed (e.g. the persecution of Jews) (Girard, 1982). Minorities, poorly integrated or distinct groups all become prime targets for discrimination and persecution. In those instances, abnormality functions as the criterion for selecting a victim who is the furthest from the social norm and at a greater risk of persecution. As such, victims of persecution become scapegoats chosen because they are vulnerable or marginal (Kirwan, 2005).

Violence

Accusing a scapegoat serves to attribute the blame for the crisis to someone else. By his/her actions, the victim is blamed for spoiling social order. It does not matter whether this is true or not, being perceived as the cause for trouble is enough to be “sacrificed”. As the scapegoat becomes the enemy of the entire group, the polarization of anger and hatred towards a single victim reconciles, mobilizes and unites people in a quest of “all against one”. Channeling violence towards one person or group has the effect of limiting and preventing more widespread violence (Girard, 1982). Since the scapegoat was perceived as

the cause of the problem, eliminating it is equivalent to eliminating the problem. As well, the action of expelling/destroying the scapegoat serves to further unify the group which “experiences transcendence and harmony” attributed to the expelled victim (Kirwan, 2005, p. 39). Girard refers to this paradoxical effect as “double transference” where there is transference of aggressivity by persecutors onto the victim, as well as transference of reconciliation associated with the catharsis brought about by the victim (Kirwan, 2005).

Girard and the Concept of “Difference”

Girard (1986) summarizes the scapegoat mechanism this way: “in order to blame victims for the loss of distinctions resulting from the crisis, they are accused of crimes that eliminate distinction” (p.21). However, a closer look at the scapegoat mechanism, and the mimetic mechanism as a whole, raises several questions about the meaning of the word “difference” for Girard. For example, if the loss of distinction is responsible for the crisis, how can expelling someone who is “different” bring back social order?

The answer lies in the fact that the word “difference” has several meanings for Girard. In effect, at least three different meanings of the word “difference” is found in Girard’s writing (Dumouchel, 1982). The first signification refers to the *illusion of difference* which refers to perceived differences between rivals. It is the illusion or perception of differences that fuels mimetic rivalry and perpetuate conflict. The more intense the rivalry, the more the rivals believe they are different from one another, and the more they try to demarcate these differences (Dumouchel, 1982). The second signification of the word refers to *illusory differences* which allude to cultural and social differences. As such, it is expected that people from the same cultural and/or social background will be inclined to stand by one another, while people from different cultural/social background may be leery of others. The third signification of the word “difference” according to Girard refers to the *absolute difference*

between love and violence (Dumouchel, 1982). In this context, the model is both adored because he/she shows what is desirable and hated because he/she prohibits the possession of the object (perceived as a competitor). Girard also explains that while similar, people within a culture are different.

No culture exists within which everyone does not feel “different” from others and does not consider such “differences” legitimate and necessary. ... There exist in every individual a tendency to think of himself not only as different from others but as extremely different, because every culture entertains this feeling of difference among the individuals who compose it (Girard, 1986, p. 21).

However, people are different within an acceptable norm. It is when people differ drastically from the norm that they become threatening to the culture of that group, and a potential scapegoat.

The signs that indicate a victim’s selection result not from the difference within the system but from the difference outside the system, the potential for the system to differ from its own difference, in other words not to be different at all, to cease to exist as a system. ... Difference that exists outside the system is terrifying because it reveals the truth of the system, its relativity, its fragility, and its mortality (Girard, 1986, p.21).

Girard and the Role of Violence

According to Girard, violence intervenes at two moments in the mimetic mechanism: at the stage of indifferenciation and at the stage of differentiation. Whereas the stage of indifferenciation has mimesis as the source of the generalized violence of all against all, mimesis makes the violence of all converge against one in the stage of differentiation where violence results in the expulsion of the victim (Atlan, 1988). Because violence towards a scapegoat serves to restore social order, Girard (1972) also describes violence as founding violence (violence fondatrice).

While not fully explainable by the mimetic mechanism, the issue of inter professional aggression by physicians against nurses is real and well documented in the literature. To this effect, a new concept is added to the mimetic mechanism. Accordingly, the concept of professional closure, based on Weber's conception of social stratification and social closure, will serve to complement Girard's framework and further our understanding of the issue of inter professional aggression. The next section explores the concept of professional closure.

Weber and Professional Closure

Scott (1996) explains that Weber viewed class, status and party as aspects of the distribution of power within politically organized communities. For Weber (1946/1970), *class* is purely economically determined and is associated to economic power. *Status* on the other hand is recognized on the basis of a positive or negative social estimation of honor and is acquired by means of social prestige (Weber, 1947/1964); and *party* refers to groups whose actions are oriented toward the acquisition of social power and toward influencing social action by means of association (Weber, 1968). Additionally, Parkin (1971) explains that for Weber, class conflicts are closely linked to economic stress, while status concerns actually arise in times of economic stability. Parkin (1982/1988) reports that Weber also perceives *classes* as heterogeneous and internally divided to act in a concerted effort for an indeterminate length of time, but views *status* group as moral communities with a strong sense of common identity thus making them able to mobilize for collective ends.

Parkin (1979) explains that for Weber, "social closure" is the process by which social groups attempt to limit resources and advantages by restricting access and opportunities to only a limited number of eligible individuals. Using medicine as an example, Porter (1998) explains how some occupational groups have reached privileged *status* both economically and in terms of positions by using professionalism as a strategy for social closure (hence the

term professional closure). As a result, “professionalization” is described as a strategy designed to limit and control the number of individuals admitted to a specific profession in order for that profession to maintain and protect its monopoly over the provision of services (Parkin, 1979).

Conversely, while members of a given profession might support professional closure, Parkin (1979) argues that groups excluded by the successful application of professional closure might decide to take action and rebel by what he calls *social closure as usurpation*. As such, “instead of accepting the position of the group that has excluded them, excluded groups will often attempt to break into the privileged ranks in order to have their own bite at the cherry” (Porter, 1998, p. 69). Thus on the one hand, groups favored by the advantages of professional closure attempt to maintain status quo; and on the other hand, groups excluded from the elite attempt to gain access to economic power and social prestige by challenging professional closure (Porter, 1998). In this context, exclusionary strategies used by dominant groups to retain monopoly over their privileges are in fact a downward exercise of power; while “usurpatory” strategies are upward exercises of power where subordinate groups engage in a form of resistance to exclusion (Witz, 1990).

Parkin (1979) also notes that in certain circumstances, both social closure as exclusion and as usurpation is combined in a two-way exercise of power described as dual closure. For example, a professional group may simultaneously “attempt to break the monopoly over privileges that those of higher social or economic rank enjoy ... while at the same time attempting to prevent those of a lower rank poaching their own privileges (Porter, 1998, p. 70). As such, nursing is cited as a prime example of a profession resorting to a dual form of closure where nurses attempt to usurp medical power while at the same time struggle to deny other professions access to their professional status (Witz, 1990).

Professional Closure and Professional Dominance

The concept of professional closure provides a fresh perspective to critically examine the issue of inter professional aggression by drawing attention to hidden practices of dominance and control. While both medicine and nursing initially struggled to gain professional closure, the issue quickly became one dominated by gendered dynamics and patriarchal closure. As a result, aspiring women doctors were barred access to medical education and examination so they would not compete with male doctors (Ehrenreich & English, 1976/2000; Witz, 1990) and males were discouraged of entering the nursing profession for fear that they might too compete with male doctors (Chua & Clegg, 1990). Nursing thus started its quest for professional closure at a disadvantage compared to medicine because “nursing is an occupation whose niche had to be constructed in the shadow of the medical profession” which lay within the institution and construction of male power (Chua & Clegg, 1990, p. 138). As such, medicine became the dominant profession in medical organizations (Freidson, 1970/2007).

To this day, physicians are said to still use strategies such as professional monopoly, professional power and professional autonomy in order to maintain their professional dominance and associated economic power and social prestige, (Porter, 1998). *Professional monopoly* is based on supply and demand where the demand for physicians is high because the supply is low (not enough physicians to meet the needs of the population). *Professional power* is achieved by the use of three tactics: 1) reduction of “professional” supply by means of restriction of entry to the profession; 2) promotion of occupational homogeneity to prevent intra competition and conflict (thus the assertion that one will get the same quality of treatment regardless of by whom one is being treated); and 3) projection of a flattering image, both personally and professionally, associated with altruism, ethicality and the

possession of complex skills. *Professional autonomy* described as the right to control its own work including the right to determine who can legally do the work and how, was accomplished by persuading the state to legitimate such autonomy (Porter, 1998).

Exclusionary and *demarcationary* strategies are also used by the dominant profession to maintain professional closure (Witz, 1990). While *exclusionary* strategies use intra-professional control over internal affairs to limit access to its rank, *demarcationary* strategies aim at inter-professional control over the affairs of a related or adjacent profession (Witz, 1990). As such, medicine was cited as a prime example of a profession using both exclusionary and demarcationary strategies as medical doctors not only enjoy occupational monopoly but are also in a position of dominance vis-à-vis other health care providers and other professions (Freidson, 1970/2007; Witz, 1990).

Professional Closure to Explain Inter Professional Aggression

While it can be argued that the nursing profession has attained a form of professional closure related to the specific requirements needed to enter the profession and practice as a registered nurse, it is also apparent that nursing is still far from being an autonomous profession benefiting from the same economic power and social prestige as medicine. Professional autonomy, defined as what “allows professionals to make their own decisions and judgment about the services they provide with minimal pressure from external sources including employers, government legislator and regulators, other professionals and nonprofessionals” (Wynd, 2003), can provide the backdrop necessary to explain the “raison d’être” of a number of instances of inter professional aggression.

As such, professional autonomy is linked to “patient ownership” which refers to having sole admitting and discharging privileges, as well as control over treatment and prescription of medication (Greenwell, 1995). As the only truly autonomous profession in the health care

field (aside from dentistry), physicians have retained “patient ownership”, thus making the other health care professions, including nursing, subordinate to the medical profession by having them ultimately practice within and follow doctors’ orders (Freidson, 1970/2007, Greenwell, 1995).

According to Porter (1998), the failure of professional closure to bring autonomy, power and prestige to nursing as it did to medicine can be attributed to the relationships of nursing with other occupational groups, namely medicine. “Autonomy cannot simply be gained by the internal restructuring of nursing. What is also needed is for nurses to challenge the power relations that pertain between themselves and physicians, and, more fundamentally, the general social structures that generate those power relations” (Porter, 1988, p.80). However, as nursing continues to evolve, the idea of the profession becoming equal to that of medicine is strongly resisted by some physicians (Crichton & Hsu, 1990) who do not always welcome the changing role of nurses (Martin & Hutchinson, 1999; Willard & Luker, 2007), and who are said to be “jealous” of their right to diagnose and predict illness, holding the privilege tightly against themselves (Friedson, 1970/2007). As such, the ensuing struggle to remain the dominant profession may result in tensions, conflict and inter professional aggression

Violence is described by some authors as an instrument of power, where the practice of violence is used in the exercise of power (Foucault, 1982, Mason, 2002). The mimetic mechanism and the concept of professional closure describe well how power is used by professionals, and can lead to instances of intra/inter professional aggression. As such, the notion of power is worth exploring further. To this end, Foucault’s conception of power is now examined.

Foucault and the Nexus between Violence and Power

Three forms of power are identified by Foucault: sovereign, disciplinary and pastoral (Foucault, 1975, 1994). While each form can be used differently to govern the population, disciplinary power offers a rich theoretical perspective to help broaden the understanding of intra/inter professional aggression. Each form of power is now described.

Sovereign Power

The beginning of the XVIII century saw power associated with monarchy (*droit monarchique*) where the sovereign *is* power, the executioner *represents* power, the condemned *endures* power, and the nation is the ground where power is *exercised*. Since crime is considered to be a direct attack on monarchy, the punishment then becomes a ceremonial of sovereignty. Torture has a juridico-political function where the crime, the procedure of investigation and the punishment are all reproduced on the visible body of the criminal (Foucault, 1977). The use of torture also becomes a scare tactic used as an example to warn against the emergence of other crimes. The body of the condemned becomes the king's possession where the sovereign can apply his vengeance and manifest his power.

The second half of the XVIII century saw the inception of the reformed jurists (*projet des juristes réformateurs*). Crime is perceived as an attack against social contract, and punishment is to protect society, a procedure to requalify people as subordinates, a symbolic representation of the offence. Forced labour or jails are the most common forms of punishment. The body of the condemned becomes a social good, a collective and useful appropriation.

Sovereign power is described as an « episodic » power where except for when exercised, power is regarded as mostly absent. “The exercise of power occurs only intermittently in discrete episodes” (Clegg, 1998, p.32). Contrary to sovereign power,

disciplinary power is capillary in nature and operates at all levels of society (Clegg, 1998).

Disciplinary Power

The most important phenomena that accompanied industrialization is, according to Foucault (1975), the birth of a mechanism of power which served to control others; a discipline that regards individuals as both objects and instruments of its exercise. Discipline therefore produces bodies that are submissive, useful and obedient, “docile” bodies (Foucault, 1977). Consequently, Foucault considers discipline as a new political anatomy where the impact of discipline increases the body’s utility, while the political influence reduces the body to a position of obedience.

According to Foucault (1975), discipline is in fact the art of distribution. To this end, discipline proceeds to the distribution of people in space in order to derive maximum advantages and minimum inconveniences. Through the use of time, discipline also exerts a form of dominance by the exhaustive control of activities and by the continuous extraction of more available moments from time. Thus appear a new demand to which discipline must respond; “to construct a machine whose effect will be maximized by the concerted articulation of the elementary parts of which it is composed. Discipline is no longer simply an art of distributing bodies, of extracting time from them and accumulating it, but of composing forces in order to obtain an efficient machine” (Foucault, 1977, p. 164). In summary, discipline creates from the bodies it controls four types of individuality composed of four characteristics: “it is cellular (by the play of special distribution), it is organic (by the coding of activities), it is genetic (by the accumulation of time), it is combinatory (by the composition of forces)” (Foucault, 1977, p. 167).

Holmes and Gastaldo (2002) explain that for Foucault, the chief function of disciplinary power is to “train” individuals to enhance their productive potential and make

optimal use of their capacities (Holmes & Gastaldo, 2002). Thus aside from the disciplinary practices outlined above, three disciplinary techniques constitute the core of disciplinary power: hierarchical observation, normalizing judgment and examination. Each are examined.

Hierarchical Observation

Foucault (1977) describes the exercise of discipline as a mechanism that coerces by means of observation. Those at the top of the power structure can monitor all activities by means of an omnipresent and insidious system of surveillance (Dzurec, 1989). Similar to the panopticon¹, the perfect disciplinary apparatus allows a single glance to continually see everything while remaining invisible, thus giving it multiple, automatic and anonymous power. Disciplinary power is then « both absolutely indiscreet, since it is everywhere and always alert, since by its very principle it leaves no zone of shade and constantly supervises the very individuals who are entrusted with the task of supervising; and absolutely “discreet”, for it functions permanently and largely in silence” (Foucault, 1977, p. 177).

Normalizing Judgement

Foucault (1977) states that at the heart of every disciplinary system there is a micro-penal mechanism that is based on the non-observance of rules. Normalizing judgement involves the upholding of established doctrines where non-conforming activities are punishable and conforming activities are rewarded. As such, disciplinary punishment is essentially corrective and has the function of reducing gaps. Corrective effects involve expiation and repentance and are obtained through training (*dressage*).

¹ Around 1787, Jeremy Bentham introduced the idea of the panopticon, a model prison that functioned as a round-the-clock surveillance machine. The design of the prison ensured that prisoners never knew whether they were being monitored or not thus resulting in prisoners self policing for fear of being watched.

In terms of normalizing judgement, two opposite poles define performance: negative and positive. As such, discipline rewards by promoting to a higher rank, and punishes by inverting the process. The rank itself is a form of reward or punishment. As such, “the perpetual penalty that traverses all points and supervises every instant in the disciplinary institutions compares, differentiates, hierarchizes, homogenizes, excludes. In short, it normalizes” (Foucault, 1977, p. 183).

Like surveillance, normalization becomes an important instrument of power at the end of the classical age. In an effort to institute normality, standardized education has introduced for medicine and generic norms of health were established for hospitals (Foucault, 1977). Additionally, membership in a homogeneous social body contributes to the classification, hierarchization and distribution of ranks. “In a sense, the power of normalization imposes homogeneity; but it individualizes by making it possible to measure gaps, to determine levels, to fix specialities and to render the differences useful by fitting them one to another” (Foucault, 1977, p. 184). In other words, as a result of measurement, the norm introduces the shading of individual differences in an attempt to standardize people and practices.

Examination

For Foucault (1977), examination is highly ritualized and combines both the techniques of hierarchical observation and normalizing judgement. Knowledge is then a form of power from which examination can measure “levels of knowledge or skill” and impose “diagnostic labels” (Dzurec 1989, p. 72). What constitutes the truth is decided and established by means of examination. According to Foucault (1977), it is the superimposition of power and knowledge that “gives examination all its visible brilliance” (p.185). Examination is thus the technique by which power permits the objectification of its subjects.

Foucault (1977) explores how hospitals became places for regular observation where patients were (and still are to this day) in a state of continuous monitoring and perpetual examination. Simultaneously, physicians gained power over religious staffs who were reduced to subordinate roles, the position of the “nurse” was created and the hospital became a place of training (Foucault, 1977). “The well-disciplined hospital became the physical counterpart of the medical discipline; this discipline could now abandon its textual character and take its references not so much from the tradition of author-authorities as from a domain of objects perpetually offered for examination” (Foucault, 1977, p. 186).

Examination is accompanied by a system of registration and documentation. The accumulation of documents resulting from examination makes it possible “to classify, to form categories, to determine averages, to fix norms” (Foucault, 1977, p. 190). As such, examination and the documentation that accompanies it has two purposes: it allows people to maintain their individual features and own aptitudes and abilities; and it makes possible via the birth of a comparative system, the description of groups and the calculation of gaps between individuals. As a result, each individual becomes a “case” that can be “described, judged, measured, compared with others, in his very individuality; and it is also the individual who has to be trained or corrected, classified, normalized, excluded” (Foucault, 1977, p. 191).

According to Foucault (1975), discipline marks the reversal of the political axis of individualization. Consequently, in a disciplinary regime, as power becomes more anonymous, those on whom it is exercised tend to be more strongly individualized. For Foucault (1977), “the transition from historic-ritual mechanisms for the formation of individuality to the scientifico-disciplinary mechanisms ... is the moment when a new technology of power and a new political anatomy of the body were implemented” (p. 193).

Pastoral Power

Developed in Christian societies around the 3rd century AD, pastoral power sanctions certain individuals to serve as a guide to others because of their religious quality. The ultimate aim of pastoral power is to assure individual salvation in the next world (Foucault, 1982). As such, pastoral power is said to oppose traditional political power as it does not reign over a specific territory, but instead reigns over multiple individuals (Foucault, 1994). Accordingly, the principal function of pastoral power is not to ensure victory and hurt enemies (triumphing power), but instead to help those it looks after (beneficent power) (Foucault, 1994). Since pastoral power is salvation oriented, it commands that one be prepared to sacrifice itself for the salvation of the flock. Thus contrary to sovereign power where the “good citizen” was expected to die for the king, in pastoral power it is the pastor (king) that is willing to sacrifice himself for the good of his flock (Foucault, 1994).

Pastoral power is said to be a kind of individualizing power (Foucault, 1982). Instead of salvaging a whole state, territory or city, the role of the pastor is to salvage individuals, one at a time; and individuals have no choice but to desire salvation (Foucault, 1994). In effect, in Christian society one cannot say no to salvation, salvation is mandatory. As such, the pastor exerts a form of power over individuals, since he can force them to do everything that is needed to achieve salvation. The pastor, by his position of authority, exerts a form of continuous surveillance and control over his flock. He requires absolute obedience from his flock, not to achieve a purpose, but for the sole purpose of being obedient (Foucault, 1994).

Christian pastors are also considered masters of truth. However, they cannot exercise their power without the knowledge of people’s conscience and the ability to direct it (Foucault, 1982). Not only do Christian pastors need to know what every member of the

flock is doing at all times, they also need to “penetrate souls, decode hearts, and reveal the most intimate secrets” (Holmes & Gastaldo, 2002, p. 562).

Thus confession, an integral element of pastoral power, requires Christians to examine their conscience and disclose to the pastor their inner thoughts, feelings and secrets (Foucault, 1994). Using the knowledge acquired through confession, the role of the pastor is then to guide the individual’ conscience so that he/she continues to act within the accepted norm. Confession is thus a form of control mechanism over citizens where individuals come to believe that their choices are in fact based on their values and beliefs, and not the reflection of the pastor’s own agenda (Holmes & Gastaldo, 2002).

Relationship between Power and Knowledge

Foucault utters that knowledge is inextricably linked to power, and explores the power/knowledge relationship through the concept of discourse (Cheek, 2000). According to Foucault, discourse both sanctions and restricts the production of knowledge by allowing certain ways of thinking while excluding others (Cheek, 2000). Foucault (1977) believes that knowledge is intrinsic to the exercise of power as illustrated by this statement:

Perhaps we should abandon the belief that ... the renunciation of power is one of the conditions of knowledge. We should admit rather that power produces knowledge (and not simply by encouraging it because it serves power or by applying it because it is useful); that power and knowledge directly imply one another; that there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations (p. 27).

Consequently, “every development of knowledge fosters an increase in specific forms of power, and conversely, any expansion of specific power required an increase in specific forms of knowledge” (Chambon, Irving & Epstein, 1999, p.275). Cheek (2000) applies Foucault’s conception of power/knowledge to explain the current status of the nursing profession. According to Cheek (2000), the way nurses and nursing as a profession is

currently portrayed is directly related to powers and practices that gave value to certain aspects of nursing while excluding others. As a result, the dominant discourse with its associated norms and values is what is shaping nursing and nurses (Check, 2000).

Another significant contribution of Foucault's analysis of power lies in his belief that power is not merely oppressive but also productive. "In fact power produces; it produces reality; it produces domains of objects and ritual of truth" (Foucault, 1977, p. 194). Thus power produces knowledge which operates as a form of lens through which one comes to recognize oneself and others. As such, by taking up and rejecting certain identities, one normalizes his/her own behaviour and that of others, making knowledge an integral part of the regulatory process (Mason, 2002).

Violence as an Instrument of Power

For Foucault, "where there is power there is resistance" and "resistance is never in a position of exteriority in relation to power" (Foucault, 1976, p. 127). As such, resistance can be compared to a chemical catalyst that brings to light power relations (Foucault, 1982), where power could be identified through the manifestations of forms of resistance (Chambon, Irving & Epstein, 1999). Mason (2002) explains that violence can engender practices of resistance; and that the perceived risk of violence is enough to exert a subtle governing influence over victims or potential victims of violence.

For Foucault (1982), while violence (and consent) do not constitute the basic nature of power, they certainly are instruments of it. "Obviously, the bringing into play of power relations does not exclude the use of violence any more than it does the obtaining of consent; no doubt the exercise of power can never do without one or the other, or both at the same time" (Foucault, 1982, p. 789). Accordingly, violence only emerges at those points where power is under threat, as the practice of violence is used in the exercise of power (Mason,

2002).

Mason (2000) argues that if violence is to be theorized through Foucault's concept of power, then violence needs to be both an oppressive and a productive practice. Accordingly, on one hand, violence can be described as a form of oppression used by power when its more subtle strategies do not work, a form of struggle between power and resistance (Mason, 2002). On the other hand, violence is said to be productive as it generates knowledge: knowledge embodied by violence which makes it oppressive (e.g. pain, fear, danger); and knowledge which contributes to the identification of possible targets and perpetrators of violence (Mason, 2002).

Power, Violence and Institutions

For Foucault, institutions are instruments of power, "where power becomes embodied in techniques, and equips itself with instruments and eventually even violent means of material intervention" (Caputo & Yount, 1993, p. 9). The notion of power, knowledge and resistance can easily be applied to employment practices, labour management conflicts and labour inequalities where divisions of labour often result in struggles and conflicts.

Obedience through disciplinary practices is also central to the production of power in organizations (Clegg, 1998). For example, surveillance is not limited to direct control but can include "cultural practices of moral endorsement, enablement and suasion, to more formalized technical knowledge" (Clegg, 1998, p.38) such as computer monitoring or continuous and intensive administrative scrutiny of managerial decisions (McKinlay & Starkey, 1998). For example, the intensification of the administrative gaze can be attributed to the promise of "rational" decision making based on notions of efficiency and bureaucracy, as confirmed by the power of "facts and numbers" (McKinlay & Starkey, 1998). Recently, using a Foucauldian framework, common workplace practices found in health care

institutions such as constant monitoring of time, measurement of workload and mandatory overtime were demonstrated to be associated with institutional violence to provide an alternate and critical perspective to a well known and well documented problem (St-Pierre & Holmes, 2008).

Integration of the Three Theoretical Perspectives

I posit that the theoretical perspectives of Girard, Weber and Foucault can serve to broaden the understanding of intra/inter professional aggression. For example, the mimetic mechanism can explain forms of intra professional aggression; the addition of professional closure to the mimetic mechanism can explain forms of inter professional aggression; and power (or power struggles) is often the basis for many instances of intra/inter professional aggression. Each example are further explored.

Mimetic Mechanism to Explain Intra Professional Aggression

I believe that the mimetic mechanism can serve to explain some instances of intra professional aggression. For example, a nurse (or group of nurses) may aspire to acquire something held by another nurse (or group of nurses) such as a university degree, a “day only” shift rotation or a team leader’s role. As the *mimetic desire* is initiated, competition and rivalry emerge between the nurses, potentially leading to conflict and aggression. At the beginning, the aggression may be indirect (e.g. spreading rumour or gossip about the nurse) or passive (e.g. refusing to help or withholding important information), but as hostility increases between nurses, the seriousness of the aggressive act may in fact intensify as well. As tension increases on the unit, the group may select a particular nurse to serve as a “scapegoat”. By becoming the enemy of the unit, the “scapegoat” acts as a catharsis by channeling tensions and conflicts towards one individual, thus saving the whole unit from demise. Martin & Hutchinson (1999) used the term “scapegoated” to describe a situation

where nurse practitioners are “driven out” by nurses as a result of jealousy, rejection and conflict.

This chapter described how *internal mediation*, where the close social distance between individuals allows them to want the same objects, often resulting in rivalry, conflict and violence. As such, it can be argued that intra professional aggression is in fact a form of “internal mediation” since the social distance between the majority of nurses is small enough for them to desire the same things and become rivals. In opposition, inter professional aggression can be described as a form of *external mediation* because the social distance between most nurses and physicians is considerable enough to prevent them from wanting the same things; thus preventing the activation of the mimetic mechanism, and subsequent rivalry and conflict.

Professional Closure and Mimetic Mechanism to Explain Inter Professional Aggression

Professional closure can easily be integrated to the mimetic mechanism in an attempt to explain inter professional aggression. In effect, professional closure can be described as a form of social differentiation based on licensing and credentials. As seen earlier, social order is based on differences. However, excluded group(s) come to desire the status, prestige and benefits associated with being on the dominant side of professional closure. This parallels Girard’s description of mimetic desire where excluded group(s) can be viewed as subjects and dominant group(s) as models.

Using usurpation as a strategy, negatively privileged groups attempt to resist professional closure by breaking into the privileged ranks to gain access to economic power and social prestige. For their part, groups favored by professional closure attempt to maintain status quo. This can be interpreted as the birth of mimetic rivalry.

As the differences between professions begin to erode, a crisis of “indefferenciation” emerges (mimetic crisis). As a way to halt this mimetic crisis, individuals or groups may attempt to channel mimetic rivalry toward a designated victim or scapegoat (scapegoat mechanism). In some instances, the scapegoat is an individual, such as specific nurse. In other instances, the nursing profession as a whole is the scapegoat.

Power, Professional Closure and Mimetic Mechanism to Explain Intra/Inter Professional Aggression

Foucault (1977) describes *sovereign power* as episodic because it occurs only intermittently and in discrete episodes. Inter professional aggression involving physicians aggressing nurses can parallel Foucault’s concept of sovereign power. In effect, as a result of professional closure, medicine is still regarded as the dominant profession in health care milieus; and physicians often perceive themselves as possessing a form of sovereign power over patients and practices. As such, any attempts by other professions to jeopardize their status could potentially be perceived as a direct attack on physicians, a threat to their reign, thus explaining the need to “hurt” the enemy and “triumph”. As such, exerting their power over the “perfect scapegoat” can deter others (if only for a while) from attempting to close ranks with physicians. The scapegoat thus represents the victim where the sovereign applied his vengeance and manifested his power.

For their parts, the three main techniques described by Foucault (1977) under *disciplinary power* are easily linked to Girard’s mimetic mechanism. First, through the use of *hierarchical observation*, nurses are watched by their peers and physicians, and must remain accountable to the team (St-Pierre & Holmes, 2008). If the nurse deviates too often from the norm, he/she will more than likely be reprimanded, punished and excluded; and will become the target for surveillance and intervention (Gastaldo & Holmes, 1999). The nurse then risks

becoming what Girard identified as a *scapegoat*, where she will be excluded from the group in an attempt to bring back social order and peace. Second, Foucault's description of *normalizing judgement* can serve to explain Girard's concept of differences. Where Foucault sees the power of normalization as imposing homogeneity (thus paralleling what Girard's identified as indifferenciation), he also describes normalizing judgement as individualizing by identifying gaps (thus paralleling Girard's conception of differenciation). Finally, as argued earlier in this chapter, *examination* is used as a tool to achieve professional closure resulting in mimetic desire (where excluded group(s) come to desire the status, prestige and benefits associated with being on the dominant side of professional closure), and giving rise to mimetic rivalry.

As part of *pastoral power*, Foucault (1978) explained that an important characteristic of the pastor is his willingness to sacrifice himself for the good of his flock. While it is true that nurses are viewed as victims of aggression and branded as scapegoats, they cannot be described as being in a position of power similar to that of a pastor, the fact that they decide to leave the team, unit, organization or even the profession for the good of the "flock" (and their own salvation) can parallel a form of sacrifice described under pastoral power. Experiencing high levels of workplace aggression was identified as a factor in the retention of experienced nurses in the literature (Farrell, 1999; Jackson, Clare & Mannix, 2002, O'Connell et al., 2000).

CHAPTER 4 METHODOLOGICAL CONSIDERATIONS

This chapter describes the study methodology. First, the research design is presented followed by a detailed account of the data collection procedures and strategies for data analysis. Finally, the chapter concludes by addressing methodological rigour in qualitative research as well as ethical considerations.

Research Design: Ethnography

Ethnographic research has the distinct characteristic of taking the researcher to the field thus allowing him/her “to learn about a culture from the inside out” (Schwartzman, 1993, p. 3). The origin of modern ethnography can be traced to nineteenth century Western anthropology, where ethnographic research provided a descriptive account of empirical investigation and comparative interpretation of non-Western communities and cultures (Hammersley & Atkinson, 2007). Nowadays, ethnographic research is no longer limited to the field of anthropology as several other disciplines namely education, medicine and nursing are now using ethnography as a strategy of inquiry (Grbich, 1999; Quantz, 1992; Reeves, Kuper & Hodges, 2008).

Classical ethnography is influenced by theoretical notions such as anthropology, sociological functionalism, philosophical pragmatism and symbolic interactionism (Hammersley & Atkinson, 2007). It is a blend of process and product where field work is the process by which the researcher comes to understand a culture, and ethnographic writing (product) is how that invisible and intangible culture is constructed and portrayed (Polit & Hungler, 1999). More specifically, classical ethnography seeks to describe and understand culture, as well as explore relationships between culture and the actions of individuals and groups (Grbich, 1999). In ethnography, culture is viewed from two distinct perspectives:

emic and etic. The emic perspective, or insider's view of the world, is the language and expressions used by group members to tell their experiences. Accordingly, the emic perspective compels us to recognize and accept the existence of multiple realities (Fetterman, 1989). On the other hand, the etic perspective refers to the outsider (researcher's) representation of the culture under study, and seeks to reveal tacit knowledge, that is unspoken and/or unconscious cultural information embedded in members' cultural experiences (Polit & Hungler, 1999). By means of the etic or researcher's perspective, the ethnographer's task is then to make sense of the information collected from an emic or insider's perspective (Fetterman, 1989). Ethnographers conduct their research over time in the natural environment of the people they want to study (Schwartzman, 1993). This naturalist approach avoids "the artificial response typical of controlled or laboratory conditions" (Fetterman, 1989, p.41). Data collection includes a variety of methods and techniques such as: participant observation, interviewing and review of documentation and artefacts (Fetterman, 1989; Hammersley & Atkinson, 2007; Reeves, Kuper & Hodges, 2008).

Critical ethnography, an accepted way of studying issues important to nursing, is a style of discourse analysis embedded in conventional ethnography (Hardcastle, Usher & Holmes, 2006; Thomas, 1993). Schwandt (1997) defined critical ethnography as "ethnographic studies that engage in cultural critique by examining larger political, social and economic issues that focus on oppression, conflict, struggle, power, and praxis" (p.22). As such, critical ethnography is described as "conventional ethnography with a political purpose" (Thomas, 1993, p. 4). Since ethnography is the basis upon which critical ethnography is posited (Street, 1992), classical and critical ethnography share many fundamental characteristics such as: collection and interpretation of qualitative data; use of

ethnographic rules for data collection and analysis; and adherence to a paradigm of symbolic interactionist (Thomas, 1993).

However, critical ethnography differs from classical ethnography as it draws from critical social theory (Georgiou & Carspecken, 2002). As a result, critical ethnography not only aims to reconstruct culture, but also seeks to understand the relationship of culture to social structures in order to shift the research focus from individual or group to that of cultural dominance and minorities (Cook, 2005; Georgiou & Carspecken, 2002). In this context, the contribution of critical ethnography lies “in its ability to concrete the particular manifestations of marginalized cultures located in a broader socio-political framework” (Quantz, 1992, p. 462). However, Thomas (1993) cautions against confusing critical ethnography with critical theory, a capitalist theory associated with the Frankfurt school.

Since critical ethnography asks “what could be” (Thomas, 1993), the role of critical ethnographers is then to challenge *status quo* by looking beneath surface appearances and taken for granted assumptions to uncover “underlying and obscure operations of power and control” thus contributing to emancipatory knowledge (Madison, 2005, p. 5). According to Thomas (1993) ethnographic emancipation, analogous to a form of cultural liberation, is “the process of separation from constraining modes of thinking or acting that limit perception of and action toward realizing alternative possibilities” (p.4). As such, emancipation is achieved by consciousness raising and praxis; where the raising of consciousness leads to conscientization which in turn directs praxis by subjecting actions to critical reflection (Christians, 2005; Fontana, 2004). In this context, research is not limited to the transmission of data but acts as a “catalyst for critical consciousness” (Christians, 2005, p. 156).

Critical ethnography is based on a set of specific assumptions that differ from those of classical ethnography. They include: 1) “false consciousness exists among people regarding

the hierarchies of power; 2) society is in a state of crisis and people are dissatisfied; and 3) society is inequitably structured and dominated by powerful hegemonic practices that create and maintain the continuance of a particular work view” (Grbich, 1999, p. 159). As such, conducting critical ethnography can be challenging because the focus of attention lies “in areas at first glance unnoticeable and within data sources possessing mechanisms to conceal, rather than reveal, their secrets” (Thomas, 1993, p.35). Critical ethnographers must then use strategies such as deconstruction, discourse analysis and examination of concepts such as social class, race, ethnicity and gender to critically and theoretically analyze situations of inscribed power (Grbich, 1999).

Critical ethnography is the design of choice for the current study as it seeks to understand “the relationship of culture to social structure that largely escapes the awareness of actors while influencing how they act” (Georgiou & Carspecken, 2002, p. 689). Because it involves the examination of everyday cultural practices to better understand forces of power, dominance and change (Foley, 2002), it is anticipated that the use of critical ethnography will serve to discover invisible relations of power contributing to the underlying beliefs and assumptions of nursing managers having to respond to and manage acts of intra/inter professional aggressions.

Furthermore, whereas conventional interpretation of causes of workplace aggression offer explanations on how culture can facilitate or impede the occurrence of intra/inter professional aggression, critical ethnography may provide an opportunity to look beyond prevailing descriptions and findings to explore **the role** of intra/inter profession aggression in health care, as well as **the reasons** why intra/inter professional aggression is persistently managed the way it is. While privileged groups are said to have an interest in supporting the status quo to protect their advantages (Kincheloe & McLaren, 2005), it is not clear whether

individuals or groups are in fact benefiting from intra/inter professional aggression, or from the way intra/inter professional aggression is currently managed.

Critical ethnography is identified by Thomas (1993) as “perhaps situated best to provide the tools for digging below mundane surface appearances of the cultural basis of violence and other forms of social existence to display a multiplicity of alternate meanings” (p.6). As a way to “dig below surface appearances”, critical ethnographers consider several different perspectives, and even sometimes conflicting views, to assess subjective experiences common to participants and to determine the significance of these experiences with respect to the social site being studied (Carspecken, 1996; Harvey & Myers, 1995). Additionally, since critical ethnographers understand knowledge as “a social product formed within social relations involving power” (Georgiou & Carspecken, 2002, p. 689), the data they collect and analyze must provide for such findings to emerge.

Settings

The study took place in two distinct organizations: a multi-site university affiliated psychiatric facility and a community based acute care hospital both located in a large metropolitan city in Ontario. These centers were chosen as the research project fits well with the organizations’ strategic objective of creating healthy and safe work environments for employees and clients.

Sampling

All nursing clinical managers and directors working in both organizations were invited to participate in the study. Key informants were also invited to take part in the study and included individuals working in the human resources departments of both organizations as well as senior managers. The study sample consisted of a convenience sample of 19 nursing managers and directors and four key informants.

Data Collection Strategy and Tools

Research on sensitive topics such as intra/inter professional aggression “introduces into the research process contingencies less commonly found in other kinds of study” (Lee, 1993, p. 2). In effect, research on intra/inter professional aggression can be perceived as threatening for both the organization allowing the research to take place and the individuals taking part in the research. Organizations may worry that tacitly accepted deviant activities and practices, not drawn to attention before, may come to light and have unexpected repercussions on the setting (Lee, 1993). As well, organization may be sensitive to the way in which their image will be portrayed (Lee, 1993). For their part, participants may be reluctant to freely discuss intra/inter professional aggression for fear that the information revealed may be stigmatizing or incriminating in some way, or that their views may be out of step with general opinions (Lee, 1993). These perceived threats can result in potential difficulties in gaining access to a research milieu as well as potential research participants since the researcher may pose an implicit threat to the culture of the organization (Lee, 1993). Even when access is granted, the institutional context in which the research takes place “will shape and limit the research agenda” (Lee, 1993, p. 20).

Entering the Field

Several steps were taken to alleviate the contingencies described above. First, both organizations were recruited in tandem with the development of the research protocol, allowing for the tailoring of the study to the needs of the milieus. Second, senior managers agreed to actively promote the study. Finally, study participants were given the option of being interviewed in their own work environment or off-site if they chose; as some participants may feel more comfortable discussing the topic of intra/inter professional aggression outside of their work environment. While a data collection strategy is presented

below, it is important to allow for the research design to remain flexible throughout the data collection process, including flexibility with data collection tools and overall data collection plan, as these may be modified or refined during the “fieldwork process” (McDonnell, Lloyd Jones, & Read, 2000, p. 386). Data were collected from several sources including: interviews, mute evidence and observations.

Interviews

In the context of studying sensitive topics, interviews provide a way of getting “beyond surface appearances and permits greater sensitivity to the meaning of contexts surrounding informant utterances” (Lee, 1993, p. 104).

Recruitment of Participants

A meeting with a senior nurse manager in each organization took place during the development of the research protocol to recruit the organization for the study. Subsequently, letters of support were written by both senior nurse managers to confirm interest in the study.

Following ethics approval, I attended a management meeting at each organization where I presented the study and invited nurse managers and directors to participate. An information sheet summarizing the study was left with every nursing manager and director. E-mail reminders to all nursing managers and directors were sent twice by the senior nurse manager of each organization encouraging managers to take part in the study. Interested nursing managers and directors contacted me directly to voice their interest in participating in the study and to schedule a mutually convenient date and time for the individual interview to take place. Prior to the interview, participants were asked to sign a consent form (Appendix B) and complete a short socio-demographic questionnaire (Appendix C). I conducted every interview which was digitally recorded with the written consent of each

participant. All interviews were conducted in English (the participants' language of choice), and at the participants' worksite (at participants' preference). All interviews were transcribed and analyzed in English (the language in which the interviews were conducted).

Mute Evidence

Mute evidence or documentary materials can include both formal and informal documents (Hammersley & Atkinson, 2007). Examples of formal organizational documents are vision and mission statement, codes of conduct, policies and procedures. Informal documents can be memos, e-mails or letters, newspaper clippings. In this study, the review of mute evidence only included formal organizational documents.

More specifically, generic organizational documentation such as organizational vision and mission statement; codes of conduct; policy against workplace aggression; job description of nursing managers; minutes of occupational health and safety meetings were reviewed to describe the broad organizational context of the study. Documents were copied and included as part of the study data base.

Observations

Observations were guided by an adapted data collection tool from Peretz (1998). Casual observations of the work environment included examining the physical layout of the facility for high noise level, crowding, working in close proximity, etc. As well, information such as the number of beds and the number of staff in the facility; examining the dress code and the types of documentation posted on the walls was gathered.

Data Collection Tools

A number of data collection tools were used during this study. These included: interview guides, data collection grids and logs for recording field notes.

Interview Guide

An interview guide helped direct the interviews (appendix D). The interview guide was developed using Paillé's (1991) six step approach for the development of semi-structured interviews. The first step consisted of a *brainstorming period* where ideas, questions, and components of prior research were all written down. The elements of the brainstorming period were then *grouped under themes* during the second step of the process. The third step saw the *themes internally structured* by order of complexity taking into account the interview, the interviewee and the research process. The fourth step allowed for the *deepening of the themes* where each question was reviewed to verify whether additional questions were required or whether questions could be combined. *Probes* were added to questions in step five; and step six consisted of *finalizing the guide* (Paillé, 1991).

A total of three topic domains was addressed as part of the interviews: 1) actual management of intra/inter professional aggression; 2) support needed to deal with and respond to intra/inter professional aggression; and 3) organizational factors playing a role in the management of intra/inter professional aggression.

Data Collection Grids

Data collection grids guided the documentation review. Elements of the workplace violence policy were examined and the process of policy implementation was reviewed using the data collection grid found in Appendix E. Job descriptions of nursing managers was reviewed using the data collection grid included in Appendix F to establish whether there was any statement about having to manage conflict, disruptive behaviour, aggression or violence. Minutes of occupational health and safety meetings and minutes of unit meetings were reviewed using the data collection grid presented in Appendix G. However, no issues pertaining to intra/inter professional aggression were brought up via that venue. Data from

direct observations was collected using a recording template, see appendix H.

Data Analysis

Data analysis began with data collection and was ongoing, as “ideas emerging from data are reconfirmed in new data, giving rise to new ideas that in turn, must be verified in data already collected” (Morse, Barrett, Mayan, Olson & Spiers, 2002). This also provided the opportunity to adjust interviews with other participants to take into account emerging findings. Morse (1994) identified four cognitive processes inherent to data analysis of qualitative research: comprehending, synthesizing, theorizing and recontextualizing. These processes provided the broad analytical framework for this study. More specifically, four of Paillé’s (1994) six stages of grounded theory analysis guided data analysis: initial codification, categorisation, co-linkage and integration. Grounded theory techniques are increasingly being used as an analytical framework by qualitative researchers as it “provides a set of analytical techniques that can be seen as representing procedures that are consistent with, or have been assimilated into, most other approaches to qualitative research” (Priest, Roberts & Woods, 2002, p. 32).

Comprehending

According to Morse (1994), *comprehension* is reached when the “researcher has enough data to be able to write a complete, detailed, coherent, and rich description” (p.27). Three techniques can serve to accelerate the process of comprehension during data collection: 1) adopting a stance of inquiry (being able to distinguish the unusual from the usual and the norm from the exception); 2) making notes frequently and as complete as possible; and 3) keeping the literature and “non-data knowledge” of the setting and topic separate from the data (the researcher cannot assume that the participants use of a term has the same meaning than when used in the literature) (Morse, 1994).

Initial Codification

Transcribed semi-structured interviews were reviewed line by line and coded in an attempt to "reveal implied meanings, cultural values, and linkages to other concepts or contexts" (Morse, 1994, p.29). Words, expressions or short sentences were used when coding. Each code was then compiled into categories according to common themes, and categories were labelled. The aggregation of data helped determine whether some areas required additional data collection (Morse, 1994).

Synthesizing

Synthesizing is the ability of the researcher to merge several stories to describe the typical patterns, behaviours or responses of the group (Morse, 1994). Synthesizing is done by inter-participant analysis (comparison of transcripts from several participants), and analysis of categories sorted by commonalities (Morse, 1994).

Categorisation

Two steps guided the categorisation phase. Initially, a list of all categories identified in stage one was compiled. This involved removing or renaming some initial codes. The second step consisted of rereading transcripts without the initial coding to try and conceptualise a larger phenomenon (Paillé, 1994). The coding encompassed one or more paragraphs. From these codes, a second list of categories was generated. Both lists were then combined and each category was defined.

Theorizing

Morse (1994) describes theorizing as the process of constructing alternative explanations until the best fit to explain the data is obtained. The first step in theorizing requires asking questions from the data to create link and establish theory (Morse, 1994).

Co-Linkage

The third stage of analysis established links between categories. The drawing of diagrams and use of the literature (Chapter Two) and the theoretical framework (Chapter Three) helped establish these links (Paillé, 1994). As well, the review of the mute evidence and observations enriched the study findings.

Recontextualizing

The goal of recontextualizing is to place the results in the context of established knowledge, to identify findings that support established knowledge and theory and to claim new contributions (Morse, 1994).

Integration

This phase allowed for the integration of the multidimensional components arising from the analysis to let the “story line” emerge from the narration. A review of the initial research objectives and questions ensured that while the study focus evolved during the research process, the study results still in fact answered the original line of questioning (Paillé, 1994).

Methodological Rigour

Two opposing views exist in the literature over whether qualitative and quantitative methods should be assessed according to the same criteria of reliability and validity or whether qualitative research should be assessed with the parallel concept of “trustworthiness of data” (Morse et al., 2002; Mays & Pope, 2000). While Morse et al. (2002) are concerned that the introduction of a parallel terminology and criteria will in fact marginalize qualitative research from scientific legitimacy and undermine rigour, others suggest that the development of a parallel terminology does not weaken rigour but places it within the epistemology of qualitative work (Tobin & Begley, 2004). Miles and Huberman (1994) have

avoided the debate by combining the criteria of reliability and validity to those establishing trustworthiness of data. Tuckett (2005) furthered Miles and Huberman's views by developing a table showing the positivist rigour criteria and associated qualitative rigour criteria for trustworthiness. The table also identifies respective research strategies and operational techniques for each criterion (Tuckett, 2005). Since deliberating these opposing views are outside the scope of this thesis, Miles and Huberman's grouping and Tuckett's suggested techniques will be used to explain how rigour will be demonstrated.

Objectivity/Confirmability

An *audit trail* was used to demonstrate that data were collected and analyzed in a neutral manner (Carnevale, 2002). The audit trail consists of five classes of records: 1) raw data (e.g. interview transcripts); 2) data reduction and analysis products (e.g. saturation tables); 3) process notes (e.g. feedback from thesis director); 4) instrument development information (e.g. pilot forms); and 5) data reconstruction products (e.g. multiple drafts of thesis).

Reliability/Dependability/Auditability

Reliability in qualitative studies refers to whether the process of the study is consistent and stable over time, and whether other researchers would arrive at the same results with the same data and procedures (Miles & Huberman, 1994). As such, special attention was made to the accuracy of the transcripts as a component of rigour (Poland, 1995). As suggested by Miles and Huberman (1994), *check-coding* also served as a reliability check and involved having the first transcript independently coded by the researcher and thesis supervisor. When discrepancies in coding occurred, they were discussed and coding was modified as needed (intercoder agreement). As well, the first set of transcripts were coded once and then again a few days later (on an uncoded copy) to check for code-recode reliability. Again, when

discrepancies in coding occurred, they were reviewed to ensure that the differences would not change any themes and sub-themes identified. The grouping of narrative materials into themes was verified by the thesis director.

Internal Validity/Credibility/Authenticity

Sandelowski (1993) argues that reliability can in fact be a threat to validity in a naturalistic paradigm since “reality is assumed to be multiple and constructed rather than singular and tangible” (p. 3). As a result, while coding and interpretation of findings differed slightly between researcher and thesis director, I concluded that the discrepancies were in fact accounts of the same story.

Triangulation, or the use of multiple methods, is described by many as a way to address the issue of construct validity (Babour, 2001; Laperrière, 2000; Mays & Pope, 2000). Several types of triangulation were used in this study. First, the study combined three data collection techniques (*within methods triangulation*): interviews, observation and mute evidence (Shih, 1998). *Data source triangulation* was also used and occurred over three dimensions: time, space and person (Shih, 1998). Data pertaining to the management of intra/inter professional aggression was collected at different points in time allowing for *time triangulation* and served to validate the congruence of the data across time (Shih, 1998). Data pertaining to the management of intra/inter professional aggression was also collected at different sites and units allowing for *space triangulation*, thus testing for consistency across sites and units within each case (Shih, 1998). Triangulation also occurred at the *investigator level* where the thesis director brought a different perspective and area of expertise with regards to the topic of workplace aggression (Shih, 1998).

External Validity/Transferability/Fittingness

A way to allow for generalization is for the researcher to provide a detailed description of the methodological aspect of the study (Jones & Lyons, 2005). However, the assumption that research findings can be generalized to other groups violates the basic beliefs of critical theorists. In effect, critical theorists believe that multiple subjective realities exist, created by both researcher and participants. As such, a description of the research context was provided not with the purpose of generalization but rather to allow for the possibility that some of the research findings may be applicable to other contexts.

Reflexivity

Reflexivity enhances the credibility of research findings by explicitly exposing personal and intellectual biases arising from prior assumptions and experiences which can influence the research process (Mays & Pope, 2000). To ensure reflexivity, I explicitly informed the reader at the onset of the thesis of my personal experiences, my epistemological stance as well as the theoretical perspectives that were used to guide the present study.

Ethical Considerations

The study protocol was submitted to the Institutional Review Board of both organizations in which the study took place as well as the Research Grants and Ethics Services of the University of Ottawa. Interview participants were asked to sign a consent form indicating that they were informed of all possible risks and/or benefits as well as all aspects of the study. Participants were informed of their option to withdraw at any time. In addition, participants were informed that their identities and responses were going to be kept confidential. Apart from an opportunity to be listened to, to reflect on their own practice and to voice their perceptions and views on the topic of intra/inter professional aggression management, participants were informed that this study had no direct benefit to them.

Compensation was not offered.

This study poses minimal risks to participants. There is said to be minimal risk involved when the risks associated with study participation are no greater than those involved in the everyday practice (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, & Social Sciences and Humanities Research Council of Canada, 1998). The study had the potential for participants to find it emotionally difficult to discuss some aspects of their work as a nursing manager. They were informed that they were free to decline to answer a particular question or questions, to request that the recorder be turned off at any point during the interview, or to withdraw from the study at any time. Participants were still allowed to take part in the study even if they choose not to be audio recorded. Participants were also informed that they were expected to share only the information they were comfortable disclosing.

Other risks are related to the confidentiality of the data; where breach of confidentiality can potentially identify sites or units where intra/inter professional aggression is an issue, thus putting at risk the reputation of the manager or unit. Several strategies were used to minimize risks related to confidentiality. First, no name appeared on the audio digital recordings of the interviews. Instead, the interview number served to identify the files and subsequent transcriptions. The digital recordings will be destroyed within 5 years following the defence of the PhD thesis. Second, all paper copy data are stored in a locked filing cabinet in the office of the researcher. The data is available only to the researcher and thesis director and will be destroyed within 5 years following defence of the PhD thesis. Third, any potential identifying information will not be revealed in any publications and study results will be aggregated.

CHAPTER 5 RESULTS

This chapter presents results arising from interviews, mute evidence and observations. First, both organizations are described. Mute evidence combined with observations served to broaden the understanding of the organizational context of each organization. Subsequently, the qualitative themes identified from the interviews are presented and explored. Noticeable differences between both organizations arose from the analysis and are reported. Finally, the chapter concludes with a synthesis of the findings.

Settings

Ethnographic research takes the researcher to the field so he/she can learn and come to understand a culture from the inside out. In order to explore relationships between culture, social structures and the actions of individuals and groups, the researcher must shift the research focus from individual or group to that of cultural dominance and minorities. Given that this study is on workplace aggression, it was important that I be able to observe the work setting of study participants. As such, data were collected from two settings: a community based acute care hospital and a psychiatric hospital. Both organizations are different in their mandates and the population they serve. A description of each organization is now provided.

Acute Care Hospital

The acute care hospital is a full service 264 beds single site community hospital. It employs over 1,500 health care professionals and serves a population of over 400,000 people. At the time of the study the hospital was expanding and had entered phase 2 of its redevelopment project. Additional front-line managers were hired in an attempt to decrease the large span of control of some managers, and a formal management skills development

training program was developed and implemented to support managers². Amidst expansion, the hospital was also undergoing some restructuring resulting in some permanent and some temporary bed closures. The bed closures had a direct impact on staffing where some employees were sent home without pay for several shifts in an effort to avoid formal layoffs.

The physical environment consists of older and new buildings. Renovated sections of old buildings and new buildings are bright with the architecture maximizing the use of natural light. Hallways are wider and rooms larger with more private rooms for patients. Utility rooms are conveniently located and no clutter is noted in hallways. Nursing stations are roomier. Several meeting rooms are available. While older sections of the building are clean, rooms and hallways are smaller and some are cluttered with equipment. Smaller windows allow only for limited natural light. Nursing stations are small and crowded. Some patient rooms were converted into office space but still had oxygen and suction outlets as well as curtain rods visible. Some offices did not have windows. Dress codes were the usual for a hospital with the majority of front-line health care professionals wearing “scrub type” uniforms and support staff and managers dressed in civilian.

While circulating in the hospital, I noticed that vision and mission statements were clearly displayed in the main entrance and in several high traffic areas throughout the hospital. Posters stipulating a zero tolerance for workplace aggression were also noted in various high traffic areas including elevators and billboards. The posters were generic in nature and did not specify the types of aggression or the perpetrators.

² To facilitate reporting and to ensure confidentiality, the term “manager” will now refer to both front-line nursing managers and directors. No further differentiation will be made unless specifically stated.

Policies, Codes of Conducts and Booklets

Since 1992, the acute care hospital has a policy on *Harassment and Aggressive Behaviour in the Workplace*. The policy applies to the Hospital Community which is described as: employees, physicians, students, visitors, patients, volunteers and agents of the Hospital. In February 2008, the policy was revised and a second policy was added: *Workplace Violence Policy*. The *Workplace Violence Policy* falls under the umbrella of the Occupational Health & Safety department and is intended to deal with intentional infliction of physical harm and threats of physical harm. The policy addresses acts of violence from patient towards staff, staff towards staff, physician towards staff/physician, and visitor towards staff/physician. It does not include a section on staff towards physician or staff towards patient and/or visitors. The *Workplace Violence Policy* was developed because overt and intentional aggressive acts often require immediate and quick responses, in some instances involving security and even police officers. For its part, the *Harassment and Aggressive Behaviour in the Workplace* policy is intended for actions needing to be investigated to determine intent and fault, often resulting in a lengthy process. The *Harassment and Aggressive Behaviour in the Workplace* policy includes a note under aggressive behaviour cross referencing the *Violence in the Workplace* policy. The policies were easily accessible using the organization's Intranet.

In addition to the policies described above, this acute care hospital also has a *Physician's Code of Conduct* (implemented in February 2008) and an *Employee's Code of Conduct* (implemented in July 2008). The Codes set out general expectations of physicians and employees' behaviours and outlines consequences of a failure to comply with such Codes. The *Physician's Code of Conduct* is strictly enforced and reported issues of physician's misconduct are taken seriously and dealt with by the medical chief of staff.

Every new employee hired at the acute care hospital receives a generic *Employee Competencies* booklet. The competencies outlined in the booklet support the hospital's vision and identify skills, abilities, characteristics and knowledge expected to be demonstrated by all employees. Section 3 entitled Collaboration and Teamwork includes two statements related to workplace aggression: c) contributes to the resolution of workplace conflict; and i) manages difficult and emotional situations effectively.

Other Tools Available

Initially designed to improve communication between physicians and nurses working in obstetrics, the "CHAT" tool, a component of the Managing Obstetrical Risk Efficiently (MORE^{OB}) program, has been adapted and implemented throughout the acute care hospital in 2008. CHAT is an acronym and stands for:

C – Context/current condition (what is my major concern)

H – History (a brief summation of the pertinent facts)

A – Assessment (what is my opinion about what is happening?)

T – Treatment Option (what do I recommend that we do?)

While treatment oriented and developed with patient care in mind, the CHAT tool can easily be used to structure communication in general. Several participants who mentioned the CHAT tool said that it is helpful in assisting with assertive communication.

Job Descriptions

At my request, I was provided with a generic job description for the position of nurse manager to determine whether the key responsibilities include a statement pertaining to the management of conflict and/or aggression. Except for the broad statement: "responsible for providing a safe environment for patients and staff" found under the responsibility of human resources management/resource utilization, no specific responsibility pertaining to the

management of conflict or aggression was noted. No job description for the position of director was provided.

Psychiatric Hospital

The psychiatric hospital is a teaching hospital. It has two sites located in two different cities: one located in a large urban center and the other in a smaller town. The large urban center is situated in a new building and has a 188 bed capacity. The site located in the smaller town is a specialized site with a 219 bed capacity. Except for a specific unit located in a new building, the site located in the smaller town is not renovated. While the site located in the smaller town has already undergone major restructuring which left several buildings empty, it is still undergoing another major restructuring with three units scheduled to close within the next 18 months. Employees and management are bracing themselves for the imminent job loss which will not only impact the organization but the small community as a whole.

The psychiatric hospital also underwent managerial restructuring. Around 2005, as a cost cutting measure, a decision was made to abolish all front-line management positions. Consequently, directors were left with large portfolios and high spans of controls; and the day to day monitoring of staff became next to non-existent. This resulted in the strongest and most influential staff becoming informal leaders. Issues and incidents, including instances of workplace aggression, multiplied. In 2008, realizing the impact of the decision, the role of front-line managers was to some extent reinstated. However, at the time of study, not every unit/department had a front-line manager on staff, and some management positions were not renewed because of lack of funding.

The reporting structure for unit directors is also somewhat unique. In effect, the psychiatric hospital has a dual-reporting structure for its unit directors which translates to a

program having both a clinical director (usually a psychiatrist) and an administrative director (usually a nurse). Some study participants were quite happy with the above described dual reporting structure while others identified it as a source of conflicts.

As stated earlier, the large urban site is located in a totally new building. As such, the physical environment is bright and maximizes the use of natural light. Hallways are wider and the majority of patients' rooms are private. The furniture is new. Nursing stations are quite large allowing for several staff to be in the room at one time. Several meeting rooms are available. Conversely, the physical environment of the smaller town site consists of several older buildings and one new building. While the older buildings are clean, hallways are narrow and the majority of patients' rooms are dual or ward type rooms (i.e. where two or four patients reside in one room). Smaller windows allow only for limited natural light. The artificial lighting is poor which leaves the environment feeling gloomy. The furniture is old and disparate. Nursing stations are small and cluttered. Not all buildings have air conditioning or call bells in patients' rooms. It was reported that heating is highly unreliable with some days/units being really hot and others barely heated.

Vision and mission statements were clearly displayed in the main entrance and in several high traffic areas of the two sites. Posters stipulating a zero tolerance for workplace aggression were also noted in various high traffic areas of the two sites, including elevators and billboards. The posters were generic in nature and did not specify the types of aggression or the perpetrators. Posters promoting a mandatory training session for the *Respectful Workplace* policy were also noted in several places at both sites.

Policies, Codes of Conducts and Booklets

A new *Respectful Workplace* policy was implemented at the psychiatric hospital in May 2009. The purpose of the policy is to outline structures and processes for reporting and

managing workplace harassment and intimidation or bullying against staff, which includes: all employees, physicians, volunteers, students, contractors and affiliates. The policy does not address issues of workplace harassment, intimidation or bullying against patients and/or visitors. Prior to this policy, there was no formal process in place to address workplace aggression. Mandatory training for all staff including all psychiatrists was part of the implementation process. However, while training was meant to be multidisciplinary, psychiatrists were provided with their own training session which was not opened to other staff. This infuriated some employees who questioned the message sent. As part of the casual observation component of this study I attended one of the training sessions. The session consisted of a PowerPoint presentation providing historical background including statistics explaining why the policy was developed as well as its intended use. An overview of the policy was provided followed by two case studies depicting examples of workplace aggression. Session participants were asked for their input on how to deal with the two situations presented and were told that the situations had in fact occurred at the hospital.

A Respectful Workplace Employer Handbook designed to facilitate the use of the *Respectful Workplace Policy* by managers was being developed by the human resources department at the time of the study. I was provided with a draft copy of the booklet. The first section of the handbook outlines 13 frequently asked questions with their corresponding answers. The second section of the handbook describes the informal complaint process and includes a decision tree. The third section addresses the formal complaint process. A *Respectful Workplace Assessment Form* is provided as an appendix in the handbook. The purpose of the form is to assist managers/supervisors with assessing a situation, recommending actions, providing support to the parties involved and documenting the process.

The human resources department of the psychiatric hospital was also in the process of developing a policy on the *Prevention and Management of Violence in the Workplace*. I was provided with a draft copy of the policy. The purpose of the new policy is to define behaviours that constitute workplace violence and to outline processes for reporting and resolving such incidents. The policy applies to all staff and extends to locations outside of the physical environment of the organization, which may involve other staff and/or patients. Responsibilities for employer, manager, staff, Occupational Health and Safety Services and the Joint Occupational Health and Safety Committee are outlined in the policy. While the psychiatric hospital has codes of conduct, I was told by a key informant that these are not used and should be revisited to assess their pertinence.

Other Tools Available

A document outlining ways to effectively communicate when encountering out-of-line behaviours was found on the psychiatric hospital Intranet. The document included two acronyms to guide communication. The first acronym (DESC) was intended for people wanting to inform someone of an out-of-line behaviour.

D – Describe out of line behaviour

E – Express feelings and impact of behaviour

S – Say what you specifically need to see changed

C – Communicate consequences if nothing changes

The second acronym (LAST) was directed at people receiving feedback

L – Listen

A – Apologize

S – Say what you will do differently

T – Thank them for their courage to share their perspective with you

While this document is readily available on the hospital's Intranet, it was never mentioned as a resource by study participants which lead me to question its usefulness and whether people were actually aware of its existence.

Job Descriptions

The generic job description for the position of nurse manager was also reviewed. A broad statement: "ensure safety and risk management practices within the service" was noted under the duties, but again no specific skills pertaining to the management of conflict or aggression were noted. A draft job description for the position of director of patient care services was reviewed. Three broad statements: "promoting and fostering a safe and healthy work environment", "adherence to patient and workplace safety policies and practices", and "adherence to respectful workplace policies and practices" were found under Accountability #2 – Management of the Human Resources functions. While not specific to workplace aggression, these statements describe duties that encourage the management of aggression.

Interview Process

A total of 23 participants were interviewed: 12 front-line managers, seven directors and four key informants including two senior managers and two people working in human resources. All but two interviews were recorded, and one participant asked that the recorder be turned off near the end of the interview. Three participants were non nurses. The majority were female (78%). Of the directors and front-line managers 63% were between the ages of 46 to 55; and 78% had been employed in nursing for more than 20 years. In terms of education, 42% had completed their baccalaureate (with an additional 10% in the process of completion); 21% had completed their masters (2 in nursing, one MHA, one MEd) while 10% were in the process of completing theirs. Ninety percent received formal training in conflict management/resolution and 42% received formal training specific to

violence/aggression management. Regarding employment, 37% were employed in their current place of work for more than 20 years, while 32% were employed for more than one year but less than five. Forty two percent worked on their unit for more than one year but less than five. As for span of control, 28% managed one unit, 22% managed three units, and 28% managed more than four units. Sixty eight percent stated having 50 or more staff reporting to them, with one front line manager having as many as 130 staff. A summary table of the socio-demographic data can be found in Appendix I

Interview Themes

The analysis of the 23 interviews identified five main themes and 15 sub-themes. These are listed below. Several categories were also identified and are used in the text.

- 1) Perceptions
 - Intent
 - Differences
 - Representation
- 2) Emotions
 - Fear
 - Frustration
 - Mistrust
- 3) Aggression
 - Etiology
 - Environments
 - Boundaries
- 4) Management
 - Modus Operandi
 - Actors
 - Support
 - Responsibility and Accountability
- 5) Power
 - Hierarchy
 - Agenda

Theme One – Perceptions

The first theme to emerge from the analysis relates to perceptions which refer to the process by which individuals organize and interpret information to produce a meaningful representation. While the actual process of organizing and interpreting information was never explored, elements thought to be linked to the process emerged. Perceptions were at two levels: 1) how one perceived others; and 2) how one believed others perceived him/her. In the context of workplace aggression, actions that are perceived as aggressive by some can be dismissed by others. As such, perception of aggression is subjective and will be influenced by the individuals involved in the interaction. These findings corroborate the subjective nature of aggression. For example, the following participant explains how people can respond differently to the same event.

And some people get more offended than others usually do too. Like there are some people that are less sensitive, more sensitive, some people are just like fluff it and OK she's having a bad day. And some will walk away wounded and in tears. (11-8)

While the above participant never openly states that perception is the basis for the difference in interpretation, one can infer that the way the act is perceived will in turn dictate how one will respond to it. The quote also brings to light another element that affects perception, which pertains to whether the person committing the act (perpetrator) is known to the person interpreting it (victim). By saying "she's having a bad day", the victim is able to contextualize the act. He/she perceives it to be out of character for that person and as such, is able to dismiss it as non-threatening. Staff may also be more tolerant of a usually nice person having a moment versus someone who is known to quickly lose his/her temper thus not having a bad day but just a normal day for that person. Over time, people may become less tolerant or lenient towards individuals who are constantly having "a bad day". The next

except further illustrates the difference knowing someone can make in the perception of an action.

But if I have an established relationship with you I may be able to make a off handed comment to you and you may even look at me and smile and ... say shut up, you're being cranky or whatever. But if I have that type of relationship with you, you will not perceive that as aggression, whereas there may be another person in the room who doesn't share that kind of, you know relationship, who might be absolutely appalled by it. So again, that speaks to the team, it speaks to the relationship, it speaks to the tolerance and perception of all of these things. (22-7)

Again, knowing an individual permits the contextualization of the act which in turn impacts the perception and dictates the response. Perceptions can also be influenced by whether someone is liked or not, or whether the victim cares about the views of the said perpetrators. In effect, it might be easier to dismiss the observations of someone we do not care about or respect versus the views of someone we value and hold in high esteem and revere. The quote also highlights how the interaction between two people can be interpreted by a third person. For example, the bystander to the action (the person who did not share the same kind of relationship as the two others) may actually feel relieved that the two individuals are friendly and comfortable enough with each other that one's response helps defuse and not escalate the interaction. The interaction also informs the bystander that this situation is not usual for the person, the smile indicates tolerance for the person, and the comment about being cranky indicates friendly banter while helping the "perpetrator" recognize that he/she is being unpleasant. By addressing the behaviour in a non aggressive, non threatening way, the peer provides the "perpetrator" with the opportunity to change his/her behaviour. The positive interaction allows the bystander to witness constructive resolution and may even provide the bystander with the opportunity to learn coping skills necessary to dealing with that type of situation in the future.

The state of mind of the victim at the time of the aggression was also identified by participants as a factor influencing perception. The following participant explains how the victim of an action can label the action as an act of aggression one day, but dismiss a similar action another day.

And a lot of it really has to do with interpretation. I also noticed that, you know, depending on how you're feeling, you know, if I'm having a great day, and you make a comment, you know you have big feet or something like that. So what right? If I'm having a bad day, and things are wrong and you know, you say I have big feet, it can be the most devastating thing, you know. (22-7)

Again, the excerpt serves to demonstrate the subjective nature of aggression but from a different perspective. In effect, while the first quotation highlighted how people may respond differently to the same event, this citation shows how the same person can respond differently to similar events. As such, depending on their state of mind, people can accept, dismiss or take personally the interaction. An individual's response to an aggressive act is thus influenced by both how he/she perceives the threat and how well he/she is able to cope on that day/moment. The analysis provided several examples of perceptions that have the potential to lead to aggression. These were grouped under three sub-themes: intent, differences and representation.

Intent

In some instances, the nature of the aggressive act substantiates whether there was intent to hurt or harm. Intent becomes obvious in cases of overt acts of aggression such as hitting, biting and pushing. However, instances of physical aggression are rare, especially among peers and colleagues. As such, it becomes much more difficult to interpret subtle forms of aggression which can leave a person wondering whether he/she was in fact victim of an aggressive act. Even if one determines that the act was aggressive, one is left to determine whether it was intentional. As described earlier, perceptions are playing an

important role in determining both.

Several descriptors were used by participants when talking about intent. For example participants would say: “one *thinks* the other one is...”, “he didn’t really *mean* to...”, “she *came across* as...”, “she is not *doing it* out of malice...”, “she *felt* it was directed at her...”, “I *wasn’t* doing that *on purpose*”, “I *didn’t realize* that you felt that way”. Depending on the situation or the person, the study found that some people were quick to perceive ill intentions from others. Reasons for this can be attributed to the victim’s state of mind at the time of the incident, the nature and state of the relationship between both individuals as well as perpetrator’s reputation.

Awareness: Emotional

Participants described how when speaking with said perpetrators of aggression, several did not realize that their behaviour was inappropriate or that they were perceived as being aggressive. Moreover, when made aware of the impact of their behaviours, many were shocked to learn that they were having such a negative effect on others as demonstrated by this passage.

Sometimes it’s just a matter on them being aware of how they come across because there has been other instances where I’ll talk to someone and they go “Oh God, I didn’t mean that, I really didn’t mean that”. So it’s just to get them to understand that sometimes it’s not necessarily what you say but it’s the manner in which you say it or your tone of voice, and once they realize that, then sometimes it’s just that awareness for themselves too, because nobody has actually sat down and said “Oh by the way, just, this is kind of how it came across” and they are totally flabbergasted by it. They had no idea. (11-9)

This excerpt also raises an important issue, that is how will one respond once aware of the negative outcome of his/her action. In effect, the “perpetrator’s” response may in fact influence the victim’s subsequent perceptions and/or behaviours. While some perpetrators feel remorseful, others simply refuse to acknowledge that they are responsible for the sender

part of the message and will blame the recipient or victim for misinterpreting the message. These perpetrators are difficult to deal with because they dismiss the fact that their behaviour can be construed as aggressive. By refusing to acknowledge some wrong doing, these people send the message that they did nothing wrong and as such will not change or seek to improve thus potentially threatening further their relationships with others.

Awareness: Physical

As part of awareness, this participant talked about the need for employees to be sensitive to the impact of their physical location on others and provided the following example.

Like say you and I were, you know my office is really long and you know I'm sitting sort of at the back here and you are sort of sitting at the front there sort of blocking the door for all intent and purposes. Well, if we were getting into a really heated argument about something, or if I'm going to talk to you about a contentious, really contentious issue between the two of us, you know, depending on my personality, I might feel uncomfortable because, because I feel kind of hemmed in, right... You have to be mindful of your position, you know, where you are in relation to the person when you are resolving what might be a contentious issue in case there is an intimidation factor. (12-1)

The above example shows how the blocking of a door way – or way out – may be a form of intimidation because the victim cannot escape from the situation when he/she may feel the need to leave. The example also highlights the need to always have an exit strategy or to avoid discussing a potentially contentious issue in a room where one could be trapped and unable to leave. The same participant also talked about the importance of being aware of one's physical presence (influenced by body size) to reduce the likelihood of being perceived as aggressive.

Like we have this one employee, he's a really big guy, has a really gruff voice, some people find him really intimidating, he doesn't mean anything by it, it's just his, he has a really kind of spooky looking, kind of rough looking, has a really gruff voice, really big you know, has a different sense of personal space, you know. He needs to be more mindful of his environment and his

surroundings when he's having a disagreement with somebody, then someone who's, who doesn't have those same kinds of, you know, parameters. (12-1)

Physical presence can also be compounded by body language. For example, when a "big guy" who also demonstrates aggressive body language, his stature and hand gestures will not have the same impact upon another as someone of small stature exhibiting the same gestures. As such, while the "big guy" cannot do anything about his size, he is able to control his body language, which could potentially escalate or deescalate a potentially aggressive situation.

The question of "personal space" is also an important piece in the perception of aggression. How much "personal space" a person needs can vary greatly depending on the person's culture, values, upbringing and personality. People who feel that their personal space is being violated will often take active measures to increase the distance between themselves and the other individual. For example, they may take a step back or move their chair. Others may choose to voice their need for more space by openly saying "you are crowding me". On the other hand, people are not always comfortable in expressing their need for increased personal space and may feel intimidated or even anxious by the close contact. As a result, being aware of how much personal space one requires to feel comfortable, and being able to voice the need for personal space if one feels confined becomes a crucial aspect of the management of this type of (perceived) aggression.

Awareness: General

The above findings highlight the importance of taking the time to verify intent and to raise one's awareness about how he/she is perceived. As such, the first step in addressing the majority of instances of aggressive behaviour is for the victim to discuss the behaviour and verify its intent with the said perpetrator. However, while health care professionals,

especially nurses, will easily advocate for the rights of their patients, they are often uncomfortable doing so for themselves. Managers reported instances where they talked to employees who were unaware that their behaviour was disruptive to their colleagues. These employees were often more upset that their colleagues did not feel comfortable talking to them and had gone directly to the manager, than to learn that their behaviour was inappropriate.

Managers can therefore play an active role in teaching their staff about the need to address difficult situations directly with the person involved. The following participant explicitly stated that as part of her role she was coaching her staff to “go to the person and say this is the behaviour that I find unacceptable and this is the impact you’re having on me” (22-1). In effect, individuals will not attempt to change their behaviour if they are not aware that the behaviour is disruptive. Additionally, if more than one person brings to the attention of the “perpetrator” the fact that his/her behaviour is disruptive; the message to the “perpetrator” is being reinforced that this is not just an isolated incident but rather a pattern of behaviour that is not appreciated by colleagues. Conversely there were times, depending on the offence and/or the repetitive nature of the offence, where managers felt the need to promptly intervene and deal with the behaviour globally while maintaining the confidentiality of the victim(s).

In some instances, whether it is because they are afraid, intimidated, shy or for any other reasons, victims do not wish to discuss the situation while alone with the perpetrator. In these instances victims can benefit from the help of a third party (for example the manager). Having a neutral and objective person present at the meeting can help diffuse tense situations, verify that what is said by one individual is in fact what is heard by the other, and can help move the discussion beyond perceptions to get at the heart of the matter. Some

managers reported setting ground rules at the beginning of the meeting to ensure that conversations remained respectful and that issues and not personalities were dealt with. Managers also talked about the importance of having both parties agree to keep the exchange confidential so that individuals could express themselves freely without being afraid that they may be talked about afterwards. While addressing the issue directly with the person can serve to clear the air and improve the situation or working relationship, talking with peers afterwards can be perceived as a form of gossiping or back stabbing that can be detrimental and even destructive to the relationship.

The following participant explains that because she knew both individuals and knew they both “had a good heart”, she felt they could both benefit from having a guided exchange. In this case, the presence of the manager (third party) ensured that both individuals really heard and understood each other. Consequently, both individuals became aware of how they were mutually perceived by each other and how intentions were in fact misinterpreted.

So they each thought something nasty about the other person. So I, knowing each of them, and knowing where they were coming from, they each had a good heart so to speak. And they had no clue that they were coming across each other. I sat them both down in a room, with their agreement, and said OK now, this is what you said happened. Is that what you heard? OK, now when you replied, is that what you heard? What do you think she was saying to you? You know and did that kind of back and forth ... They were really surprised that the other one was hearing something that they didn't intend. It was totally miscommunication. (21-5)

As seen in this example, when done well this type of intervention has the potential to repair relationships and foster a culture of trust and mutual respect. Additionally, the abilities and communication skills acquired during the exchange can provide tools for positively dealing with future situations.

A number of participants reported being surprised by the lack of awareness of some of

their employees. The following participant explains that even when confronted with facts, the employee could not acknowledge wrong doing and started crying.

The funny thing is the ... main instigators don't have an awareness. Like when you bring it to their attention, they're totally, like they don't seem to acknowledge it, and they deny it, and usually start crying. And so you get this total personality switch. But usually like, if you were to tell me something like a constructive criticism or something I'm not doing well, like I would have some awareness or yeah, I'm not very good at that, or yes, I do need to improve on, that's something I'm working on. But to have no hum, recognition of their negative behaviour, I just can't understand that. (11-6)

The above quote describes a troubling situation reported by some managers who found themselves witnessing an employee's radical change in behaviour following a discussion about an unacceptable behaviour. Managers expressed being left to wonder whether the "total personality switch" was as a result of the individual not being able to deal with the new found awareness and needing help, or whether it was a form of manipulation to avoid taking ownership of the problem. A third possible explanation which was not explicitly raised by managers is that people who are aggressive, display bullying behaviour, or are highly critical of others do so because they have poor self esteem. For these people, diminishing others serves to make them look better. Conversely, when confronted with their bad behaviours, these people tend to cry because the criticism reinforces their poor self esteem. They also do not want their peers and especially their superior to think badly of them.

Differences

So far the results have shown how perception, especially the erroneous perception of intent, can be related to aggression; whether it is perceiving that others are aggressive towards oneself or that one needs to retaliate as a way of responding to perceived aggression. Coping skills were also identified as playing a role in perceptions. For example, highly functioning individuals have the potential to de-escalate situations and often have others best

interest at heart, while poorly functioning individuals may be more inclined to perceive that everyone is out to get them. The analysis also showed how the perceptions of differences can play a role in workplace aggression. People, including health care professionals, tend to compare what they do, what they have and how they are treated to what they perceive others to do, to have or to be treated. In some instances, the perception of differences leads to interpretations that serve to “justify” intra and/or inter professional aggression. Four contexts were identified: differences in training, differences in practice, differences in management styles and differences in roles and responsibilities.

In Training

Education level was acknowledged by some participants as a potential cause for intra professional aggression. A few participants discussed the difference between nurses pursuing their education and wishing to implement new ideas and nurses coming to work to do their job and wanting to maintain the status quo. The following participant specifically talked about the basic training of nurses. He described how experienced registered practical nurses (RPNs) were able to fast track through a college level registered nursing program to become registered nurses (RNs).

In 2005, Ontario changed the entry level to practice. They recognized the shortages that were coming so every community college in the world offered a fast track program to nursing. So they took RPNs who had 10 months worth of formal education possibly 20 years ago, really didn't engage in continuing education as we would expect, and they put them all in these really fast RN programs which taught them the find and fix approach, didn't teach them the conceptual frameworks to nursing, didn't teach them the science of nursing but got them a diploma. So now we have a whole workforce of nurses to fill that who have come out and they have the RPNs who went to school a little bit but they may not have shifted their thinking... So then to move from a profession that's close to a registered nurse to now a leadership who's expected to have a conceptual thinking, to use an evidence based approach, to look at best practice. They haven't engaged in that. They just know what they did before and they're now the RN leading, and so we're not getting the quality in the nursing trenches because the number of baccalaureate students hasn't caught up to where we

should get. And our health care workforce is mostly RNs that are fast tracked or diploma prepared. So you get the nurses coming with a find and fix mentality I call it, from the old medical model – “what the doctor say, we do”. (22-5)

The above participant also talked about the difference in thinking between these experienced RPNs turned RNs and the younger registered nurses whose basic training is a four year university nursing program. He describes the younger nurses as having their thinking structured around their learning experience, as having a sound theoretical foundation, as having an evidence based approach and at placing patient at the center of the care.

Similarly, the difference in basic education between seasoned [college trained] nurses and younger [university trained] nurses may be an explanation for nurses eating their young. In effect, seasoned nurses may perceive younger nurses as treats because newer nurses will more than likely surpass them in knowledge and skills. Resentment towards younger nurses may also be related to younger nurses having more education (e.g. their BScN) than several older nurses thus sidestepping them for promotions. The same participant describes how the difference in training may generate conflict.

I think that they're [older nurses] intimidated by the younger nurse. I think the younger nurse comes in from a degree program and approaches things different, because the way they're thinking has been structured over their learning experience. They approach things with evidence based approach – “before I make a decision, I better look to see what supports me in making that decision. (22-5)

This excerpt also draws attention to the fact that differences in training will ultimately result in differences in practice, resulting in intra professional tension. The differences in practice are further explored below.

In Practice

Individual practices can differ greatly between health care professionals. For example, some people tend to practice “by the book” and are quite rigid while others show more latitude and flexibility. While these differences may in fact have little impact on the quality of patient care delivered, such differences may serve to fuel perceptions of laziness, of not being committed to ones work or not doing ones job properly thus leading to conflict and aggression in the workplace. The following participant’s comment demonstrates how differences in practice can lead to conflict.

I think that some people, they have in their mind a very particular way of doing something, and they become critical of someone not handling it the way that they would handle it, and that would be a source of conflict. (12-1)

The way in which novice nurses practice nursing is often quite different than their experienced counterparts. For example, novice nurses are traditionally very competent on the computer. They were trained to research things and will not hesitate to use the hospital computer system to look up information. Furthermore, novice nurses tend to quickly understand new technology whereas many seasoned nurses are afraid of computers. Nowadays, a lot of new technology is computer based which can bring an additional stress on seasoned nurses. Novice nurses are also used to experiencing change frequently and therefore will more than likely be receptive and adapt to change better than their older peers. The following participant describes how experienced nurses are not always receptive to new ideas and may in fact attempt to discourage others from implementing change.

And the experienced nurse will say “we tried that it didn’t work, we tried that it didn’t work, we tried that it didn’t work, we tried” and you have the new nurse going “well the evidence says lets try this” – “oh we tried that before”. And that creates conflict. (22-5)

Similarly, this participant talks about experienced nurses being set in their ways, and not being receptive to new knowledge or students.

So we were looking at a culture that's you know, an older generation of people who have been here 25+ years. And you know, it's very different to change their ways of thinking. And they're not very receptive... they're not receptive to nursing students... they're sort of done with the whole educating part of it. Like they just want to kind of do their time, retire, be done. (21-1)

Likewise, a few participants talked about employees working for the same employer, and even on the same unit for the duration of their career. As such, when new employees are recruited to work on units staffed by seasoned workers and start to ask questions about established practices, especially if different than what they are accustomed to, these new employees may trigger some defensive responses from the seasoned staff. This is particularly true if the seasoned staff perceive that the differences highlighted suggest their practice may not be according to standards.

Another reason why younger staff may be more receptive in changing their practice may relate to the fact that as novice practitioners, they are used to being corrected and/or do not have complete confidence in their skill set. However, as they gain self-assurance, master skills and become seasoned, these nurses may be reluctant to let go of practices that served them well in the past.

While health care professionals have the common goal of delivering quality patient care, practitioners often come from different backgrounds and may have different personal values, morals and work ethics. These differences can influence the way people view their purpose which will be reflected in the way they practice. These differences are not always welcomed on a unit, especially in the presence of cliques with established practices. These cliques may also pressure people into acting/practicing differently than they would otherwise, in order to be accepted by the group. As demonstrated by this excerpt, being

different may lead to being ostracized.

[She was] the kind of person that thought outside the box, so she might do things a little bit differently. And I think that's where the targeting came from, the fact that she did things a little bit differently, that she wasn't so rigid in the range she dealt with patients and other people. (22-3)

As alluded to earlier, doing things differently may also relate to the generation you belong to. Younger nurses are taught to be critical and are not afraid to question the practices of others (including their older peers and/or physicians). This can be perceived as a lack of respect by some and bring about conflict.

One manager suggested that people have different motives to become health care professionals. While some might have altruistic reasons and want to be there for the patient, others may chose to be a health care professional for more selfish reason such as status, income or job security. As such, these differences in "purpose" might contribute to intra and/or interpersonal conflict and aggression.

In Management Style

Employees are also prone to compare their units to other units and the way these are managed compared to theirs. Health care professionals who work on multiple units can easily compare unit culture and management styles. These comparisons can result in perceptions of unfairness thus triggering negative emotions. Staff may also refuse to work on certain units because of their perceptions or the unit's reputation. The following participant expresses how inconsistent practices between managers can in fact result in some units having difficulty recruiting casual staff.

You know, because we have a lot of casual staff so they work all over the hospital, so if the managers are not consistent and there's not any organizational like protocol, it can become very messy and then it's like splitting of where, which units they go to. (21-1)

Conversely some units are not very welcoming of casual staff either. Due to the nature of their position (e.g. floating from units to units), casual staff may ask more questions and need more support from the regular staff. While the actual work might be similar from unit to unit, each unit is also different (e.g. different culture, different employees, different way of working, different team dynamics). Furthermore, it might be difficult for casual staff to remember where things are physically located or who the doctors and nurses assigned to the unit are. People who have never “floated” and/or have not been out of their comfort zone in a long time tend to lack empathy towards casual staff. Being perceived as needy or not knowledgeable may alienate the casual nurse from some nurses on the unit. If casual staff do not feel welcome or are made to feel badly, they may not want to return to the unit. Moreover, casual staff may share stories with staff from their “home” unit or between themselves thus creating some rivalry between units. Nursing managers can play a role in making sure that employees, including casual staff, feel welcome and as belonging to a team when working on their unit.

Participants also reported instances where staff perceived that they were being bullied by their managers when in fact managers were only exercising their management responsibilities. In effect, some managers may set expectations differently than others, leaving room for interpretation of intentions.

In Roles and Responsibility

The roles and responsibilities of health care providers are not always clearly defined and/or understood by others. Consequently, respecting the scope of practice of each of the different professions can be difficult, especially when working in a multi-disciplinary team. One participant clearly articulated this reality by stating that “sometimes what causes conflict is not having a clear understanding of what the roles are” (11-1).

Additionally, roles and responsibilities may often overlap thus making it difficult to determine who does what when. Role confusion can easily lead to frustration and conflicts, especially if specific tasks cannot be performed by a profession during an assigned block of time (i.e. during 9 to 5 Monday to Friday) but can be by that same profession the rest of the time. Example of such situations include nurses not being allowed to assist patients with physiotherapy during the day as it is the physiotherapist's responsibility, but can do so when the physiotherapist is off at the end of the day shift as no one else is available to do so then.

Representation

The third sub-theme to emerge was related to factors influencing perceptions and affecting their interpretation. Three main topics were identified: expectations, assumptions and taking it personally.

Expectations

Participants mentioned that there is an expectation among some nurses that they should not have to ask for help, that others should instinctively be aware of their needs. Consequently, nurses are often frustrated when they are busy but see their colleagues (e.g. other nurses or orderlies) sitting and not helping.

Participants also noticed that many nurses have high expectations toward their peers, some even expecting "perfection". For example, some employees will compare their overall work outputs with that of their peers and will get upset when they perceive someone not pulling their weight, but making the same salary as they do. The following participant openly talks about how unsupportive and unforgiving nurses can be towards their peers.

The profession doesn't cut you much slack. If you're on staff and you're making a salary close to mine, then you should get to look after the same type of patients that I can look after. And if you can't do it, you're not pulling your weight and what's the problem. And that's where, you know, so when you get somebody that would come forward and say "look I'm really not comfortable

with that”, instead of embracing that and saying OK let me help you become comfortable, it’s turned to “well obviously you’re not one of the better nurses on the floor” and so you kinda get pushed to the side ... instead of supporting and I mean, here we are in a profession (laugh) that is supposed to be caring and nurturing and supporting and moving towards wellness and being the best individual health wise that you can be, we turn on ourselves and say “if you can’t cut it, you’re gone”. (22-2)

The above quotation also illustrates how one’s perceptions play a role in explaining another’s behaviour. In effect, instead of trying to understand what prevented his/her peer from “pulling his/her weight”, the nurse quickly interpreted the behaviour and judged the peer -“obviously, you are not one of the better nurses on the floor”. This type of attitude reinforces the perception that needing help is a sign of weakness or of not being knowledgeable. As a result, the “weak” nurse may come to lack confidence in his/her skill set even more, or may try to hide his/her need for help so that his/her peers do not think that she/he cannot cope or he/she is a bad nurse. This type of behaviour provides a clear example of an “eating our young” type of mentality.

Similarly, nurses are often complaining about unmet expectations between shifts. For example, the day shift may expect that bed baths be given at night because the night shift is not as busy (no medical rounds); and the evening shift may expect that new physician orders be updated during the day because there is more staff during that shift. As a result, when these expectations are not met, employees often find themselves annoyed and/or frustrated.

The matter of high or unmet expectations is not just experienced intra-disciplinarily but also inter-disciplinarily where there is sometimes a lack of understanding and respect for what other health care providers do. For example, as part of their duties, orderlies are often required to do a lot of physical work including heavy lifting, turning patients, and in the operating room holding patients’ limbs in static positions for long periods of time.

Consequently, these health care providers may require a recuperative period between “physical” duties. However, if other health care providers observe the orderly “resting” while they themselves are busy with their assignments, they may not always be aware of the extent of the physical duties and instead assume that the orderly is lazy for taking a break instead of helping. The above examples also highlight the link between expectations and assumptions. The subject of assumptions is further explored below.

Assumptions

Generally, it can be said that people have the tendency to turn their perceptions into truths and draw conclusions from those. Often assumptions are made without verifying the *raison d'être* of the perception or a person's intent. What follows demonstrates an instance where a nurse assumed that it was her duty to openly criticize her peer in order to help her improve her practice.

One in particular was sort of framed as giving feedback to the other individual and hum, the feedback was given, she felt she was the spokesperson for a number of other different people, and that hum, the person probably didn't know that she wasn't doing things correctly so she felt it was necessary to tell her what she was doing wrong, what she was forgetting at the end of her shift. But it was the way in which she gave it to her. She gave her a letter and you know, just said “this is what you did wrong, this, this, this and this. And she left it in a place where it wasn't confidential, was folded over, put on the bulletin board for the other person to find along ... (11-9).

While this nurse's intention may have been might be noble, the nurse did not necessarily reflect on how to deliver her message and the impact of the said message on her peer. In this case, the nurse was surprised and even defensive when confronted by her manager about her action. She did not understand why people were upset with her for having intervened. Although one cannot conclude that the nurse providing the criticism was intending to hurt her colleague, the situation exemplifies a lack of consideration and a lack of awareness of the impact of criticism on others.

Taking it Personally

Participants also reported that some employees were prone to take comments or decisions personally, always assuming that the comment and/or decision is in fact a way to penalize them for their inadequate performance. The following manager expresses the importance of reassuring her employees that her decisions are not meant to penalize them but rather are an attempt to do what is best for both the patient and the unit.

I think that people take a lot of things that we do at work very personally, and it has nothing to do with it. Here I always have to say “this is not personal, like this has nothing to do with you specifically, it’s just, this is how we’re dealing with the patient and...”. So lots of people take everything very personally. (21-1)

The same participant went on to describe how a staff nurse perceived a change in patient assignment as a covert way of being told she was incompetent and “a bad nurse”.

I had a nurse who became very angry with all her co-workers when we switched the patient from her. She was ... the primary nurse, and we switched that patient because the patient had made a number of complaints against the nurse. The patient was horrible too, just treated that nurse horribly ... So we approached her, she says “fine, fine, yeah take her, that’s fine”, and then at the next nurse meeting she said “I can’t believe you guys didn’t think I was a good enough nurse, and forget it now, I want nothing to do with that patient, and you guys are apparently all better nurses than I am...” (21-1)

The staff nurse in this excerpt clearly perceived ill intent from her manager and peers. She assumed that members of the team wanted to castigate her because they did not think she was able to handle a difficult assignment. Instead of validating her perception with others or openly verbalising that she was hurt by the decision, the nurse simply lashed out at her peers while acting as if the decision did not affect her.

Nursing is a profession dominated by women; and men and women are known to interact differently in social contexts. The following participant perceives women to be much more emotional than men, resulting in women taking things much more

personally then their male counterparts.

I'm constantly amazed at the differences between how women and men respond to conflict. And what I mean by that is that women very much personalize, hum, their job is who they are. Their, their efforts are who they are. And so, if that, if they perceive that to be challenged, they're very emotional about their reaction. And sometime that doesn't position as well, we may have a very good point but if we're too reactive to it, it comes across as defensiveness and personalizing. Hum, that's where I see aaa how women respond sometimes, very emotional, that it's sort of you fall short of what the real issues are. Whereas ... my male counterparts do it, aaa and it's not always true, I'm making very, very general statements, so it is they have more on an analytical response, little less emotional. It's not about me, or not liking me, or not liking them. It's what is the issue and going from there. (22-7)

As described in the above excerpt, emotion can play a role in perception which can in turn generate further emotion. Similarly, the personalization of issues can easily escalate one's emotional response. While not explicitly stating it, the above participant suggests that a person who displays out of control emotions can in fact be diminishing his/her credibility. The above participant also describes how having mixed teams (composed of both women and men) can be positive and beneficial to a unit/ organization because mixed teams change group dynamics by providing different perspectives

Theme Two – Emotions

Throughout the analysis, it became clear that perceptions often prompted strong emotions. Participants reported that the interpretation of facts was often clouded by emotions, preventing people from thinking objectively and rationally. As such, intense emotions were perceived as contributing to people overreacting to situations; and out of control emotions as contributing to an escalation in behaviour and acting out. Participants felt that only when emotions were back under control could a peaceful resolution be achieved. As such, participants view the need to keep emotions under control when responding to a situation and to deal with actual facts only as a mean of achieving resolution.

The coping skills of an individual can also play a role in his/her ability to deal with an emotionally charged situation. As discussed earlier in this chapter, people faced with similar event may respond differently to the event; or a person facing two similar events may respond differently to each. As such, the ability to respond to a situation may be influenced by the emotional state of the individual at the time of the event. Participants identified three emotions that can be linked to workplace aggression: fear, frustration and mistrust. These will be analysed next.

Fear

Fear can either cause someone to close up or lash out. While employees never overtly state that fear is what is paralyzing them, managers provided several examples of situations when staff chose inaction as a result of being afraid. For example, managers reported instances where employees were afraid to provide their opinion related to patient care because they did not perceive themselves to be credible and felt as though others would belittle them. As such, these employees would not offer any feedback during rounds or team meetings. In one organization fear was also linked to risk. The following participant relates how some employees are reluctant to make decisions about patient care for fear that if something went wrong, they would be blamed.

When you're dealing with risk and you have to make a decision, we end up being reluctant to make the decision because if it goes wrong, there's fear of blame... And it causes them an increased anxiety about making a decision knowing that you're going to be reviewed by your peers. And if it's not the right decision, or someone comes in with a different idea, we feel shame and guilt for thinking that way. (22-5)

The above participant describes well the fear and associated emotions experienced by staff if/when making a wrong decision. The same participant also talked about the divide that can happen in a team when health care professionals do not agree on a treatment plan for a

patient. Ultimately, a decision must be made; and an unpopular decision may create conflict and/or fear. This fear of blame highlights the belief in health care milieus that mistakes are totally unacceptable.

Fear was also identified as a possible reason for the underreporting of intra/inter professional aggression. For example, some participants were aware of staff choosing not to report instances of peer aggression for fear that their peers would retaliate against them and not help them in times of crisis. This was particularly true of employees working with mentally ill patients where some employees were told that if they reported their peers' unacceptable behaviour, they would not get help during a psychiatric emergency such as a code white. The following participant referred to a "*code of silence*" to describe the non-reporting of workplace aggression where "the code of silence is an unsaid golden rule that you don't tell" (22-7), a form of loyalty amongst professional staff where "you don't rat out one of your own" (22-7).

Participants also acknowledged being aware of instances where team leaders were afraid to make decisions regarding staffing assignments for fear of being openly criticized by particularly vocal employees. Instead, team leaders chose to let these vocal employees decide on their own assignments resulting in inaction from the team leader and frustration by other team members. Frustration is explored next.

Frustration

Whether it is related to the work environment, peers, clients or a combination of multiple factors, frustration is often experienced in the workplace. Several examples of situations that may potentially generate frustration have been previously discussed. An individual's ability to cope with a particular situation was also discussed. As has been shown, individuals who are not able to cope positively with frustration have the potential to

act out. Moreover, frustration can also affect the work environment where high achievers may choose to leave a unit and/or an organization, and middle performers may become indifferent or lower their performance.

While frustration can explain some bad behaviours, the issue is rarely openly discussed. Instead, some individuals attempt to cope with frustration on their own to the best of their abilities. However, since many healthcare providers are already emotionally strained (stressed, depressed, burned out), they may in fact have trouble handling another emotional charge such as frustration. Furthermore, employees who go to their managers with an issue can become frustrated if they perceive that the manager is not helping them deal with the situation. The following excerpt reveals how employees can become irritated and even discouraged by their manager's seeming lack of active involvement in helping them resolve an issue.

To me there's got to be a balance there. Because a manager who always says, you know "here are the tools, you fix it", is not managing. All they're doing is that they're sitting off on the side and they're playing a parental role in some way. I think the trick to being a very effective manager is to finding that balance because absolutely, you must empower the individuals so that the next time they can fix it themselves. But you don't do that by saying here you go, go away and tell me when you've got it fixed. You need to work carefully with them, and maybe you have to do that two, three, four times with the goal being to empower. But it doesn't work just to say here, you're empowered, you go fix it. Because what you get on the other hand is a whole lot of very frustrated employees who feel as though their manager is completely ineffective 'cause they never help them and nothing ever gets done. (22-2)

What the above passage suggests is that while employees need to be actively involved in resolving their own issues, managers also need to provide employees with the help and support they need so they are able to positively resolve the problem, especially if the employee actively sought assistance from his/her superior. Frustration can also be related to the perception of (un)fairness which may be influenced by (mis)trust.

Mistrust

Several factors can lead employees to mistrust their colleagues and/or supervisors. As the following statement suggests, managers do not necessarily have or take the time to meet one on one with their employees just to say “you are doing a really good job”, employees can come to mistrust their managers’ intentions when they are called to a meeting with their superior.

And so we had a code two weeks ago and it was a pretty bad code ..., and we wanted to meet with the staff just to see how they were doing, and saying that you know, you guys did a good job, and the whole week ... leading up to that meeting, they were all writing notes down, and saying “oh my gosh, we thought we were in so much trouble, and we thought we were gonna, you know, you were meeting with us to discipline us”. And it was, even that sort of reaction of saying obviously we don’t have enough time just to sit with them and make them feel comfortable and stuff, they always think the only time they’re gonna see their manager is when they’re in trouble. So that just puts everybody’s guard up too. (21-1)

As such, the above citation highlights the importance for managers taking the time to meet with their staff on a regular basis to develop a trusting relationship. The importance of balancing positive and negative feedback is also revealed so that employees do not always expect the worse when their direct supervisors request a meeting with them.

Another manager spoke about a situation where she was relieved to see one of her staff request a transfer to another unit because the trust between them was gone.

Well certainly a major sense of relief that she was gone and hum, ... the majority of the staff who are working on [that unit] were quite relieved as well. ... Really and truly I think that, at that point certainly the hum, the, you know, whatever if there was any trust or regard was hum, I don’t think, it certainly was beyond repair. I was beyond repair. I think her, hum, you know, I think her opinion of me was you know, hum there was nothing there, and aaa, and frankly, I didn’t particularly like her by the end of it either. (21-3).

The excerpt illustrates the importance held by trust and respect to maintain a healthy relationship. It also describes how relationships can deteriorate “beyond repair” if trust is

lost. On the other hand, trust can be gained when one is perceived to be transparent and genuine. The following participant explains how by admitting to making a mistake, she gained her employees trust and respect.

I told him sorry, OK, you do what you have to do [go to the union because she forgot about seniority when assigning a shift] and it's my mistake, and I know that that person was saying nobody did that to me, ever, like say I did a mistake... So hum, they like it and I think it's a trust too, they trust me. (21-4)

The employee referenced in the above citation felt heard, understood and respected by his manager. By being transparent and open about making a mistake, and spontaneously apologizing to the person, this manager not only gained her employee's trust but she also diffused the situation where the employee decided not to grieve the incident.

Mistrust can thus bring about two distinct behaviours: aggression or inaction. Employees who mistrust their managers or peers may choose to voice their unhappiness by complaining to others instead of addressing the issue directly with the person they mistrust. This may contribute to gossip and an unhealthy work environment. Conversely, managers reported that they knew of instances where staff did not report acts of aggression because they did not trust their managers and/or felt that nothing would be done, that aggression was part of the job and that they had to put up with it. Additionally, managers reported that staff became distrustful of managers and/or the system when they perceived that peers "got away with it [bad behaviour] 'cause nothing really happened [no consequence to staff]" (22-7).

As such, fear, frustration and mistrust can be powerful emotions. Workplace aggression was defined by a participant as a "heightened sense of anger or agitation" (21-1) and by another as "an increased expressed emotion" (22-5). Aggression was the third theme to emerge from the analysis.

Theme Three – Aggression

While aggression can be described as the loss of control of intense and powerful negative emotions; it can also be explained as a defence mechanism or as a form of retaliation. As such, aggression is said to be multifaceted. Many factors were found to contribute to intra/inter professional aggression resulting in various types of aggression as well as different perpetrators and victims.

Some managers reflected about the type of individuals who were capable of displaying anger or aggression at work. In effect, these managers raised the point that if these individuals are capable of being aggressive against other professionals in the public spot, what must they be like in the privacy of their home where they do not need to account for their behaviours. More importantly, some managers wondered how they could ensure that an employee capable of aggression towards his/her colleagues would not be capable of aggression towards patients.

Managers also reported being concerned about a health care professional state of mind, ability to think critically and provide safe patient care following an outburst of aggression in the workplace. For example, managers have wondered whether employees “acting out” needed time to cool off and regain control of their emotions post outburst, and if so how much time was actually needed. Other questions included: can the staff finish his/her shift or does he/she need to leave before the end of the shift? If he/she leaves, who will cover the patient assignment until the end of the shift? Furthermore, managers reported worrying about the state of mind of the victim of an outburst. The following participant expresses the dilemma faced by nursing managers when aware that aggression took place.

I guess there's always that worry as a manager or as the person responsible, are they OK to go back out again, and what impact did that have on the other individual or for themselves. Do they feel enough resolution A) to continue on

themselves, and B) is the other person OK to go back out? 'Cause when we're in a giving profession like we are in patient care, it's not as if you're just going back to your desk and sort of a little bit preoccupied with something. The risks associated with not having a full attention or full critical thinking to our patient care, hum always worries me. (11-4)

The above participant also raises the issue of risk. In effect, the manager who is aware of an altercation between staff also wonders whether the employees (both perpetrator and victim) are able to resume work without putting their patients at risk. By the same token, the manager must also determine whether it is in the best interest of the patients to temporarily remove the employee(s) from direct patient care to prevent a potential mistake (as a result of being preoccupied).

Some participants stated noticing an increased in reported cases of workplace aggression. This was described as positive and attributed to the fact that employees now perceive that workplace aggression is taken seriously and that something will be done if reported. A manager also explained that while not necessarily to report instances of aggression, her staff felt comfortable enough to come and talk to her about issues that bothered them. Following an open discussion, employees often feel better because of feeling heard and validated.

Etiology

Participants were asked if they perceived a general root-cause for intra and/or inter professional aggression. While no single root-cause was identified, participants identified several possible reasons.

Grounds for intra-professional aggression were often related to performance where some nurses were identified as being high achievers and in return had little tolerance for people not as fast or as good as they perceived themselves to be (this issue has been addressed in the section differences in practice). Similarly, not feeling acknowledged or

respected by peers was also identified by a few participants as contributing to dissatisfaction, frustration and in some instances workplace aggression.

Reasons for inter-professional aggression included frustration and “turf wars”. For example a participant described a physician being paged 15 times by different nurses and when he called, nobody knew why he was paged. Some participants also talked about role confusion where different health care professionals could in fact perform the same duties creating some misunderstanding and potential conflicts. Having the support and capacity to be able to work to one’s full scope of practice was raised as an issue by several managers.

Several managers reported that employees were explicitly told that they did not have to accept a bad behaviour coming from a physician, and could either decide to address the issue themselves or refer it up to their manager. Managers also mentioned that they were aware that not addressing physicians’ bad behaviour could potentially lead to patient safety issues. For example a staff afraid of a physician’s bad temper may be reluctant to bring relevant issues forward to that physician for fear of reprisal.

Participants also talked about generic root-causes for workplace aggression. These included the fact that aggression gets perpetuated if not addressed. As such, managers talked about employees escalating their aggressive behaviour when not held accountable. Additionally, a few managers recalled instances where some employees who were not otherwise aggressive developed an aggressive behaviour in order to survive and avoid being ostracized. As such, the issue of first time offender versus known offender was also raised and is discussed further in the Modus Operandi section.

One manager provided the example of employees being reactive versus responsive when dealing with stressful situation. While an aggressive behaviour may be explained by the fact that an individual is under stress, it should not however become an excusable reason

for bad behaviour. On the other hand, the individual on the receiving end of a bad behaviour [the victim] might be the one who is oversensitive and/or overreacting. In such cases, there might be a need for easily offended people to develop better coping skills to deal positively with difficult situations. As such, the above manager mentioned the need to openly discuss with her team about what people find acceptable behaviours and what are not, as these can be subjective.

Respect, or lack of respect, was also acknowledged as contributing to aggression. More specifically, some participants spoke about a lack of respect between professions where some health care professionals might perceive other professions as having a higher status than themselves. The following participant made a distinction between respecting a person for who he/she is as an individual versus respecting the same person for what he/she does (his/her professional status), and described how team members were bullying a nurse because they did not respect her as a person.

I realized the nurses who bullied her didn't have respect for her... Not that they didn't respect her as a nurse, they didn't respect her as a person at all... they had no value for her. So it was hard. (21-4)

This distinction is important as it highlights the fact that in some instances several employees may target a specific individual for a particular reason, where in other times the aggressive behaviour is not directed at a specific individual but rather at people working in a specific profession. While interpersonal relations were identified as playing a role in instances of aggression, ineffective communication was also acknowledged by a number of participants as a precursor to aggression. For example, as the following statement demonstrates rather than address an issue directly with the person involved, some people preferred venting to others.

Not being able to hum, discuss that with them openly ... or approach the other person, and so it just festers and gets worse, and they talk to other people rather than to the person who, that they're having the problem with and starts this whole cycle of bad feeling. (11-3)

By choosing to talk about the issue with others rather than with the person directly involved, the "victim" also contributes to perpetuating a bad behaviour and even potentially escalating it. This results in the victim now having to deal with two issues: the initial aggressive interaction and the inappropriate sharing with peers. Additionally, people who constantly berate their peers come to be known as telltale. They can become alienated from others where no one feels safe or excluded from this type of talk coming from that person.

Some participants perceived that perpetrators of aggression were often themselves the victim of aggression at some point in their lives. While not excusing the aggressive behaviour, knowing that someone was a victim of aggression may serve to explain their aggressive behaviour. For example, people who were victims of aggression may have a greater tolerance to it or not perceive their behaviour as aggressive when it is. This type of rationalization reinforces the notion that, regardless of their circumstances, people should be made aware that their behaviour is considered aggressive, inappropriate and unacceptable.

Another participant raised the issue of "inter-units" aggression and attributed most of the problem to bed management and bed shortages. The following describes a negative spiral of incivility and conflict where everyone is competing to get the job done amidst scarce resources (in this case beds).

You can feel it, when we have a problem with beds, there's conflict between managers, because the manager of emergency is wanting to get the patients out, so she's trying to push the medical nurse manager to get the beds empty, hum the OR nurse manager doesn't want to cancel surgery so she's pushing back to try and keep patients in emergency, so that creates conflict between the managers, which when that starts to happen, then you know they're the role models for the staff, so the staff are gonna be having conflict with each other. (11-3)

The excerpt draws attention to a kind of informal hierarchy between units where the emergency department and the operating room appear to have priority over other units in terms of areas to be decanted. The perception that some units are getting a preferential treatment over others may also contribute to a sense of animosity between units.

Several other factors in both the physical and social environments were identified as contributing to intra/inter professional aggression. These are explored further in the next section.

Environments

As part of the interview, participants were specifically asked to identify factors in their environment that could either contribute to or alleviate workplace aggression. All participants agreed that the work environment played a role in instances of workplace aggression. However, while some perceived that both the physical and social/cultural work environment played a major role, others were more guarded in their affirmations, especially when describing the role played by the physical environment.

Physical Environment

In general, participants agreed that the physical environment could easily contribute to workplace aggression. Patient care today was described as being very different than patient care thirty years ago, and older buildings not designed for today's patients. For example, today's patients are usually more acute, necessitating a lot more equipments such as blood pressure monitors, intravenous pumps and lifts. Older buildings have smaller rooms making it difficult to accommodate such equipment. There are also more isolation cases than in the past. However older buildings do not have ante-rooms, so material needed to enter isolation rooms is often left in the hallway. The following statement describes situations where small

rooms and crowded corridors make it difficult to easily move both equipment and stretchers, resulting in walls being banged or objects being pushed erroneously giving the impression that the employee is upset.

In the old building, the rooms are smaller, they don't have room to get the equipment in easily, they're pushing things around trying to make room and then people take that as they're upset with the other person. (11-7)

While having to work in an older building is a reality that cannot be avoided, staff who are aware that they may be perceived as upset when navigating crowded spaces could easily dispel the perception by remaining calm, explaining what they are doing or commenting on the situation. For example, saying "oops, I did not mean to do that" with a smile can easily dissipate the perception of being mad if something gets banged.

Participants also reported that in some older buildings the communication system from patients' rooms to the nursing station is non-existent. As a result, if a health care professional was to need help, they either have to walk back to the nursing station or walk on the unit to find another staff to help. This contributes to staff feeling isolated and perceiving limited support from others. In some instances, staff may need to call out or speak loudly down a corridor to get help. This may also contribute to perceptions that the staff are shouting at each other or are noisy. Managers also identified that the lighting in some older buildings is poor, the heating sporadic or more than generous in the winter, and the air conditioning spotty during the summer. The following statement makes clear the role of the physical environment on comfort and tolerance to other irritants.

The physical environment is old and dingy and contributes to a level of frustration which I believe probably facilitates a level of aggression on both patients and staff. (22-2)

Furthermore, several participants reported that because of limited physical space available, health care professionals no longer have staff rooms or restrooms on their units.

This removes the ability for staff to take a quick but much needed respite during their work day, especially if only having a few minutes to decompress before having to return to their busy schedules. Similarly, having to walk a long distance to access food, beverages or even a washroom may mean that staff will forgo such necessities thus making them physically uncomfortable and lending them to be less patient. The lack of private rooms also makes it difficult for staff to get away from one another, to relax without having to behave professionally and to have a private talk with someone. The unavailability of staff rooms also results in staff socializing at the nursing station or in common areas thus increasing noise level in those areas. Additionally, employees having to work in these common areas (e.g. clerk) are then interrupted by the chatting and the noise thus breaking their concentration and increasing their frustration. Moreover, employees who happen to be in the common area where a private conversation is held may only hear segments of the conversation, leaving them to draw their own conclusion about what they heard. As such, bystanders may assume that they heard something when in fact the discussion was about something else.

Managers having to manage several units reported finding it challenging not to be physically located on some units. There was a belief that when staff did not see their manager, they then perceived the manager to be unavailable and not taking care of issues. This issue is discussed further in the section entitled manager's visibility.

Some participants identified isolated areas as having the potential to facilitate aggression. Isolated areas included working in physically segregated areas in the building or when working late and being the only one left in an unlocked and deserted area.

Social/Cultural Environment

Participants identified several social/cultural factors contributing to workplace aggression. These were aggregated under six topics: change and new initiatives, workload, work design, manager's visibility, cuts/budgets, and unit/individual culture.

Change and New Initiatives

While staff turnover was identified as a facilitator in changing organizational/unit culture, staff turnover was also reported to result in health care professionals not knowing their peers thus reducing team cohesion and collaboration. One participant cautioned about management using low turnover rates to conclude that people are happy at work. In effect, she explained that because her organization is the only specialized mental health facility in the region, people wanting to specialize in some area of psychiatry have only the one employer to go to.

Turnover in management was also identified as facilitating culture change. Participants reported that new managers and directors were very much on board with the premise that workplace aggression is unacceptable and needs to be managed.

Participants expressed that many older health care professionals working in the same organization and on the same unit for decades were not necessarily receptive to change or new ideas, and tended to consider themselves as experts thus not needing to take part in continuing education initiatives. Such attitudes often resulted in tensions with newer staff who expressed fresh ideas or suggested different ways of doing the work. This issue has been addressed in the section entitled differences in practice. Participants also described that the introduction of new initiatives is often not coordinated resulting in units undergoing multiple changes simultaneously. As such, too much change at once can result in stress and conflict

regarding competing priorities and may leave staff with the impression that “the left hand is not talking to the right hand”.

A number of participants at the psychiatric hospital attributed the change in organizational culture surrounding workplace aggression to the 2007 Coroner’s Jury Recommendations following the Dupont Inquest (where Dr. Marc Daniel killed his former girlfriend nurse Lori Dupont at their mutual place of work, the Hotel-Dieu Grace Hospital in Windsor Ontario). As a result, changes were perceived to have been mandated and not necessarily out of the employer’s good will.

Workload

Managers agreed that heavy workload made it difficult for staff to discuss issues with one another. Heavy workloads also resulted in a number of health care professionals not stopping for breaks or meals thus limiting the opportunity to socialize, discuss and address issues. Some participants perceived that because staff have limited opportunities to socialize and get to know each other, they were more prone to snap or attribute negative intentions to someone they did not really know.

Work Design

Some participants perceived that always working with the same people could in fact contribute to workplace aggression. In effect, people working on smaller units or units that are only open Monday to Friday [thus working with the same colleagues all the time] have nowhere to hide if there is a problem with a person on the unit; whereas staff working on larger units or working shift work may be able to avoid working with certain individuals for a while, giving them a much needed break from difficult individuals. The following passage expresses the challenges associated with working with the same individuals in a setting where you cannot always avoid interacting together.

You see them everyday and if you had an issue today and you don't deal with them, you work with them again tomorrow, it's gonna just escalate a little bit right. (11-6)

The statement emphasizes the need for individuals to promptly address issues, especially when having to work with the same people on a daily basis. Conversely, others perceived the constant change in rotations due to shift work as potentially contributing to aggression. For example, as a result of shift work very productive and high functioning groups may not always be able to work together on an ongoing basis because of change in rotation thus creating some frustration.

Managers also talked about team work [or lack of team work] as contributing to intra/inter professional aggression. Even if team work is actively encouraged, many perceived that team work was in fact declining and that more people worked in silos. As such, participants perceived that many health care professionals only felt responsible for their patients, are not working together and are not aware of each other's needs. Some managers went further suggesting a loss of accountability to patients as a result of multi-disciplinary teams. In effect, some health care professionals were described as being concerned by the treatment of illness only and not seeing the patient holistically, thus potentially leading to frustration and aggression within health care teams. Conversely, others described multi-disciplinary teams as being stronger teams than those comprised of nurses only, and multi-disciplinary rounds as beneficial to patients as a result of the different perspectives raised.

Manager's Visibility

The importance of having the manager visible on the unit was briefly introduced earlier. According to several participants, the visibility of managers will have a direct impact on how they are perceived by their staff and what will be reported to them. The following statement acknowledges the value of physical presence on the unit so staff can easily report

issues to her, and more importantly so she can see for herself what is really happening.

If you have to call your manager, if you have to physically pick up the phone, make the decision to pick up the phone and call the manager to say something is not right or somebody is not being respectful, or whatever the problem is. If they have to do that, depending on the person, they are unlikely to do it as often as they need to. But if you're visible, available, and all that, ... you'll be talking and they'll say "Oh by the way, have you got a minute?" And then you'll hear what you need to hear. ... The presence on the unit of the manager, hum and to have the span of control such that they can be visible and available and, you know, to their staff, and to observe what's going on. Maybe the person doesn't even realize they're being aggressed upon, if they say "wait a minute does so and so always talk to you like that? Oh, OK, what do you think of that?" But if you're not there to see it, you know, like if you nip it in the bud, it makes a big big difference. (21-5)

Additionally, being present on the unit and witnessing issues allows the manager to speak to the interaction in a first person point of view instead of addressing hearsay, providing added credibility and arguments when speaking to an issue. Visibility is thus important for the manager who needs to communicate and provide feedback to his/her staff as well as close loops when dealing with issues.

Similarly, large spans of control were identified by participants as impeding the manager's visibility and potentially resulting in chaos and aggression. Some managers in this study had more than 100 people reporting to them. As expressed in the following excerpt, a manager who is not able to provide guidance and support to his/her staff will soon lose his/her authority and the ability to influence.

The nurse manager that was there before has too big of a span, there's no way she would provide her attention to the, to the staff, so there was a lot of almost like free for all. Whoever was the strongest would control the floor. (11-8)

The above participant also raised the issue of formal versus informal leadership where some employees are able to "control the floor" even when in a position of informal power. Managers also felt it was difficult for them to be visible and to communicate important information to some staff, especially employees working week-ends only. As a result some

managers perceived that not every employee was getting the same messages or was aware of important information, potentially leading to frustration and conflict. Conversely, some participants felt that it was the employee's responsibility to ensure that they remained aware and knowledgeable about new information. As such, both managers and employees were identified as having responsibilities with regards to knowledge dissemination. Managers are responsible for implementing solid means of communication with staff as well as clearly communicating their expectations, and employees need to make concerted efforts to keep current and be accountable for accessing the information.

Cuts and Budgets

Several participants voiced their frustrations at trying to create and maintain healthy work environments amidst budget constraints and budget cuts. Managers often felt a dichotomy between their talk and their actions; that their efforts to create a healthy work environment were in fact undermined and spoiled by budget cuts and layoffs. This uneasiness is openly expressed in the following statement by a manager who felt torn by this type of situation.

Well it's a, I find it very challenging to promote healthy work environment, to promote all this positive you know, best practices, to promote cordiality between the staff, hum when on the other hand, we're threatening their livelihood... So it's pretty hard on one hand to say I'm here for you, if there is anything I can do to make this place a better place for you, and in the next breath, you're gonna go home, I've got no money to pay you. (11-8)

Conversely, a manager cautioned about using budget cuts as an excuse to stop working towards creating a supportive and healthy work environment, and stated that it was in fact during these difficult times that managers needed to be the most visible and available to their staff. The same manager reinforced the need for managers to model behaviours they counted on while verbalizing their expectations, especially in times of instability and insecurity.

Additionally she stressed the need for managers to remain honest with staff about what was and was not in both hers and their control, while ensuring that available resources like the employee assistance program (EAP) were known to those struggling.

Participants also described the challenge of trying to explain staff layoffs to employees when brand new buildings and infrastructures were being built. Managers reported staff not understanding budgets and financing. For example, a manager reported staff not comprehending that money came from different pockets and that “even if pocket A is short of money, you can’t necessarily take the money from pocket C” (11-8). The above example highlights the importance for managers to help their staff understand the budget process and share as much as possible with them information coming from senior management.

Unit/Individual Culture

Unit culture is said to be stronger in influencing behaviours than organizational culture. Participants who managed more than one unit noticed that even if several units have the same manager, the culture can still be very different on individual units. Managers also reported that some units appeared more difficult to manage than others. The following excerpt suggests that some units may require a specific “type of personality” to deal with the demands associated with the work of that unit.

So the clientele, more often than average is aggressive towards staff. And so again my personal opinion is staff that are quickly and easily intimidated don’t work in this environment for very long. They move on to somewhere else. And so you end up with a concentration of people who are more comfortable in an aggressive, in a more aggressive setting. And so from my experience, the language tends to be a bit rougher, the social graces are perhaps a little lower. And so, you’re just a little closer to that edge, if I can term it that way. (22-2)

While the above passage raises a valuable point, the observation also suggests that managers may need to be even more visible on such units to ensure that employees benefit from the manager’s influence and his/her ability to respond to specific issues. Conversely,

some managers may be intimidated or feel they have little influence over the staff working on such units. As a result, these managers may avoid or limit the time spent on these units leaving staff to self-manage. A manager observed that some of her staff behaved differently when they knew she was on the unit. This manager saw her presence as a constructive force in dealing with the tougher personalities. Furthermore, a few managers perceived that some units would not function well unless there was a cohesive team at hand while other units could still function reasonably well with individual practices rather than a team approach.

Some participants reported experiencing a particular challenge when having an issue with a staff member who worked on their unit but whom they did not manage (e.g. staff from a floating team or part time staff taking an extra shift on a different unit). The following excerpt describes how one manager attempted to discuss an issue with a casual staff's own manager only to be told to deal with it herself.

We've had a lot of issues with casual staff on the unit and they might get into a fight with somebody or they might disagree with a plan of care or get upset about it and aaa you know, when I go to their, what I think is their manager [because] I don't really know who manages them, they say "well they were on your floor that day so you manage, you have to deal with that situation". But I don't know anything about the individual. I don't know their background. I don't know anything about that person... But they're saying because they're on my floor that shift, I have to fulfill my responsibility. (21-1)

These remarks highlight the importance of managers working together and sharing information about part-time/casual staff. In effect, determining whether the incident is an isolated one or a pattern of repeated bad behaviour is important and may play a role in the management of that behaviour. The excerpt also highlights the lack of support and collegiality between some managers or at least towards this specific manager. The same manager further described how addressing an issue with part time/casual staff she did not manage was next to impossible "cause I might not see them again now for another six

months”. (21-1)

Some managers reported issues with staff performance appraisals not being done on a regular basis. These managers stated that it was difficult for them to document and even address bad behaviours displayed by staff who were working for the same employer for 20 years and yet had never had a letter of direction put to their file or a bad (or in some cases even a single) performance appraisal done. As such, these managers worried that if they were to start accounting for unacceptable behaviours after 20 years of having no issues documented, their actions could appear biased against that staff. Additionally, employees who were allowed to display bad behaviours for most of their career may find it difficult to suddenly change their conduct, especially if their behaviours were normalized over the years.

Boundaries

Workplace aggression was defined broadly by participants. All agreed that workplace aggression was more than just physical aggression, it also included psychological aggression. Physical aggression was defined as a very overt form of aggression with a clear intent to harm or to instil fear. Examples of physical aggression included pushing and shoving. However, physical aggression is rarely seen in the context of intra/inter professional aggression.

Psychological aggression was defined as both overt and covert aggression. In some instances, aggression was passive aggression and intent was difficult to determine. Examples of psychological aggression included rolling the eyes, silent treatment, gossiping, bad mouthing, blaming, tone and inflexion of voice, always dismissing another’s ideas, manipulation (such as planting a seed to cause chaos), people being upset about something/someone but “taking out” their frustration on someone else, leaving the room when a specific colleague walked in, having a party but not inviting one specific person,

bullying and intimidation. Several participants stated that psychological aggression, especially talking behind people's back, is the most damaging type because it is covert, and "hearsay" is difficult to address. A few participants described the perpetrator as wanting/needing an audience to display aggression, some even trying to gather a cohort when targeting a specific individual.

While workplace aggression was usually defined as happening within the physical boundaries of the workplace, three participants extended their definitions to include acts outside the workplace but related to activities in the workplace or that linked back to the workplace. Examples included: an instance of cyberbullying where the bullies and the bullied all worked for the same employer; and an instance where colleagues from different workplaces worked together collaboratively on a project but kept excluding one team member because her ideas did not fit with that of the rest of the group.

Players

Participants identified perpetrators of intra-professional aggression as nursing students, nurses, and ward clerks; and perpetrators of inter-professional aggression as physicians, orderlies, and ward assistants. Managers openly reported instances where they themselves were victims of workplace aggression. Perpetrators of workplace aggression towards management included upper management (superior), other directors/managers (peers) and staff (subordinate). Sadly, one manager stated that her biggest complaint about being a manager was the way she was being treated. The following passage provides an example of subordinate aggression and explains how staff aggression towards a manager may not start as such but as the discussion gets heated, the employee may retaliate by turning the tables on his/her manager.

I've seen the person really got under the nurse manager's skin, because it got to be a personal attack on top of everything else, And it just, it can go either way, they're [the nurse manager] either gonna get really mad or they're going to end up becoming a little bit more passive as well, because it hit to the core (11-4).

The excerpt also draws attention to the coping skills and state of mind of the manager at the time of the "attack". In effect, managers who already have low self esteem or are insecure in their ability to positively manage a team may see such retaliation as a confirmation of their ineptitude thus striking them "to the core". On the other hand, managers who feel competent, confident and have good coping skills might see the attack as a personal challenge to their authority and "get really mad".

Perpetrators were also identified as people witnessing aggression and not doing anything to stop it thus being guilty by association. The following statement by a manager describes how a staff nurse working on her unit did not realize that by not doing anything to stop the unacceptable behaviour; she was in fact contributing to the bad situation.

And this one nurse came to me and said "I don't gossip". I said yes, but you sit there and listen to it and don't stop it. So you are part of the aggression, you are part of the gossip that nurse A is doing towards nurse B in their absence. I said you are part of it because you are listening to it and not saying something (21-5)

People may not realize that by not condemning a behaviour they are in fact condoning it. This excerpt thus calls to attention the need to raise awareness and educate peers about the active role they can play in aggression management. Conversely, peers may want to do the right thing but not know how to address an issue. Managers can thus provide tools to help staff respond to these types of situations. Actively engaging peers in halting instances of intra/inter professional aggression has the potential to create an environment that is proactively managing a long existing practice, that of the silent bystander. The next section addresses in more detail the management of intra/inter professional aggression.

Theme Four – Management

Participants reported that conflict might be tolerated more than it should because some disagreements may not be perceived as acts of aggression by people. One participant stated that her biggest surprise when she became a manager was to realize just how much conflict there was in the workplace. As such, the management of aggression was compared to the tending of a garden, where without regular intervention, issues just multiply.

Managing is like tending a garden, if you weed it once a week, you'll have a nice garden. If you turn your back on it for a month and come back, it will be infested. (12-0)

Another manager explained that as she empowered her staff and provided them with the right tools to promptly address issues while remaining visible and setting clear expectations, she was able to observe that the dynamic of her team slowly and positively began to change. As such, the remarks of this manager can be added to the above garden analogy to complement the message – “as the gardener tends to his/her garden with the proper tools, he/she adds mulch to assist the garden in self managing weeds thus requiring less and less of the gardener’s time”.

Participants also talked about the emotional time commitment and emotional strain of having to deal with workplace aggression. They stressed the importance of being able to debrief, especially when not feeling good about a situation. The following passage demonstrated an inability to move forward when left with a bad feeling.

You're so busy, you're just done, onto the next thing. But meanwhile, you just can't get to the next thing because it's still bugging you about this one. So you almost need an opportunity to debrief. (11-2)

Implicit in the above excerpt is the need for support and feedback. Being able to reflect and discuss with someone what went well, what went poorly and ways to do things differently may help develop a manager's ability to positively address similar issues while

feeling competent and confident in doing so.

Modus Operandi

An objective of the current study is to explore strategies deployed by managers to deal with intra/inter professional aggression. As such, participants were asked to describe how they responded to instances of aggression. Participants agreed that if at all possible, the first step in dealing with aggression should be for the victim to speak with the perpetrator to inform him/her that his/her actions are not acceptable and are in fact hurting him/her (the importance of this step was explored in detail in the section on awareness). As such, when an employee reports experiencing aggression from a colleague, depending on the type of aggression and the context, he/she should be encouraged to first discuss the issue with the said perpetrator. If the victim does not feel confident in approaching the said perpetrator, managers can act as mentors to support and guide the victim on how to discuss the issue with the colleague.

Participants reported instances where issues were not resolved following the victim's intervention. In these cases, managers met individually with the victim and the perpetrator to get both sides of the story. Managers reported that in some instances, stories varied greatly when hearing both sides. Following fact findings, managers then determined whether the issue could be resolved informally by the parties or whether it needed to go through a formal process requiring the involvement of additional actors (i.e. HR, unions, etc.). As highlighted in the following passage, participants agreed that the rule of thumb should be to try and keep the process of dealing with intra/inter professional aggression as informal as possible.

Because the more that they can resolve things in earlier stages, before things progress and get out of hand, all the better. You know the worse conflicts are the ones that sit and fester over time because things build up and it becomes more difficult to hold back. The more formalized a process gets, people's backs tend to get up more. So they become increasingly worried about what the

implications are, and the process and then the outcomes. (12-1)

When important discrepancies between stories are noted or when complaints need to be formally dealt with, the process usually includes a thorough and more formal investigation where not just the people directly involved with the issue are interviewed but witnesses as well. Participants commented on the time and resources required to conduct such an in-depth investigation, thus further delaying the resolution of the issue.

While participants agreed that the best way to deal with intra/inter professional aggression was to have both victim and perpetrator resolve the issue on their own and informally, they were aware that in some instances both victim and perpetrator needed to meet together with a third party acting as facilitator/mediator. The purpose of a third party mediated meeting is for both parties to have the opportunity to speak up (voice their perspective) and hear the other person's point of view (where the other is coming from). Some participants suggested setting ground rules at the beginning of the meeting. Additionally, facilitators may need to ask very direct open-ended questions during the meeting to assist a person in expressing his/her thoughts. Some participants also reported asking a peer (either their boss, another manager or HR) to be in the room with them when dealing with situations they were not sure how to address or were afraid of retaliation/aggression from the employee. On the other hand, a few managers cautioned about having to balance their need for support with the potential that the presence of a third party may in fact take away some of their credibility as manager or make the employee feel uncomfortable because he/she is out numbered.

Some managers also provided employees with a copy of the organization's aggression policy or code of conduct as a way to remind them of their obligations. The following passage suggests going a step further to highlight pertinent sections of the policy with

stickers saying “read this”.

If you highlight it, it just means that you’re serious, that you take it seriously, that you’re just not fluffing it off or you’re not just getting a slap on hand. That, you know, we’re gonna have this conversation again. I’m gonna give it to you again and then there is gonna be consequences. So I think that the actual act of giving it to them is gonna show that you’ve actually done your research. (11-2)

Several participants expressed the need to have a letter added to the employee’s file following such a meeting. The letter is to describe the issue(s), document the discussion and subsequent action plan including expectations and expected outcomes. A number of participants also stressed the importance of follow-ups. These can be done informally, by talking to staff to inquire whether the situation has improved or formally by scheduling a follow-up meeting. The follow-ups were also to remind people of expectations if they were not already met.

Participants described situations where one party refused to meet with the other. In these cases, managers respected the person’s wishes and dealt with the parties individually. Managers also reported that known or repeated offenders were usually dealt with differently than people acting out for the first time. However, if serious enough, a one off behaviour may be dealt with sternly to send a clear message. Setting expectations, intervening promptly when expectations are not met and being consistent were all steps identified as necessary to positively manage aggression.

Timing

Participants also stressed the importance of addressing issues without delay. Not only can issues escalate between people if they are not dealt with in a timely manner, but it can also be challenging to get all parties involved together again once a shift has ended because of people’s schedules (shift work and rotating schedules). The following excerpt describes

how “unaddressed” issues have the potential to spiral out of control with potential consequences on patient care.

If you have aggression in your work environment, that’s not a healthy work environment. So, if you don’t, if you don’t address it, it just snowballs, and then all of a sudden, you’ve got a major problem, Hum, your work environment is not healthy and it will affect patient care. (11-2)

Timing also referred to the optimal time for a manager to address a delicate issue with staff. Since health care professionals have emotionally demanding jobs and must ensure patient safety, they need to be able to concentrate on their work and provide good patient care. The following passage describes the dilemma associated with timing a potentially emotionally charged meeting.

And timing of the meeting too. Are you gonna do it during their shift, and then get them upset? Are you gonna do it at the beginning of their shift, and then they can’t do their shift? Do you do it at then end of their shift? So ideally, I mean in a perfect world, you have them come in, you know, replace them, let’s say an hour before the end of their shift, but that’s not always ideal either. So timing is really tricky. (11-2)

As such, the timing of a meeting should ensure that health care providers are able to safely perform their duties post meeting and that other help and/or support (such as occupational health or EAP) is available if needed. Managers also ought to consider the need for a replacement to cover the health care professional if they are to discuss an issue during their shift. As such, meeting with a staff during their shift may involve a financial cost.

Actors

The analysis revealed that the management of intra/inter professional aggression can in fact involve several actors. These include: individuals, peers, managers, human resources department and unions.

Individuals

Each person, whether victim or perpetrator, has the ability to decrease and/or prevent instances of workplace aggression. Participants described how individuals should use self-reflection to examine their behaviours and practices. Participants also stated that individuals should remain aware of their non-verbal cues, how they use body language and how they are perceived by others. Some participants felt that individuals should avoid taking issue personally in an attempt to separate the person from the problem (these two last suggestions were addressed earlier in the section on perception). Additionally, managers expressed the need for staff training on how to deal with conflict and/or aggression.

Peers

Peers were also identified as having an active role to play in impeding aggression. In effect, peers have the ability to intervene when witnessing aggression, whether it be active aggression like someone being threatened, or passive aggression like gossiping. Managers have also accused peers of being guilty by association if they chose to listen to gossiping without interrupting it. Some managers reported telling their staff that gossiping would not be tolerated and setting the expectation that staff put a stop to it. One participant expected her staff to say “I’m not listening to this or I don’t like what you’re doing or you know, if you want to talk take it elsewhere but not in front of me” (21-5).

On the other hand, one manager agreed that while peers can be pivotal in silencing gossip, they also needed tools and help them positively manage such situations. In effect, it is not always easy for peers to assert themselves with colleagues. As such, employees must know that the organization, their manager and their colleagues expect them to play an active role in impeding intra/inter professional aggression. Additionally, employees need to be

engaged and committed to addressing the intra/inter professional aggression and be provided with coaching and training on how to communicate respectfully to deal with the problem. One manager referred to the process of coaching/training staff as providing them with a tool box of strategies and scripts for positive aggression management.

Managers

All participants agreed that they had a responsibility to respond to and address workplace aggression. As such, participants described their roles as being that of a mediator, a coach, a facilitator, a mentor, a teacher, a peacekeeper, a role model, an investigator and a disciplinarian. Ultimately, participants knew that they were the people with the authority to discipline and the power to implement change. However, participants expressed that the extent of their involvement needed to vary greatly depending on the situation. In effect, managers stated not being able, and not wanting to be involved in every disagreement. The following passage illustrates how self-reflection would determine involvement in a particular situation.

Like sometimes two people will be over there fighting, I'll be like do I want to do anything about this? ... You know what I mean? I've, it's not so blatant but you know what I mean? Do I want to get involved, do they need me to sit down and, is that the most fun part of my job? No, it isn't. (21-2)

This self reflection and subsequent decision not to get involved can also be described as a management strategy where employees who were empowered by their managers with tools to manage conflict are then able to “put their tools to work”. Conversely, if managers always step in, employees will not grow or learn to deal with these difficult situations on their own.

Participants reported that they were sometimes taken aback by employees' out-of-line behaviours. The following excerpt explains how one manager felt unprepared to quickly respond to a subtle out-of-line behaviour.

And so one time we had a little huddle and there was like a verbal comment made. And at that time, I was like you know how you're just stunned? Then you just, well you absorb it, then you walk away and you think "hum, I could have handled this better", like just nip it and address it professionally but in front of everybody. (11-8)

Following the incident, the manager reported the need to take time to reflect on the situation and identify the reasons for her ill-feeling. This self-reflection allowed her to be better prepared to respond to the next out-of-line behaviour as evidenced in the excerpt below.

So another time it happened, then I was able to, just because I had made the awareness and the thought process, I was able when I recognize the second time, I was like "OK, here it comes". So I just said to the staff "this is not an appropriate area to discuss this, we should discuss it privately". And so, but it's this awareness, when you asked about the rolling of the eye, if you don't really, it only comes after, and sometimes there's some behaviour that becomes normal for that person, that you don't always, like you only realize it after because, hum, how could I put it? It's kind of like that's who she is. (11-8)

The last part of the passage highlights another phenomenon - the normalization of a bad behaviour. In effect, a bad behaviour that is not being addressed may in fact become the norm for that individual. Instead of dealing with the ongoing bad behaviour, people come to excuse the person's conduct by saying things like "don't take it personally, that's who he/she is". In such instances, people made the choice (consciously or not) that excusing the behaviour was easier than addressing it.

Self reflection was also identified by another participant as a tool to help her identify specific areas where she might need help. She described the need to take a little bit of time at the end of each day to review and reflect on her practice.

Taking 5 – 10 minutes out of your day to self reflect on those key items you had to deal with during your day that you had to put a lot of thoughts into and took a lot of your energy for whatever reason. ... And I think from that you would probably get a list of things that "Oh OK, I should do that next time"... And over a period of time, if you self reflect over time, you'd kind of go "ya, that day I was, this is what I had a problem with, and I got the same problem on this

day, so I must have a problem with that, I probably need help with that. (11-2)

The above passage reflects the need for regular self-reflection as it is only over time that some issues might become noticeable. Self-reflection was also described as a kind of self-debriefing where issues that are left outstanding but are still nagging can come to light and be dealt with.

Participants also reported that in some situations, their confidence in their abilities as managers was affected by some conflicts. The following excerpt demonstrates how one manager became to question whether she was contributing to conflicts on her unit.

But when you have difficult people you're dealing with, it gets to you sometimes, and you do, your confidence does get a little shaky sometimes, you doubt yourself, especially when you're getting it from everybody criticism, you know, it washes down... and it does make you question if you're doing the right thing. So you get doubt about your abilities and you're trying to figure out, you know, why there's conflict. Is it related to you not being a good leader, like you start to question yourself, you know. (11-6)

The excerpt exposes the vulnerability felt by this manager. She doubts herself and her abilities, she feels responsible for the conflicts on her unit. The citation substantiates the need for managers to have access to support, someone with whom they can confide and openly express their struggles and fears without being judged.

Experience was also identified as playing a role in the management of aggression. In effect, most participants reported that initially, they did not feel prepared for their roles in having to respond to workplace aggression. Seasoned managers reported receiving no formal training or preparation in becoming a manager, and coming in equipped with personal life experience as well as front-line nursing experience only. Many reported being mentored on the job and learning tips by sitting with other managers and scribing for them while they were dealing with issues. Conversely, a few participants reported feeling prepared in dealing with workplace aggression because they had slowly progressed through the ranks from front-

line staff, to team leader, to coordinator, to assistant head nurse, to head nurse, gathering experience and expertise while working in each position. Managers reported that the more experience they had dealing with workplace aggression, the more they felt competent and able to successfully respond to complex issues involving health human resources.

Human Resources Department

The human resources department in each organization was identified by participants as being extremely helpful in dealing with workplace aggression. Participants reported that being able to just pick up the phone and call with a question or to request help was appreciated and reassuring.

The psychiatric organization reported that this positive relationship with the human resources department was new (past couple of years) and was attributed to a change in staff and mandate. Before that time, the human resources department in that organization was described as a “black hole” where there was a real reluctance to address any contentious issues.

Unions

Unions were identified as playing an important role in conflict resolution and aggression management. While unions have a duty to represent their members, they can also help support positive conflict resolution. Dealing with intra-professional aggression adds another challenge for unions who have to represent two of their own constituents. Participants reported that in some instances of intra-professional aggression, unions were accused by their constituents of siding with one individual at the detriment of another, thus fuelling the perception of being treated unfairly by both the employer and the union.

Several managers described examples where unions were not supportive in dealing with intra/inter professional aggression. Often unions were seen as attempting to undermine the manager's decision to discipline and as trying to dilute the reprimand. For example, participants reported instances where unions ask for a verbal reprimand instead of a written letter of discipline, or that the wording on a letter of direction be changed.

Numerous participants working in the acute care organization reported good working relationship with unions. However, these positive relationships were forged over time and required a lot of work on the part of managers. An example of a good working relationship between management and union included a unionized staff going directly to her manager to discuss an issue instead of going to her union, and the managers contacting the union to inform them of the situation.

Participants working at the psychiatric hospital reported difficulties in working with some unions. Instead of being part of the solution, unions were often identified as being part of the problem. Unions were described as wanting to represent their members' interest at all cost, even when the member was clearly in the wrong and the behaviour required a consequence. Unions were also known to encourage their member to grieve managers' decisions or actions, even if these were warranted. These behaviours from some union representatives can be described as "old school" were there might have been the need for a "teamster like" approach to labour demands at one time in history but not anymore. The following participant questioned the need for the union to interfere and protect a unionized employee when it is clear that the said employee did something wrong. She expresses the need for unions and management to work together instead while having in mind the best interest of the patient.

As a union member, I don't want to work with somebody who I know that somebody was totally, but I am talking right now over the top. I don't want that person to be protected by the union. Why? So here I see management and union should work together to protect the public, to protect the patients, to protect themselves and their position and, I don't know, the pride to be a nurse. (21-4)

Similarly, collective agreements were also identified as contributing to aggression. In effect, some managers stated having to hire staff, even knowing that the values of that staff did not fit with the values of the unit, because that person had the most seniority. The following passage explains how unions are in fact preventing managers from hiring the best candidate for the job.

Well one challenge in working in a unionized environment is that a lot if it has to do with seniority. In the private sector, you get to interview and choose your best candidate so you're not obligated by seniority or collective agreements. (22-7)

Furthermore, seniority was described by another participant as contributing to envy, jealousy and bringing about resentment, frustration and even aggression as indicated by the following passage.

So imagine a situation where I'm more senior than you. I mean, does that really, should that truly exist in humanity? I've been here longer so I get dibs on everything I want. That's a really artificially created, it's not necessarily the best way of, you know... I mean I don't think it's a natural way of doing things, assigning work, you know, so you might, you're a new nurse you get the shitiest job... There's a ward here where the senior nurses are sort of, they come in and they write out who, which patients go with who. And they chose the easiest person, people for themselves ... That's just brutal ... it's beyond passive aggression, but it is. It's so subtle and it's reinforced. It's sort of like going to prep school... and there's an initiation "you have to take it for 6 years because I took it for 6 years"... So within ... the nursing profession... I think that the job conditions are a precursor for the animosity that can occur between people (21-2)

The above excerpt also brings to light the conviction of some nurses who believe that because they had to go through a difficult integration, others should too: "you take it for 6 years because I took it for 6 years". As such, instead of attempting to prevent others from

having to endure what they did, some view this period of torment as a necessary “rite of passage”; and it is only when one has “suffered” enough that he/she gets to be a respected member of the nursing team.

Support

Participants perceived upper management at both organizations to be serious about wanting to create a work environment free from aggression, and as such felt supported by upper management when attempting to deal with instances of intra/inter professional aggression. Participants felt that having a consistent message delivered from upper management, directors and front-line managers would eventually trickle down to staff and change the culture. Participants reported that regardless of staff shortages, upper management and human resources still supported letting go of individuals who were deemed aggressive, not willing or unable to change and contributing to an unhealthy work environment.

Sources of Support

Participants reported having access to several sources of support to assist them in dealing with instances of workplace aggression. Sources of support were found both within the organization and outside the organization. Within the organization sources of support included their own boss, their peers, the nurse educators, the human resources department including labour relations, the legal department, occupational health services and spiritual services.

External sources of support included peers working in a different organization, practice consultants with the College of Nurses of Ontario (CNO) to discuss standards for professional practice and the Employee Assistance Program (EAP). Some managers also

reported being part of an on-line distance education program where they had access to discussion groups and other professionals working all over the world, providing a form of support by way of innovative ideas on how to deal with difficult situations.

Support also came from the literature (books, articles, Internet). For example, several participants reported being aware of the RNAO Healthy Work Environment practice guidelines as well as information available on the Ontario Hospital Association website. In some instances, participants also reported asking the hospital's librarian to conduct literature searches for them.

Responsibility/Accountability

Participants reported that senior management at both organizations were working hard to develop a culture of accountability where employees were expected to behave according to the organization's mission and values, and would be held accountable if they choose not to. The issue of accountability came out strongly during the interviews. The following passage illustrates the importance of holding people accountable for their actions and the consequence if they are not.

Making sure that we hold people accountable. 'Cause if these people have been doing this for ten years, but there is nothing in their file and no one's held them accountable to it, it's like giving the a permission slip to continue. (11-4)

On the other hand, some participants questioned whose responsibility it was to teach employees' social skills, good behaviours and professionalism. For example, one participant felt that if she hired and paid for the services of a regulated health care professional, then she expected that person to conduct him/herself according to the professional standards of his/her regulatory body as suggested by the following.

Unfortunately, when you put too many policies in place, we assume too much responsibility for that, you know. If I'm gonna teach you to be professional and talk to me professionally, I've assumed responsibility of that. If I've hired you

as an RN to make \$80 to \$100 000 dollars a year, at what point is that your responsibility as opposed to mine. ... Where is it that we start putting some of that professional responsibility back on the individual that we hire? (22-7)

As such, the above excerpt describes having the expectation that hired health care professionals behave professionally and be held accountable for their actions. This participant's line of reasoning also brings another important question: when should employers deal internally with instances of workplace aggression and when should these be reported to the regulatory body of the health care professional?

Several participants reported that for the most part they did not perceive employees as wanting to play an active role in conflict resolution, and that employees did not expect to have to come up with a solution when bringing forward an issue. Rather, the majority of employees were quite content to leave their problems with their managers expecting them to resolve them for them. The following excerpt recounts several examples of employees coming to a manager's office to "informally" report issues.

We get a lot of "I'm not complaining about somebody but I just want to tell you about them", you know, "just want you to know that so and so did this". Or you know, "I don't like the way they talk to me then but it's not a complaint". Hum, but here, you have it, you take that information and do with it what you want 'cause now it's in your lap. And that happens on a daily basis, so it goes back to the ownership and the personal responsibility and that people just don't, I don't know, a lot of staff just don't get that they have any responsibility for the cohesive working of that team, that it's somebody else's job to ensure that they're happy working with their colleagues and they don't have to do anything to better it. (21-3)

The citation also brings to light the belief held by many that it is the responsibility of others to ensure that things go well. As such, these people do not perceive that they have an active role to play in dealing with issues. Conversely, these same people are often inclined to perceive that their complaint is not taken seriously by their manager if management does not appear to respond and resolve the issue. As such, several managers felt they were in a no win

situation.

Theme Five – Power

Managers reported instances where power issues and power struggles appeared to be the basis for aggression. Managers witnessed instances where victims asserted themselves while remaining professional at the time of an incident. These people not only diffused a potentially explosive situation, but by directly confronting their colleague they levelled the playing field and ended up having a better rapport with the person following the incident (perpetrator was more respectful following a polite challenge). Conversely, managers have also witnessed instances where victims had not called colleagues on their behaviour and as such have given them a “permission slip” to continue.

Power was also discussed in the context of leadership. As reported earlier, participants at the psychiatric hospital witnessed how informal leaders were able to take on unofficial leadership roles when front line managers were removed as a cost cutting measure. Unfortunately, these informal leaders were not always positive, helpful and effective leaders. In effect, some people came to power not because of their qualifications, but because the environment became ruled by the strongest.

Hierarchy

Hierarchy was identified by several participants as contributing to inter professional workplace aggression. While many organizations are still considered very hierarchical, hierarchy was even more pervasive in the past. For example, the following passage alludes to how history contributed to hierarchy which in turns contributes to aggression.

So everyone had their place more so in history, or historically had their place, and so whenever that, any were trying to break that mould, in my opinion, often resulted in aggression. (22-2)

The perception of hierarchy can also contribute to people/profession feeling devalued and subjugated. In effect, some health professionals perceive themselves and their profession powerless and at the bottom of the totem pole, leaving them feeling that they have nothing to contribute to the team because their views will not be heard or taken seriously. This was referred to by one participant as “academic arrogance” where people with higher education or a higher “status” because of their education did not perceive that lower “status” colleagues could contribute to the team. These “superior” professionals made their beliefs known by openly dismissing any comments or contributions made by “inferior” people. As a result, some participants felt that inter professional aggression was related to some disciplines perceiving of themselves as above others. The following passage demonstrates how some professionals perceive it to be part of a nurse’s job to take “crap”.

There is the, I still think a perception of OK, you are here 24/7 and, like you’re the nurse and that’s the drudge and you have to take that crap from patients and staff, because pretty much that’s what you’re here for. (21-3)

Conversely, while some participants were aware that the nursing profession was not always highly regarded, they felt that nurses had an active role to play in promoting themselves and their contribution. One manager believed that this could be achieved by nurses actively taking part and speaking up during medical rounds.

Physicians were specifically identified by several participants as actively contributing to the hierarchy issue, with some physicians perceiving themselves to be above other health care professionals and expecting to be treated accordingly. As described by one participant, some physicians think rather highly of themselves.

Depending on the professions involved, there are some physicians who hum, for lack of a better word, think they’re God (laugh), and what they say goes and, you know, have a very abrupt manner. (21-5)

Similarly, a number of managers knew of physicians who were aware of their aggressive behaviour but who also felt that they had the right to act that way since their behaviours did not impact patients. Participants also reported that some physicians perceived that the physician shortage gave them *carte blanche* to be aggressive as the organization would not confront them with the issue for fear of losing them. The following excerpt describes how people were, and to an extent still are, afraid to confront physicians about their bad behaviour because physicians may just threaten to leave and the organization would then have a bigger problem on their hands.

But of course nothing ever happened 'cause people were afraid to approach the physicians and actually deal with them ... Like well if you say that to me then I'll just leave and then what will you do? There's a physician shortage and who do you think you are to tell me what to do, and you know that kind of a thing. Like they are, I guess they were sort of a law under themselves, and I must add in here that that's changed quite a bit right now. (21-5)

The issue of physician recruitment was particularly true for the site located in the small town where recruiting and retaining physicians was even more challenging. However, participants at that site reported that the culture was slowly changing and that physicians were getting better at seeing themselves as members of a team rather than the person in charge.

A few participants reported that for some seniority amounted to status (hierarchy). Consequently, some employees perceived junior employees as being less credible and less deserving of privileges than senior ones. In effect, for these employees credibility and privileges come hand in hand with seniority. A manager who was new to the organization reported finding it difficult to manage employees who had been working for the same employer for decades. She explained that these employees acted as if they knew the organization and she did not, and sometimes made derogatory comments showing that they

did not respect her as a manager. Similarly, another manager who was much younger than the majority of her staff felt that her authority was often challenged because of her age. The same manager also perceived that she had limited credibility with seasoned nurses because she did not prove herself as a staff nurse before becoming a manager - "but I know that you have people on the floor who don't think that I've put in my time in order to be in this [manager's] position" (21-1). Participants who worked for the same employer for a long time, who started as front line staff and were promoted to a managerial position, spoke to the challenge of managing former peers. These managers felt the additional burden of having to ensure that decisions were fair so staff did not perceive favouritism towards friends.

Agendas

Some participants attributed instances of professional aggression as being related to personal agendas. The following passage describes how issues are sometimes lost to people's personal agendas.

People have agendas, and that's what I think steers a lot of ... people's behaviours. It may not be discussing the issue for the issue. It will be discussing an agenda against the issue. (22-5)

Hidden agendas were also attributed to concealed competition between employees and to individuals wanting to be recognized as moving forward or as being successful even if at the detriment of others. In these instances, hidden agendas can undermine team work and team cohesion. Some participants provided concrete examples of hidden agendas such as physicians verbally attacking staff and managers when not getting what they wanted because they did not want their statistics to be affected and reflect poorly on them; as well as members of a management team deliberately sabotaging meetings and the collective efforts of a working group to prevent delivery of an important document.

Acute Care Hospital and Psychiatric Hospital: Is There a Difference?

The analysis revealed that the environment including the culture of each organization varied greatly. Important differences were also noted in the history of both organizations, the role of hierarchy, the investment in leadership, the relationship between groups of actors, the perception of fear and risk, and the date of policies and procedures pertaining to aggression and violence. Each topic is now further explored.

History

While history contributed to shaping both organizations, participants working at the site located in the small town talked about the importance of history in shaping their practice. In effect, the site of the psychiatric hospital located in the small town was open almost a century ago and was once an asylum. As such, while the way of treating mentally ill patients has evolved greatly over the years, some of the practices are still guided by deeply-rooted beliefs and values. These old-fashioned and sometimes even obsolete ways of practicing are not always understood by new staff. Conversely, new practices are not necessarily well received by seasoned staff. Habits and behaviours can thus create tension, especially when attempting to standardize practices between people and sites.

As well, history continues to play an important role in the two sites of the psychiatric hospital. As with any type of forced amalgamation, people at one site often end up feeling slighted at the detriment of the other site. This is the case for people working at the site located in the small town who, to this day, still feel victimized, disrespected and like “the poor cousin” of the large urban site. These emotions are contributing to feelings of frustration and are the source of some conflicts between the sites.

Hierarchy

While hospitals in general can be described as highly hierarchical organizations,

psychiatric hospitals seem particularly entrenched in the medical model and the medical hierarchy. In effect, physicians appear to be more powerful and influential at the psychiatric hospital where participants described psychiatrists as thinking they were “Gods”. Other issues related to hierarchy included front-line staff being afraid to discuss/confront issues with physicians and the organization not wanting to address some physicians’ bad behaviours for fear of attrition (especially at the site located in the small town).

Leadership

This study was conducted at a time where the acute care hospital was investing in developing and supporting its nursing managers. As such, they had put in place a formal management skills development training program and each manager was provided with a management binder. The binder, divided in modules (similar to the training), was to provide managers with background material and tools to assist them in their duties.

For its part, the psychiatric hospital was still recovering from its 2005 decision to abolish all front-line management positions. While they have been hiring managers since 2008, at the time of the study not every unit/department had a front-line manager on staff and some front-line management positions were not renewed because of lack of funding. The reporting structure of unit directors was also different in the psychiatric hospital. In effect, the dual-reporting structure (clinical/administrative directors) was identified as both challenging and a source of conflict in some instances. At the time of the study, the psychiatric hospital did not have formal management training in place or a management binder to develop/support/assist managers.

Relationships between Groups of Actors

According to several participants, many of the employees working at the psychiatric hospital had both a professional and a personal relationship with one another. However, these

personal relationships between staff were not always known by others, especially new staff coming from other organizations. These undisclosed personal relationships proved to be challenging to new staff when discussing issues with peers. Additionally, having a personal relationship with someone or knowing about the personal relationship between two colleagues was making it more difficult for one to set boundaries with a colleague. The following passage depicts how surprised one manager was to learn just how true the notion of the hospital being a big family was.

Everybody is related to somebody, everybody. So you meet somebody in the hallway and they're a nurse, and you find out their husband works in shipping and receiving, and their daughter is an orderly. So I think that adds to it, so when you have maybe an issue with someone, it's not even like you can talk about it very often because you don't know [who is who]. So the culture of, like it's nice 'cause it's a very family, there's like a family atmosphere, but at the same time, you know that's a lot of personal baggage that comes into a work setting. (21-1)

The issue of personal relationships at work was even more pronounced at the psychiatric site located in the small town. Participants at that site talked about "things" being accepted because of the hospital being located in a small town where "it's been generation after generation after generation working in the same facility" (22-3). As such, participants reported that some bad behaviours were tolerated or even accepted because employees knew the parents and/or children of the perpetrator as well as his/her family background/history.

Participants at the psychiatric site located in the small town also talked about issues following individuals through their entire lifespan because of living in a small town. In some instances, the only way for people to free themselves from the stigma attached to them was to not only leave the employer, but to also leave the town. The following passage recounts the story of a nurse who had been ostracized since nursing school. The "victim" ended up leaving the organization.

I think it had also come through that some of this had been occurring in her school years, when she was training. And of course she trained in the same hospital that she ended up working in, so it kinda came through there with her classmates. (22-3)

Participants at both organizations reported some challenges in dealing with unions and collective agreements. However, participants at the psychiatric hospital, especially the located in the small town, felt that unions' way of doing business had not evolved over the years. For example, some union members were said to still use intimidation to achieve the resolution they wanted.

Fear and Risk

Fear had a different connotation in the psychiatric hospital. For example, health care providers working on the front-lines in some specialized units have an omnipresent relationship with fear because of some clients' high propensity for violence. Staff working on these units have a distinct relationship with clients and with each other and as such are not likely to report peer aggression for fear of peer retaliation (this issue was addressed earlier in the section pertaining to fear).

The concept of risk, and the fear associated with risk-taking and/or having a risky situation go wrong was openly discussed with participants working at the psychiatric hospital. In effect, participants reported that employees were aware that sending the wrong patient on a week-end pass could have devastating effects on the patient, the organization and the community at large. As such, for these employees the fear associated with making the wrong decision and the consequences arising from that wrong decision is real and in some instances even paralyzing (i.e. staff will refuse to make a decision and will leave the burden to others). Participants at the psychiatric hospital also reported intra/inter professional conflicts arising from differences in opinion related to patient care and treatment plans.

Policies and Procedures

The acute care hospital has had a policy to address workplace aggression for seventeen years longer than the psychiatric hospital. In effect, the acute care hospital's policy on *Harassment and Aggressive Behaviour in the Workplace* was implemented in 1992, while the psychiatric hospital implemented its *Respectful Workplace* policy in May 2009. Additionally, the acute care hospital implemented a policy on *Workplace Violence* in 2008, whereas the psychiatric hospital was still in the process of developing its policy on the *Prevention and Management of Violence in the Workplace* at the time of this study. Furthermore, the acute care hospital also implemented a *Physician's Code of Conduct* in February 2008, and an *Employee's Code of Conduct* in July 2008. Both were in use and the Physician's Code of Conduct was already enforced by the hospital. For its part, the psychiatric hospital did not use codes of conducts.

Summary of Results

The analysis presented in this chapter served to address the three research objectives of the current study: 1) To understand the management of intra/inter professional aggression from the nurse managers' perspective; 2) To explore how nurse managers can be supported when having to manage intra/inter professional aggression; and 3) To identify organizational factors that can facilitate or impede the management of intra/inter professional aggression. While data saturation for the five main themes and several sub-themes occurred after 17 interviews (Appendix J), all interested participants were nonetheless interviewed.

A significant finding related to the research objective is that the management of intra/inter professional aggression is in fact a process where *perceptions* and *emotions* play a fundamental role in the subsequent decision to become *aggressive*. For its part, the *management* of intra/inter professional aggression was found to be the responsibility of not

just managers, but rather was found to be a collective obligation between individuals, peers, managers, human resources department and unions. The process of aggression and aggression management is shaped and influenced by omnipresent forces referred to as *power*.

The study identified several sources of support used by managers to assist them in managing instances of intra/inter professional aggression. Support was found to be both from internal and external sources. External support was described as being especially important as it provided unbiased perspectives and allowed participants to uncover different and novel ways to address a particular issue.

Several organizational factors, including factors in both the physical and the social/cultural environment, were identified by participants as contributing to aggression and/or its management. While the majority of these factors are not new and have in fact been described in the literature, each factor plays a role in intra/inter professional aggression. The interdependence of these factors is similar to cogs on a wheel, where strategically addressing certain factors (thus removing cogs) could potentially impede the wheel of aggression from turning.

The findings from this study support most of the captions identified in Workplace Aggression Management framework proposed in Chapter Two. In effect, health care professionals were found to be both perpetrators and victims of intra/inter professional aggression. As well, physical and psychological aggressions were types of aggression identified by study participants. However, the participants did not identify instances of sexual or financial aggression. Furthermore, both the physical and social environments were found to contribute to and/or impede workplace aggression. Finally, while the management practices identified focused more on steps taken post aggression, participants identified prevention (pre-aggression) as well as the role played by peers (during aggression) as

important management strategies. The Workplace Aggression Management (WAM) framework was revised to take into account the five themes identified in Chapter Five: perception, emotions, aggressions, management and power. The new framework is represented in figure 5.1.

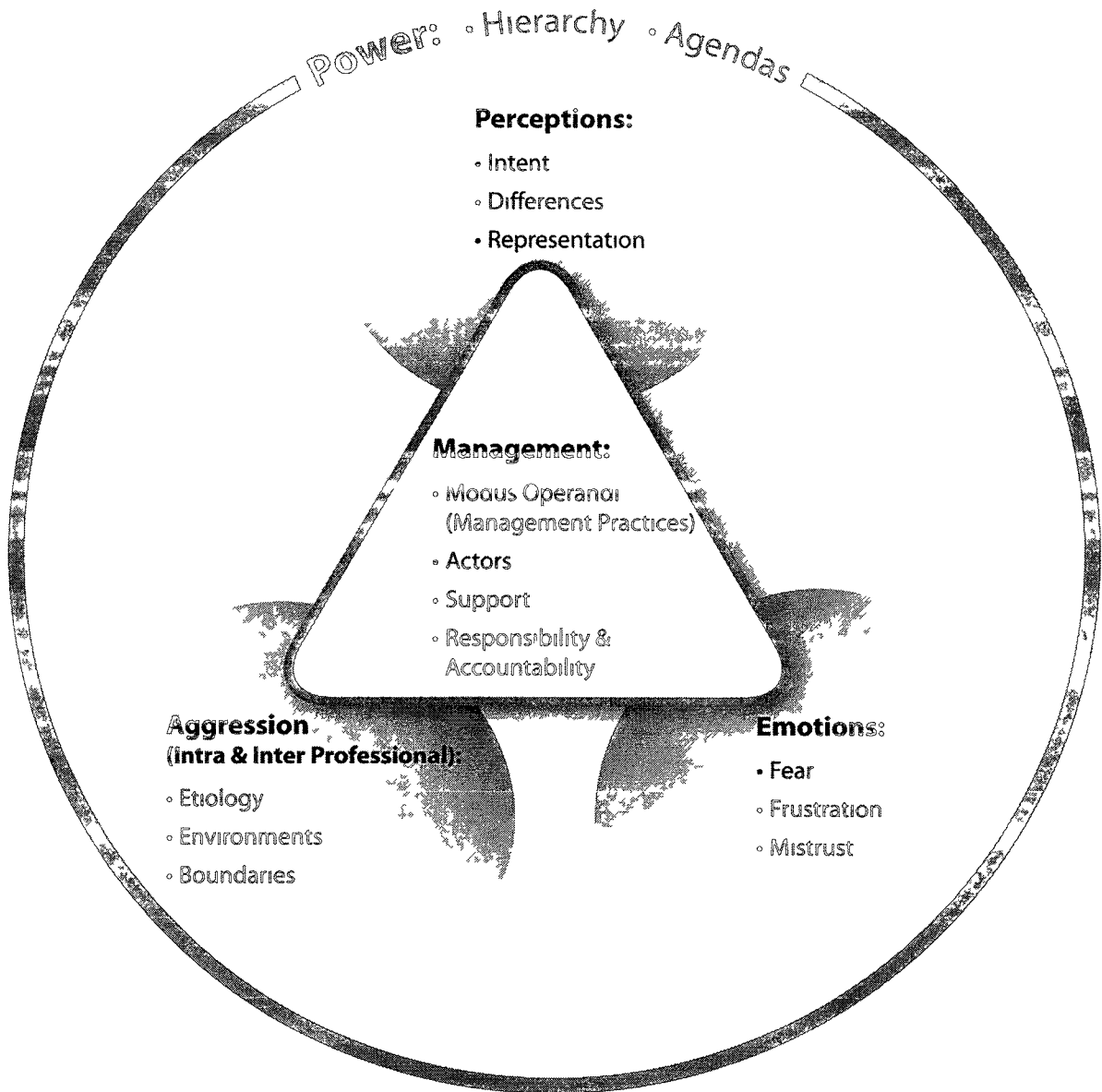


Figure 5.1: Revised WAM (Workplace Aggression Management) Framework Applied to Intra/Inter Professional Aggression

CHAPTER 6 DISCUSSION

Chapter Six presents a discussion of the main findings revealed in the analysis performed in Chapter Five. The theoretical approaches introduced in Chapter Three serve to explain and contextualize some of the findings. The findings are also contrasted with the current knowledge on the topic, including information summarized in the literature review found in Chapter Two. The chapter concludes by offering implications and recommendations for nursing practice, education, research and administration.

The discussion also provides an opportunity to re-theorize intra/inter professional aggression as well as the management of the issue. This section presents the re-theorization of the five main themes:

- 1) Interpreting the Event
- 2) Internalizing the Perception
- 3) Acting Out
- 4) Managing the Situation
- 5) Politicizing Relations

Interpreting the Event

The role of perceptions as it relates to aggression has been extensively examined in the context of health care. In effect, the literature is rich with studies looking at nurses' perceptions in response to patient aggression (Jansen, Dassen & Jebbink, 2005; Jonker et al. 2008; Mackay, Paterson & Cassels 2005; Needham et al. 2005). As early as 1997, Jansen et al. developed the perception of aggression scale (POAS), an attitude inventory assessing nurses' attitudes toward aggressive patients. Their 32 item scale explored three dimensions of aggression: aggression as a normal and/or acceptable reaction to anger, aggression as a

violent reaction to being exposed to a threat, and aggression as a functional reaction. Since then, the scale has continued to be tested, refined and shortened (Jansen, Middel & Dassen, 2005; Needham et al. 2004).

The literature review found several studies addressing nurses' perceptions in the context of patient aggression. However, none were identified that explored the perceptions of health care professionals in the context of intra/inter professional aggression. The only study found to examine a related topic was a Canadian study by Sui, Spence Laschinger & Finegan (2008) who examined the impact of nurses' perceived professional practice environment on their quality of conflict management approaches. The study results found that nurses who perceived themselves as working in positive practice environments were more likely to report effective conflict management skills.

As such, I believe that the current research contributes to the body of knowledge around *perception* by exploring perception from a different perspective – that of health care providers' perceptions in response to colleagues' actions. In effect, the analysis conducted in Chapter Five revealed that health care providers often compare themselves and their practice to that of their peers. Subsequently, individuals interpret their assessment in light of their perceptions. It is the interpretation of these perceptions that can lead to positive or negative emotions. For example, employees may experience frustration or anger if they assess that their colleagues are lazy or incompetent because of the way they practice. Because they feel frustrated and/or angered, these employees might not be forthcoming when their peer approaches them for help or feedback. They might be prone to make a snide remark or just ignore the request. They might also share their frustration with their peers, which can in turn be interpreted as gossiping. In this context, the uneasiness between employees can arise from perceptions.

Perceptions were also discussed in the context of knowing an individual. In effect, participants described how some employees were known to be rude or cranky but had their behaviour excused because “that’s just the way they are”. In such cases, because no ill intent was perceived, the bad behaviour was excused and did not trigger an overly negative emotion. The perception of “intent” thus becomes an important factor in the mechanism of aggression. The results of the current study showed “intent” to be an important sub-theme of perception.

Intent was explicitly explored as part of the initial literature review where it became clear that authors did not agree on whether aggression should always be defined as intentional (Rippon, 2000; Waddington, Badger & Bull, 2005). The findings from this study confirm the decision to exclude intent from my definition of workplace aggression. In effect, the study found that several participants believed that aggressive employees were often not aware that they were in fact being aggressive. For example, employees were not always aware that the tone of their voice combined with their physical stance could in fact be perceived as aggressive by some. Moreover, once employees’ awareness was raised, participants reported that a number of them were shocked to find out that they came across as being aggressive and were remorseful and apologetic about their behaviours. Conversely, the fact that no one had ever taken the time to approach these employees’ about the way they presented themselves, explaining that it was not necessarily what they said but how they said it that contributed to erroneous perceptions, could in fact have perpetuated the problem.

It is for these reasons that I believe that the definition proposed in Chapter Two is valid and that workplace aggression can be defined as: *Any act violating an organization’s current recognized and accepted norms which is known or ought to have known to cause harm to an employee while at work or on duty; including perceived or actual threat to one’s life, safety,*

health, integrity or dignity. The proposed definition also addresses another important matter that emerged during analysis – that of the need for people to self reflect about their behaviours and how these may affect others. In effect, the statement that individuals “*ought to have known*” that their behaviours may cause harm suppose that an individual has the ability to and will self-reflect.

However, the current study found several participants concerned about health care professionals’ lack of self reflection even after being made aware of their bad behaviour. For example, some employees were said to be unable and/or unwilling to acknowledge any wrong doing even when confronted with facts. These employees would simply deny allegations and/or attempt to justify their behaviours. They would deflect statements and/or blame others for their actions. They refused or were incapable of reflection on how they could in fact be contributing to the issue. The limited ability of some individuals to self reflect is troubling in light of the fact that reflection is a practice requirement of several regulatory bodies including the College of Nurses of Ontario.

The use of reflective practice as a strategy to address dysfunctional nurse-nurse relationships was examined. For example, Taylor (2001) explored reflective practice in the context of horizontal aggression management. Following a period of dedicated time to reflect about their practice, the 12 study participants identified low self-esteem, gender issues, professional jealousy and the use of power in a manipulative way as factors contributing to an ongoing culture of horizontal violence. The participants also discussed strategies that they prioritized into a plan of action to suggest ways to act more effectively in the above situations. Interestingly, most of the strategies mentioned in Taylor’s study were also identified in the current study. For example, strategies like “starting a culture of positive strikes and acknowledgement; dealing with the nurse directly and immediately through

recourse to policies and procedures; providing strong leadership and engaging in conflict resolution; as well as building skills to deal with situations directly and/or ask for facilitation as soon as possible” (Taylor, 2001, p. 411) were talked about and/or already used by several managers taking part in this research.

The above definition of workplace aggression also speaks to the issue of perception of threats. In effect, a section of the definition explicitly states “*including perceived or actual threat to one’s life, safety, health, integrity or dignity*”. The current study identified the perception of differences as potentially “threatening” for some health care professionals. In effect, whether the difference was in education, in practice, in management, or in roles and responsibilities, being different from the norm was in certain instances perceived by some group members as menacing. This was especially true when a specific nurse on a unit was found to be practicing fundamentally differently than her peers, or when scopes of practice overlapped resulting in different professions taking on the same tasks but from a different angle. The process by which differences come to be perceived as “threatening” was described in the theoretical framework proposed in Chapter Three where as part of his conception of the mimetic mechanism, Girard (1972) explained how the perception of differences can be menacing to some and even lead to exclusion. As such, Girard’s mimetic mechanism is described as a process often leading to scapegoating. Initially, the differences may not be perceived as menacing but instead can generate desire and envy where one person may want what the other has (mimetic desire). As envy intensifies, it can lead to rivalry between the people involved where one person wants to remain different but the other wants to have/be the same (mimetic rivalry). The more the people become alike, the more they lose their identity (crisis of indifferenciation). As a result, people who are radically different from the “norm” can be perceived as intimidating and daunting, thus needing to be

excluded to bring back social order and group cohesion (scapegoat mechanism). Study participants reported instances where their employees were ostracized and persecuted by others because of perceived differences. For example, a nurse who was identified as an “outside the box” thinker and perceived by her peers as not rigid enough in her dealings with patients became unpopular and the center of gossip amongst her colleagues. The mimetic mechanism is described in more detail in a recent article describing a renewed way to theorize intra/inter-professional aggression (St-Pierre & Holmes, 2010a). Figure 6.1 illustrates the mimetic mechanism with nursing examples of intra-professional aggression.

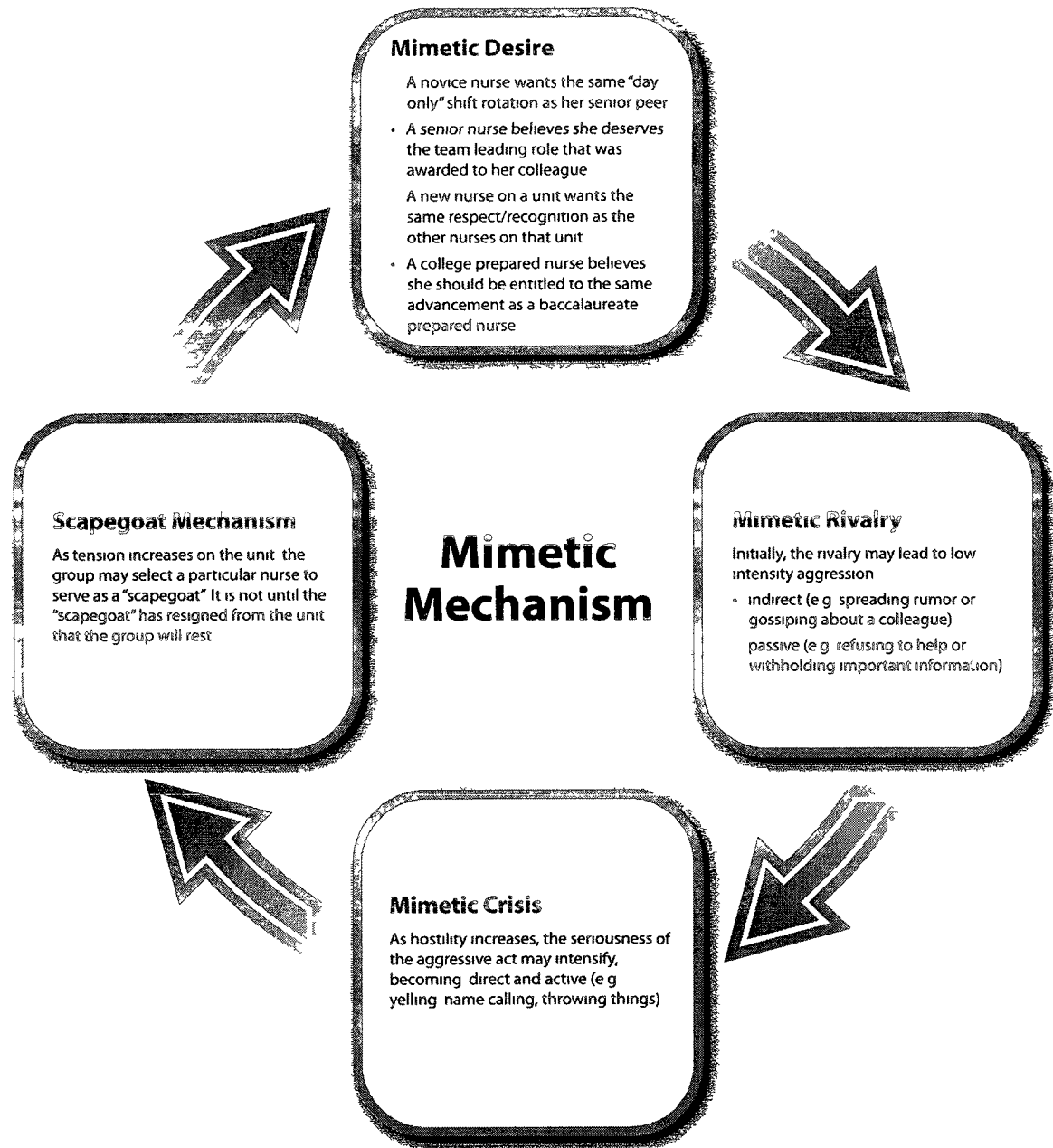


Figure 6.1: Mimetic Mechanism According to Rene Girard Applied to Intra Professional Aggression

Internalizing the Perception

Three main emotions arising from perceptions were identified by participants: fear, frustration and mistrust. In the nursing literature, the concept of fear as experienced by front line nurses was mostly studied in the context of patient aggression. In effect, authors have reported instances of nurses experiencing fear following an assault by a psychiatric patient resulting in defensive responses from these nurses and ultimately influencing their practice and the way they cared for patients (Foster, Bowers & Nijman, 2007). A recent study by Jacob (2010) found that fear reinforced the need for nurses to create a safe practice environment, and that in the context of forensic psychiatry personal safety always took precedent over patient care.

However, what happens when employees fear not only their patients but also their colleagues? That very issue was raised in the current study where fear was mostly related to apprehension about bad decision-making or fear of retaliation from peers. In effect, in the context of intra/inter professional aggression, fear is most likely to arise in contexts of criticism or blame related to decisions made, or to the way individuals choose to practice. However, similar to fear of patient aggression, fear of peer aggression had the potential to influence the way health care providers practiced which in turn impacted patient care. For example, a number of study participants reported that they were aware of employees' choosing to remain silent and not voice their opinion about patient care for fear of being blamed if something went wrong with that patient.

While the culture might slowly be evolving to allow for the reporting of near misses without fear of punishment, there is still a legitimate concern amongst health care employees that they will be penalized if deemed responsible for a bad decision. Consequently one can

view employees as experiencing a kind of dual fear: fear of making a mistake that will have a negative outcome on patients, and fear of being punished for that same mistake. Conversely, if used as a learning opportunity, people could learn a great deal from mistakes made or near misses.

Fear was also identified in the context of retaliation. Study participants reported that they were aware of employees not wanting to report instances of intra/inter professional aggression for fear of retaliation. For example, managers reported being aware that some employees working in psychiatry were afraid that they would not receive assistance in a timely manner during a code white if their colleagues became aware that they reported them to their manager as being aggressive. In an environment where the risk of patient aggression is high such as in psychiatry, it is imperative that health care providers know that they can count on their colleagues to assist them in a time of crisis. Employees who cannot trust that they will be helped if in danger will more than likely change the way they practice (thus ultimately impacting patient care). They might also choose to leave the unit and/or the organization, or go on sick leave related to stress.

Furthermore, health care milieus tend to be stressful work environments where patient behaviour can be unpredictable. As such, the need for stable working relationships and the ability to count on colleagues becomes that much more important. Colleagues who become an additional source of stress have the potential to destabilize areas that should be safe. Regardless of how, fear of peer retaliation always results in negative outcomes whether it be for patients, providers, and/or the system. The current study did not examine how to deal with fear.

For its part, frustration was studied in great depth in the context of aggression. As early as 1939, Dollard et al. developed the frustration-aggression hypothesis and started their book

by affirming that “aggression is always a consequence of frustration” (p1). More specifically, they believed that 1) “the occurrence of aggressive behaviour always presupposes the existence of frustration”; and 2) “the existence of frustration always leads to some form of aggression (Dollard et al., 1939, p.1). While mostly in agreement with Dollard et al’s frustration-aggression hypothesis, Miller (1941) offered to rephrase the second part of the proposition by suggesting the following: “Frustration produces instigations to a number of different types of response, one of which is an instigation to some form of aggression” (p. 338). For his part, Pastore (1952) explored the role of arbitrariness in the frustration-aggression hypothesis by studying the perception of justified and unjustified aggression. His work showed that frustration perceived as justified resulted in less intense feelings of hostility than frustration perceived as unjustified (Pastore, 1952).

In 1989, Berkowitz proposed a model to explain how justified frustration could lead to aggression. Berkowitz (1989) posited that people were more likely to become aggressive when they thought that someone had deliberately and wrongly prevented them from reaching their goal rather than if they perceived the interference as accidental or necessary. As such, according to Berkowitz (1989) “frustrations are aversive events and generate aggressive inclinations only to the extent that they produce negative affect” (p. 71). In 1995, Dill & Anderson acknowledged that as a result of cognitive processing, initial reactions to frustration could either be suppressed or enhanced to further aggressive reactions. Cognitive processing could also lead the individual to attribute frustration to a specific cause or to some other individual.

Frustration was defined as “the blockage of goal attainment” (Anderson & Bushman, 2002). The findings of the current study support the premise that staff can feel frustrated when perceiving that someone or something is preventing them from achieving their goal,

whether it be to properly care for their patients or to complete their tasks in a timely manner. This research shows that some staff may be better at controlling their frustration and remain calm while others may spontaneously retaliate. The analysis also describes how some employees do not always retaliate against the perceived source of their frustration (for example if they perceive the source of their frustration as being in a position of power or as able to strike back), but instead may chose to assail someone else (aggression by proxy).

In some instances, frustration can be viewed as a symptom of a deeper problem. For example, employees can be tired and stressed as a result of heavy workloads. They can be discouraged by a perceived lack of action by their manager and/or the organization to improve their working conditions. While employees who seek help from their managers should be encouraged to address the situation themselves, they should also feel that their managers genuinely want to help them and are not just dismissing them because they are themselves feeling overwhelmed and frustrated. As such, simply telling staff that they should deal with the situation is not enough. Managers need to actively listen and provide staff with tools to enable success. A poorly handled peer to peer situation will more than likely result in increased peer to peer problems that the manager will inevitably have to deal with. Proactively dealing with situations as they arise can ultimately save both managers and staff time and anguish.

A person's affectivity, that is where some individuals have a propensity to feel vulnerable and experience distress, feel a sense of helplessness and inadequacy more readily than others, can influence an individual's response to frustration. Similarly emotional susceptibility, or the tendency to be negative, pessimistic or cynical, can predispose people to frustration. These traits can also influence people's coping skills where negative or cynical individuals may not believe that they can positively change a situation. The current study did

not explore how to deal with frustration.

Participants also identified mistrust as an emotion arising from perceptions. According to Williams (2006) “no trusting organization can exist without a pervasive sense of justice” (p. 30). As such, trust is often linked to a perception of fairness and justice (Lewicki, Wiethoff, & Tomlinson, 2005). While relatively new to nursing the concept of organizational justice, which is closely linked to trust, is well researched (Cohen-Charash & Spector, 2001; Colquitt et al, 2001; Nowakowski & Conlon 2005). Organizational justice is also linked to instances of workplace aggression, and the perception of justice is associated with the quality of coworker relationships (Greenberg & Alge 1998; Jawahar, 2002; Skarlicki & Folger, 1997). For example, employees occupied at “keeping score” on the way they are treated and the rewards they receive compared to that of their peers may be less considerate, helpful and supportive of their colleagues (Forret & Love, 2007).

Specifically, interactional justice, which pertains to the human side of organizational practices, is said to be related to interactions with authority (Colquitt et al., 2001). Managers in the current study described situations where their actions, or lack of actions, have lead employees to distrusting them. More specifically, as was suggested in the narrative of one manager, most managers are not in the habit of meeting staff one on one to praise them for a job well done, employees were suspicious when summoned to their manager’s office. Other managers talked about trust being a two way street and difficult to regain once lost. They acknowledged that in some instances relationships are beyond repair, requiring one of the people (either the staff or the manager) to transfer from the unit in order to be able to carry on.

The current study also saw a number of participants expressing how they were at lost to create a fair and just work environment amidst ongoing restructuring and downsizing.

Managers were aware that some of the decisions they made in response to budget cuts were also undermining employee's trust. Several participants also voiced their concerns that given their current working conditions, they did not perceive that they could adequately manage instances of workplace aggression and/or create and maintain positive work environments. For example, while several managers found their workload and spans of control impeding their ability to be visible on units, they were also aware that to build a sense of trust they needed to be visible and available to their staff. Being physically on the unit also allows managers to directly observe situations, thus providing a sense of fairness and understanding when addressing unit problems.

The concept of organizational justice can therefore serve to explain how perceptions of fairness can be affected by the environment in which people practice. Table 6.1 summarizes factors in the work environment of managers that can be associated with the five dimensions of organizational justice. As well, the table suggests actions that managers can take to promote a sense of trust and fairness amongst their employees. It has been argued that nursing managers could in fact be considered victims of organizational injustice, and their difficult working conditions could impact negatively upon their ability to create trusting and fair culture (St-Pierre & Holmes, 2010b).

<i>Dimension</i>	<i>Sub-dimension</i>	<i>Definition</i>	<i>Examples of injustices in the work environment of nursing managers</i>	<i>Implications for nursing managers' practice</i>
Distributive justice		The perception of fairness derived from a ratio between one's perceived contribution and the outcome received from the organization (e.g. pay/work equity, promotion). Leads to outcome focused reactions such as absenteeism, turnover.	<i>Role overload</i> from large span of control or managing several units. <i>Limited training</i> in management or continuing professional development opportunities.	Managers can ask employees how they feel and listen to their concerns, especially when employees perceive being under appreciated.
Procedural justice		The perceived fairness of the process by which outcomes are determined (e.g. performance appraisal, organizational support). Leads to organization focused reactions such as organizational commitment, productivity, efficiency, performance.	<i>Role conflict</i> from the dichotomy between nurse managers' professional and personal values (such as respect for people, human dignity, equity and caring) and the values set by the organization (such as efficiency and productivity). <i>Limited support</i> such as feeling neglected or excluded from the wider decision making process.	Managers can provide venues for employees to provide input on upcoming decisions. They can also ensure that the process is consistent across people and time, free of self-interest, based on accurate data or corrected when data were not accurate, has taken into account various opinions and is moral and ethical.
Interactional justice		Pertains to the human side of organizational practices. Leads to supervisor focused reactions such as negative attitude and/or conflict towards supervisor.		
	Interpersonal justice	The extent to which individuals are treated with respect and dignity	<i>"Part of the job"</i> where managers are treated disrespectfully or become the target of aggression.	Managers can ensure that they treat their staff in a polite and respectful which is free of improper remarks.
	Informational justice	The extent to which individuals are provided with information or rationale for how decisions that affect them are made.	<i>Limited communication</i> where managers are not informed about decision in a timely manner.	Managers can ensure that information is communicated clearly and in a timely manner.

Table 6.1: Summary of Dimensions of Organizational Justice with Examples and Implications

Acting Out

Participants provided many reasons as to why they believed that intra/inter professional was able to flourish at work. These included perception of differences (where high achievers had little tolerance for others practicing differently than they were) and the inability to control one's emotions (when a frustrated employee just lashed out at a peer).

The fact that no single root-cause for intra/inter professional aggression was identified also supports the notion that workplace aggression is complex and multi-faceted. As such, the research findings confirm that Girard's mimetic mechanism as described in the theoretical framework developed in Chapter Three can serve to explain some instances of intra-professional aggression. For example, participants voiced that in some instances, intra-professional aggression was related to the perception of inequities or differences. Differences can lead to desire (want what we do not have), rivalry (leading to low intensity aggression), crisis (as hostility increases) and scapegoating (where an individual is "sacrificed" to bring back peace and team cohesion).

For its part, inter-professional aggression can be described as a form of power struggle to maintain social differentiation (often based on licensing and credentials), and supports the combination of Girard's and Weber's work. For example, negatively privileged groups (such as registered nurses and/or registered practical nurses) attempt to oppose professional closure (or being left out) by encroaching into the privileged ranks to gain access to power and prestige (called usurpation). These groups often encounter resistance from the groups favoured by professional closure (e.g. physicians) as they attempt to preserve status quo.

While professional closure can serve to explain some instances of inter-professional aggression, the issue of physician aggression towards nurses is one that is also rooted in history. Professional dominance over other health care professions relates to physicians'

traditional position of ultimate professional authority where no other professionals were to question their actions (Freidson, 1970/2007). While arguably, this belief is no longer true and the culture is said to be slowly changing, instances of physicians rebelling against being questioned by other professionals, most particularly nurses; and physicians being verbally aggressive towards nurses remain a frequent occurrence. This was especially true in the psychiatric hospital where psychiatrists were portrayed by respondent as holding a privileged status and for the most part not held accountable for their aggressive outbursts. On the other hand, several participants from the acute care setting stated that their organization was serious about implementing a zero tolerance policy pertaining to physician's disruptive behaviour; and that the incidence of physician aggression was said to have decreased following the implementation of the physician's code of conduct.

Additionally, the findings of this study clearly demonstrate that both physical and social/cultural environments play an important role in facilitating or impeding workplace aggression as well as workplace aggression management. Physical environments such as small and crowded nursing stations, poor heating and/or air conditioning and lack of staff restrooms all contributed to increasing frustration and/or instances of aggression. Factors found in the social/cultural environments such as the simultaneous implementation of multiple initiatives combined with heavy workloads and a shortage of health care professionals, seemed to contribute to the proliferation of instances of workplace aggression. As such, the results of the current study support the findings of Sui, Spence Laschinger & Finegan (2008) who established that effective conflict management skills were greater in nurses perceiving their practice environments as positive.

In terms of boundaries, participants provided examples of both physical and psychological aggression. Participants agreed that in the context of intra/inter professional

aggression physical aggression was rare but psychological aggression was widespread. Psychological aggression was broadly described as including verbal aggression, harassment, bullying and abuse of power. Examples of psychological aggression provided included such behaviours as being rude, humiliating a peer in front of others, failing to speak up for someone, refusing to help someone with his/her duties, excessive scrutiny and critiquing of another's work, spreading malicious rumours, gossiping and backstabbing. These examples parallel what is reported in the literature (Farrell, 1999; McKenna, Smith, Poole, & Coverdale, 2003).

A relatively new form of psychological aggression was experienced in the acute care hospital where a few participants reported having to respond to an incident of cyberbullying. Cyberbullying, defined as "an aggressive, intentional act carried out by a group or individual, using electronic forms of contact, repeatedly and over time against a victim who cannot easily defend him or herself" (Smith et al., 2008, p. 376). Cyberbullying differs from face to face bullying in four ways (McColgan, 2009). First, cyberbullying is said to be more intense and takes place over a longer period of time than traditional bullying. For example, cyberbullied individuals can receive constant emails or text messages regardless of time of day and location. Second, cyberbullying can include a larger audience since text messages and emails can be sent to more than one person at a time. Conversely, face to face bullying happens in smaller groups. Third, cyberbullying is said to be relatively anonymous since there is no face to face confrontation. As such, bullies feel relatively safe in perpetrating their actions. Finally some suggest that cyberbullies may not realize the repercussions of their actions since without the face-to-face confrontation, they have little feedback on the effects of their actions.

As stated above, cyberbullying is relatively new in the context of health care. A review of the literature found only one study exploring cyberbullying in the context of workplace aggression. The exploratory study surveyed 103 male (response rate 7.3%) working in an Australian Manufacturing Workers' Union and found that all victims of cyberbullying also experienced face-to-face bullying (Privitera & Campbell, 2009). The research also raised the issue of the role of the organization in regards to this new form of bullying, i.e. to what extent is the employer required to intervene in acts of cyberbullying.

The same review of the literature found only one commentary exploring the issue of authority and responsibility when responding to cyberbullying (Willard, 2007). The commentary was written in the U.S. and discussed the issue of cyberbullying in the context of off campus online right to freedom of speech versus students' safety and security. The commentary suggested that "failure [by schools] to exercise reasonable precautions or to intervene could lead to liability under negligence or civil rights laws" (Willard, 2007, p. S.64).

While there is still no extensive case law to serve as examples in cases of cyberbullying, one can foresee employers being held responsible and accountable for instances of cyberbullying under the "due diligence" segment of the Canadian Occupational Health and Safety legislation. Due diligence "means that employers shall take all reasonable precautions, under the particular circumstances, to prevent injuries or accidents in the workplace" (CCOHS, 2008). As such, employers are expected to exercise reasonable precautions to prevent, or intervene and deal with instance of work related cyberbullying. Additionally, workplaces may have to modify their workplace violence/aggression policies to take into account this new form of aggression. In the current study, the employer actively dealt with the issue once aware that cyberbullying was taking place between employees of

the institution.

Managing the Situation

Broadening the understanding of the management of intra/inter professional aggression from a management perspective was the main objective of this study. Since there is a paucity of published articles on this topic, the current research offers new insight into the issue. Data analysis found that the management of workplace aggression is a non-linear and dynamic process. Depending on the severity of the aggression, the process of management can be relatively simple or can become complex and even cumbersome.

The current study identified several actors who could play an active role in managing workplace aggression. Managers agreed that every employee has a responsibility to act in order to alleviate instances of intra/inter professional aggression, and that one person alone could not do it. As such, the management of intra/inter professional aggression starts with every individual needing to take time to self-reflect and assesses how his/her actions are perceived and how he/she presents him/herself to others. Individuals are also responsible for validating their perceptions of situations that are generating frustration and/or anger by addressing the issue directly and in a timely manner with the person involved. While it is important to verify intent, people should also have their emotions under control as much as possible when addressing an issue with colleagues. Peers can also play an important role in managing aggression. Instead of being a passive listener and/or bystander, peers can play an active role in diffusing a situation either by saying something at the time the aggressive situation is taking place (direct intervention) or by openly refusing to hear negative and/or destructive conversation.

In light of the fact that out of control emotions can potentially result in negative outcomes for the individual, patients and the organization, this study highlights the

importance of being able to keep emotions under control as much as possible. The review of the literature found two concepts linked to coping skills: self control and emotional skillfulness. These concepts may provide insight on how to assist individuals to remain calm and in control even when experiencing strong emotions.

Self control, or the ability to manage one's emotion, was studied in the context of workplace aggression (Buss, 1961; Douglas & Martinko, 2001). Buss (1961) posited that individuals with low self-control tended to be more aggressive than individuals with high self-control. According to Buss (1961), this is related to the fact that low-self-control individuals lack strong inhibition, a characteristic found in individuals with high-self-control. Individuals with low-self-control display a "stable tendency to react offensively to minimal provocations" (Baron & Richardson, 1994, p. 212) and tend to be more impulsive (Hynan & Grush, 1986). As such, training exploring ways to improve self control and reduce impulsivity may offer a novel way to prevent and/or impede instances of workplace aggression.

Emotional skillfulness was defined as the "ability to recognize and respond to emotions in ways that enhance one's life and one's relationships" (Mansfield et al, 2009, p. 223). The term appears to have originated from the work of Cordova, Gee, and Warren (2005) who explored the role of emotional skills in the context of intimacy and marital satisfaction. Recently, Mansfield et al. (2009) introduced the term in the context of aggression and violence research. According to these authors, emotional skillfulness has at its core an emphasis on acceptance. It is not limited to a person's ability to recognize and talk about emotions, but also includes the capacity to respond to emotions in ways that are helpful to oneself and to one's relationship (Mansfield et al., 2009). Emotional skillfulness is thus a skill that can be learned and practiced. It involves becoming aware and identifying strong

emotions in light of situations that generate them, and then learning to appropriately respond to the emotional load. Again training aiming at developing an individuals' emotional skill may offer a promising option in the fight against workplace aggression.

While managers have an important role to play in managing aggression, the current study found that managers did not always feel capable or well equipped to deal with difficult situations involving intra and/or inter professional aggression. Several managers not only questioned their abilities to respond to aggression but also worried that they were in fact part of the problem. For example, some managers perceived that the amount of conflict on their unit was a direct reflection of their management skills and that if conflict was flourishing, it was probably because they were a poor leader.

The work environment of nursing managers was also identified as affecting their ability to manage aggression. Heavy workloads, large spans of control, limited training in management including conflict and performance management, and role ambiguity were all identified in the current study and supported in the literature as greatly reducing managers' ability to address human resources issues. Interestingly, unions were the only actors who were repeatedly perceived by the managers interviewed as hindering and thwarting the management of aggression. This was especially true at one site of the psychiatric hospital where union representatives appeared to have retained the view that employers deliberately want to use and abuse their employees who should be protected at all cost. Collective agreements where seniority often takes precedent over an individual's qualification and personality, were also identified as contributing to workplace aggression. Conversely, human resources departments including labour relations and occupational health services were described by several participants as being supportive and helpful in dealing with workplace aggression.

Some participants talked about responsibility and accountability and raised important questions regarding the extent to which an employer is responsible for ensuring that regulated health professionals practice according to their professional standards. For example, in Ontario registered nurses are regulated by the College on Nurses of Ontario (CNO) and as such, are expected to practice according to seven professional standards: accountability, continuing competence, ethics, knowledge, knowledge application, leadership, and relationships including therapeutic nurse-patient relationships and professional relationships (CNO, 2002). Under accountability, it is clearly stated that “nurses are responsible for their actions and the consequences of those actions. They are also accountable for conducting themselves in ways that promote respect for the profession” (CNO, 2002, p. 4). Additionally, under professional relationships, it is clearly stated that a nurse must “demonstrate effective conflict resolution skills” (CNO, 2002, p. 12). Moreover, CNO also developed a Conflict Prevention and Management Practice Guideline (2009) which includes a section specifically addressing conflict with colleagues as well as workplace conflicts. Each section includes a brief discussion on key factors associated with the issue as well as suggestions for the prevention and management of the issue. In light of these expectations, the question raised by some managers was “*should nurses taking part in intra/inter professional aggression be reported to their regulating institutions instead of being disciplined by their employers?*” The question also brings to light the need to remind health care professionals of their responsibilities under their regulatory obligations, and suggests that in-services or workshops to educate them and refresh their memories might be worthwhile exercises.

Politicizing Relations

Power was identified by several participants as contributing to intra/inter professional

aggression. While not specifically in the context of workplace aggression, the concept of power was repeatedly researched and a plethora of books and articles exist on the subject. One of the most common conceptualization of power comes from French & Raven's (1959) who developed a framework outlining five forms of power: *coercive* (individual has the ability to punish to secure compliance); *reward* (individual has the ability to reward by controlling assets such as promotion and pay); *legitimate* (individual has the legitimate right and/or authority to be in power), *referent* (individual is liked, admired and respected); and *expert* (individual possesses skills/abilities that are valued/needed). While French & Raven's model is one of the most cited models in management texts to this day, the model has also been criticized for not having been validated empirically (Braynion, 2004).

Michel Foucault's conceptualization of power is also well documented in the literature. In effect, much of Foucault's work examined the relationship between knowledge, truth and power. One of Foucault's (1975) convictions is that by using disciplinary power, society aims to produce useful and productive "docile bodies". As such Foucault (1975) describes disciplinary power as being everywhere, invisible and insidious and as operating by internalizing and normalizing the thoughts and actions of subjects. In Foucault's view, the judges of normality are everywhere and it is through discourses that "truth" is established.

I believe that using the work of Foucault in the context of workplace aggression provides a fresh way to conceptualise violence. For example, Foucault's concept of disciplinary power was used to explore institutional violence from a critical perspective (St-Pierre & Holmes, 2008). The findings demonstrated that power, surveillance and disciplinary techniques are used at all levels of hospital management to control and contain both human resources and costs (St-Pierre & Holmes, 2008). The authors demonstrated an association between common workplace practices, such as mandatory overtime and workload

measurement, and institutional violence (St-Pierre & Holmes, 2008). They concluded that employers who have a policy of zero tolerance toward workplace violence ought to re-examine their ways of operating if they wish to practice in accordance to their own workplace violence policies (St-Pierre & Holmes, 2008). In Chapter Three, I introduced Michel Foucault's conception of power to help explain intra and inter professional aggression as I felt that Foucault's perspective fit well with this critical ethnography.

Power is said to be most pervasive in "total" institutions such as forensic psychiatric institution where there is an "agenda" of social control (Holmes & Federman, 2006). Total institutions were defined by Goffman (1968) as a place of residence and work where a large number of people in similar situation, live cut off from the larger society for a considerable period of time, lead a reclusive life together where modalities are explicitly and meticulously regulated (p. 41 – free translation). "Inmates" living in total institutions have tightly scheduled daily activities imposed from above through a system of explicit and formal rules which are enforced by a body of officials (Goffman, 1968). As such, in these institutions employees are often in a position of formal power over "inmates" who need to request permission to be allowed simple acts such as smoking, shaving or even using the telephone. Consequently, these "total" institutions have a different conception of and relationship with power.

Fundamental differences were identified between the two organizations included in this study. For example, the psychiatric hospital appeared to still be guided by medical hierarchy where psychiatrists were still perceived as superior to other health care professionals and where many front-line employees were still afraid to discuss/confront issues with psychiatrists. While the psychiatric hospital was attempting to change its culture, there was still evidence of reluctance to hold psychiatrists accountable for their bad behaviours,

especially at one site. The fact that the psychiatric hospital was once an asylum and is rooted in history dating back a century might serve to partially explain the ongoing medical dominance and resulting power struggles.

Hospitals are known to be hierarchical organizations. The current study identified hierarchy as an element of power. The “traditional pyramid of hierarchical power” was defined by DiPalma as:

“a series of horizontal levels of authority that are broader at the base and narrow toward the peak. The pyramid does not merely stand on its base with a single point of power at the top. The bureaucratically organized pyramid of hierarchy is strengthened by the support of horizontal stacks of authority controlled from the top down to the base. Through its tidy lines of authority and communication, hierarchy offers comfort and clarity” (p. 298)

As such, hierarchy can be described as both a *structure* and *process* where “the shape of the structure will influence the processes that are possible within it” (DiPalma, 2004, p. 299). Vredenburg & Brender (1998) explained that there are a lot of incentives that make people want to abuse power in organization, incentives such as reward and status acquisition as well as autonomy.

“Power represents the currency in organizations that allows individuals and groups to gratify needs and attain goals. In addition, institutionalized forms of power constitute a primary source of privilege and prestige in a democratic society” (p. 1338).

The study findings substantiate the assessment that hospitals are hierarchical organizations and support Weber’s concept of professional closure described in Chapter Three. Weber’s work on professional closure can be summarized using the following example. The evidence of hierarchy continuing to play a role in relationships remains prevalent today and is made visible within health care organizations by the position physicians and most especially specialists hold. As other health care professionals struggle to

have their disciplines recognized and advanced, the dominant disciplines push back in an attempt to maintain their positions. As demonstrated by the analysis, this sometimes creates conflict and aggression.

While they have not used the work of Weber to base their analysis, a Canadian study by Salhani & Coulter (2009) explored the micro political struggles of nursing to gain professional legitimacy and therapeutic space amidst a new era of collaborative practice on a psychiatric unit. The study found intra-professional struggles within nursing where nurses with different academic degrees (baccalaureate versus masters) and non degree nurses had different loyalties and interests resulting in tensions. The study also identified inter-professional struggles between nursing and non-nursing professionals (such as psychiatrists, social workers, psychologists, occupational therapists and chaplains) arising from nursing's attempt to gain professional autonomy and expand its professional jurisdiction.

The current study identified hidden agendas as an instrument of power. In effect, while it is possible to observe how some people appear to repeatedly sabotage initiatives, it is often harder to understand the reason for such behaviours. In this study, hidden agendas were framed in the contexts of competition and rivalry whereby certain individuals were identified as willing to go to great lengths to move personal agendas forward and achieve success. While people with hidden agendas may be successful in attaining their goal(s), they may do so at great cost to themselves and others. Their reputations might be tarnished and they may be identified as non-team players. Moreover, their peers may distrust and disrespect them, knowing that when collaboration is needed, they may not be able to count on them. Finally, the overall perception of organizational justice may be blemished as a result of hidden agendas for "an organization" may be portrayed as being competitive and dishonest.

Conversely, it is important to validate intent when hidden agendas are suspected. In effect, some individuals can be perceived as sabotaging initiatives because of a hidden agenda when in fact they may be only displaying an inability to cope with change. While the end result remains the same (i.e. the initiative is undermined), these people cannot be described as being malicious. They are attempting to maintain status quo to protect themselves.

The above example also raises the issue of formal versus informal power, referred to as *legitimate power* by French & Raven's (1959). While people attempting to sabotage an initiative are not always in a position of legitimate or formal power, they can however hold enough informal power to be able to derail a project. In some instances, people with informal power (e.g. informal leaders) can in fact have more power and influence than individuals who hold legitimate/formal power (e.g. manager). In the context of change management, it is therefore important to have informal leaders included in the decision making process so they understand the reason for the change and buy into it. Otherwise, they may work hard behind the scenes to derail the project, hence the perception of having a hidden agenda. On the other hand, not everyone has the power to sabotage an initiative. People who do not hold either formal or informal power will have limited influence on others. In effect, people with little credibility or power tend not to have many followers.

Limitations of the Study

Research is always susceptible to bias. In this study, every interview was conducted face to face with participants. As a result, it is possible that some participants might have provided answers compatible with popular social norms or with what they thought the researcher wanted to hear resulting in a social desirability response bias. Additionally, as per participants' preference, all interviews were conducted at their workplace. Consequently, one

might wonder if participants would have answered questions differently had they been interviewed outside the organization for which they work. As well, since they were at work, some participants might have been preoccupied by other activities going on around them at the time of the interview thus disrupting their thought processes and preventing them from solely focussing on the interview questions. Some interviews were actually interrupted by people needing to speak to participants. In such cases, participants may have forgotten information they wanted to share as a result of having their thoughts interrupted. As well, some might have expedited the interview process following the interruption so that they could return to work soon to deal with the issues at hand.

Given the small number of participants taking part in a qualitative study, the contribution of each participant becomes crucial. As such, one might wonder about the self-selection bias of participants. While it may be argued that the views of 23 participants are more than enough to be representative and achieve data saturation (Guest, Bunce & Johnson, 2006), there is still a concern that people who chose not to take part in the study might have provided a different perspective than those who agreed to be interviewed. It is hypothesized that only individuals who felt articulate enough to participate in a face to face interview volunteered to take part in the study, thereby excluding people who might have had valuable information to contribute.

While this study was based on the principles of critical ethnography, an “authentic” ethnography was not conducted. As such, a different perspective could have been acquired if direct observation of actual behaviours would have taken place. Additionally, only the perspective of nursing managers was acquired during this study. A larger study designed to collect data from different groups would have made it possible to compare perspectives. For example, a study designed to observe the interaction of several health care providers and

managers could have provided valuable insights into professional relationships and how these contribute to the management of intra/inter professional aggression.

The analysis included the interpretation of interview transcripts. As with any type of interpretation, there is a risk that the researcher's pre-conceived ideas, values and/or experiences influenced the thematic analysis thus providing deficient or erroneous findings. While this remains a possibility, steps were taken to reduce such risk. For example, the thesis advisor reviewed and discussed the findings, and I acknowledged my epistemological stance at the beginning of the study. I explicitly positioned myself as adhering to a critical theory paradigm. In openly articulating the epistemological stance, the reader is alerted up front that the study results might have been understood differently if interpreted by someone adhering to a totally different paradigm.

Implications for Nursing

The findings of this study provide a number of directions for the future. These are discussed in the context of nursing practice, education, administration and research.

Practice

Several recommendations for nursing practice arose from the study findings. First, as role confusion was identified as one of the reasons for inter-professional aggression, there is a need for health care professionals to better understand each other's role and how they all fit together. Inter-disciplinary meetings can serve as a venue to discuss roles and scopes of practice. Such meetings could see each profession describing its roles and responsibilities and what is within its scope of practice. A description of the role and scope of practice of managers should also be included.

Second, since the roles and scopes of practice of different health care providers often overlap, there is a need to discuss which health care provider is best suited to provide a

certain type of care in a specific context. While several health care providers may be able to provide the same care, it is not always cost effective as well as beneficial to the patient to have the providers with the most qualifications provide care. The idea of having health care providers practice to the full scope of their abilities suggests that while they may take on new tasks, they will also have to delegate other tasks to other providers.

Third, the study identified high functioning teams as having the potential to impede intra/inter professional aggression. As such, team development and team building activities ought to be implemented. However, participants cautioned that team building activities should be delivered by knowledgeable people as building teams involved more than “gathering people together in a room”. To be relevant, the learning acquired during team building activities should be transferable and sustainable once team members are back functioning at the place of work within their respective teams.

Fourth, the study identified establishing a peer council as a potential strategy to support the management of workplace aggression. The peer council would be an employee led initiative where trained front line staff would act as mediators to serve as an intermediate step between staff attempting to sort out issues on their own rather than staff having to bring their issues to their manager thus making the complaint more formal. Since the peer council would have no real authority, its role would be to support individuals formulating resolutions rather than the peer council intervening to solve issues for staff.

Finally, responsibility and accountability were raised on several occasions by a number of participants. As such, there is a need for employers to remind regulated health professionals, who are obligated to practice according to standards and codes of conducts, of their responsibilities under their professional license. Employers could offer information sessions where representatives of health care professionals’ regulatory body (such as the

College of Nurses of Ontario) would review professional expectations and inform employees of consequences if expectations are not met. As a result, regulated health care professionals may think twice about behaving badly if they know that their governing body does not uphold such behaviours.

Education

Nursing education is a continuing process occurring initially at the entry to practice level (i.e. initial college/university preparation) and continuing throughout a nurse's career via continuing education opportunities (i.e. professional development activities). The study highlighted the importance of acquiring skills in effective communication and dealing with difficult people, especially in light of the fact that these are becoming skills required by employers. As such, training on managing professional relationships, team work and assertive communication skills should be included in the entry to practice curriculum while health care professionals go through their basic education. The early acquisition of such skill would not only help students during their clinical placements, since many will have already experienced aggression and bullying, but would also equip them with the skills now required as basic competencies by many employers.

The need for ongoing training and development opportunities for both managers and front-line staff was repeatedly identified during this study. The importance of increasing knowledge and skills in conflict resolution, dealing with difficult people, dealing with workplace aggression and ineffective communication was clearly stated. However, study participants cautioned that training should be more than an overview of theoretical concepts, especially in light of the fact that all employees have more than likely experienced some challenges with communication as well as having to respond to some form of conflict. As such, training should include case studies, scenarios and role playing opportunities where

people bring examples of real life situations they had to deal with and discuss lessons learned. Whenever possible, training should also be multidisciplinary to ensure that different perspectives are heard and should include take-home materials for future reference such as tool kits or handbooks.

The importance of coping skills was also highlighted in this study. *Self control* as well as *emotional skilfulness* were identified as promising concepts to improve coping skills. Training around these two concepts could be integrated to both entry to practice curriculum as well as continuing education activities. Additionally, training could include a personality assessment component where participants (either students or employees) would have the opportunity to learn more about themselves, their coping tendencies, their triggers etc. Once better aware of who they are, people could better understand how other personality types may react to them, and how these will impact team work.

The issue of workplace aggression also has a legal component. For example, on December 15, 2009, the Ontario Occupational Health and Safety Act (OHSA) was amended to include measures to prevent violence and harassment in the workplace. These amendments take effect on June 15, 2010 and require employers to: 1) create policies that will address workplace violence and harassment; 2) to develop procedures to address both workplace violence (including domestic violence) and harassment; 3) have employees undertake training; 4) conduct a workplace violence risk assessment, 5) recognize new worker rights to refuse work, 6) ensure new employer reporting requirements if a worker is disabled from performing work due to workplace violence. As a result, employers should take this opportunity to provide employees with training that will inform them of the change in law, review the organization's policy on workplace aggression, inform them of the roles and responsibilities each party holds in dealing with this issue.

This study identified power as playing a role in both aggression and aggression management. As such, entry to practice curriculum should include a component addressing the issue of power, and how power and politics are omnipresent in the workplace and can contribute to both power struggles and aggression.

Administration

Several strategies relating to the hiring process were identified in this study. First, there is a need to incorporate as part of recruitment interviews questions pertaining to hospital values and ability to manage conflict. Second, “ability to manage conflict” or “possess conflict resolution skills” should be incorporated as a core competency in all job descriptions. Third, the importance of “gut feeling” and not hiring a potential candidate if someone on the selection committee has a “funny feeling” was raised. Finally, the need to keep on top of probationary period to ensure that employees who are made permanent fit well within the organization was stressed.

The issue of fairness in dealing with intra/inter professional aggression was also acknowledged during this study. Some strategies to ensure fairness were identified. First mandatory training on policies pertaining to workplace aggression (including related policies) and codes of conduct (if any) should be provided for every employee, followed by consistent application and enforcement of these policies. Similarly, whenever possible or appropriate, protocols should be implemented organizationally to ensure consistency between units and managers. This strategy would help alleviate staff cross comparisons. Second, a review of every discipline case going beyond a level of verbal warning should be undertaken by senior management (either by the vice president of nursing practice or senior manager of another discipline) to ensure consistency between directors and managers. Third, management should be able to make enforceable recommendations where staff would have

to show that they have complied with recommendations (e.g. took an anger management course). Additionally, a “follow-through” should be ensured once a process is initiated, regardless of how complicated or litigious the issue becomes. Fourth, the use of progressive discipline should be encouraged including suspension without pay and dismissal for extreme cases or in cases where no improvement or sustained improvement is realized over time.

The need for a “formal” follow-up processes following instances where managers had to deal with workplace aggression was also recognized. The follow-up should include an opportunity for managers to debrief and discuss, without fear of being judged, how the management process went, what went well and what could have been done differently and be reassured regarding actions taken. The follow-up could be in the form of a more formalized peer support system or having access to professionals specializing in conflict resolution.

The value of having managers and directors informally discuss issues was mentioned. As such, a room for the purpose of informal management meetings (such as a lunch room dedicated to management only) should be available. Such a room would allow for informal networking and mentoring.

Research

To my knowledge, this is the first study in which nursing managers were asked to provide their perspective on managing intra/inter professional aggression. As such, future research should investigate whether taking a pro-active step toward the management of intra/inter professional aggression by actively managing perceptions and emotions before they degenerate into aggression do in fact decrease instances of aggression. Future research should also explore the issue of accountability (or lack of accountability) including developing strategies to ensure that people are held accountable for their actions and whether holding people accountable might alter acting out behaviours.

The need to invest in human resources was clearly identified in this study. However, given this time of budget cuts and constraints, human resources are often identified as costs rather than assets. Further research should include a cost analysis comparing the money saved in increased retention, decreased absenteeism, and decreased intra/inter professional aggression, to the money required to create a healthier work environment for health care professionals. As well, in light of the amount of time and energy required of managers and other professionals (such a human resources department, labour relations officer, etc), there is a need to include a cost analysis comparing the time (cost) currently required to deal with issues of workplace aggression, to the time (cost) necessary to (pro) actively deal with such issues. For example, if the amount of time spent on dealing with intra/inter professional aggression is reduced, there would be time and resources available for designing and implementing initiatives to improve and strengthen the workplace such as empowering high and middle performers instead of always focussing time, energies and resources in dealing with low performers.

CONCLUSION

The issue of workplace aggression is well documented in the literature. While there is a need to manage all forms of workplace aggression, responding to intra/inter professional aggression is crucial as this form of aggression is said to be more devastating for the victim. While nursing managers were identified as playing a central role in the management of workplace aggression, their perspective as to whether they are able to deal with instances of intra/inter professional aggression given their current work environment and working conditions is absent from the literature. This study thus provided an opportunity for this group to voice their point of view regarding this issue.

As a starting point to undertake this research, a new theoretical model was proposed derived from a combination of the work of Girard, Weber and Foucault. The resulting theoretical framework, which was subsequently published, allowed for a re-theorization of intra/inter professional aggression including the provision of a broader understanding of the factors underpinning the issue.

This research found that intra/inter professional aggression often occurs as a result of erroneous perceptions and out of control emotions. Several factors in both the physical and the social/cultural work environments play a role in the issue. Factors such as small and crowded nursing stations, poor heating and/or air conditioning and lack of staff restrooms; as well as the simultaneous implementation of multiple initiatives combined with heavy workloads and a shortage of health care professionals all contribute to the proliferation of instances of workplace aggression.

Furthermore, the findings identified that dealing with workplace aggression can be difficult and time consuming for nursing managers. In effect, managers do not always feel

prepared to deal with the problem of intra/inter professional aggression. In some instances, they come to question whether they are good leaders or maybe contributing to the problem, and sometimes even doubt their abilities to be able to positively resolve such a widespread problem. A few managers, who related experiences where they themselves became the victim of inter-professional aggression, wondered if they would in fact remain managers. These findings highlight the need for managers to be supported when having to manage intra/inter professional aggression. Participants identified sources of support both within and outside the organization. Sources of supports within the organization included their own boss, their colleagues, nurse educators, the human resources department including labour relations, the legal department, occupational health services and spiritual services. External sources of support included colleagues working in a different organization, practice consultants with the regulating body (College on Nurses of Ontario), the Employee Assistance Program and discussion groups such as being part of on-line distance education programs. For the most part, managers felt supported when having to respond to instances of intra/inter professional aggression.

The analysis also found that managers were more comfortable responding to instances of intra/inter professional aggression when it involved employees they were managing. Having to deal with instances of intra and/or inter professional aggression involving staff they did not manage (e.g. staff on a float team), or staff not considered an employee of the hospital (such as physicians) proved to be more challenging. Additionally, the type of aggression also played a role in the choice of action taken. A repeat offender or someone committing a serious aggressive act (even for the first time) were often dealt with more sternly than someone for which being aggressive was out of character or that the aggressive act was identified as having little consequences.

The findings also included a description of strategies and specific actions that could be taken by nurse managers to prevent, impede and/or respond to intra/inter professional aggression. These are summarized using a well known model in public health, that of primary, secondary and tertiary prevention. More specifically, primary prevention is an intervention directed at preventing the initial occurrence of a disorder (Diem & Moyer, 2005). In the context of workplace violence management, primary prevention strategies can be described as strategies aiming to identify and manage precursors of aggression and violence, i.e. before aggression and violence occur. Primary prevention strategies at the *individual* level can include: an *orientation* to the work environment (including policies and procedures relating to workplace aggression and violence, and grievance procedures); *education* about types of workplace violence and *training* to recognize early warning signs of aggression and ways to diffuse potentially volatile situations; training can also focus on the development of good communication skills including assertive training and conflict resolution.

Primary prevention strategies at the *organizational* level can include interventions such as: the *careful selection of personnel* (by including questions pertaining to aggression during the initial job interview), as well as to ensure a “good match” between employees’ skills and job requirements; the provision of *adequate staffing* both in terms of numbers and qualification to facilitate positive job performance; a *management style* based on caring and respect combined with good communication skills; the provision of *information* in a timely manner, supported by a strong message by management of zero tolerance towards workplace violence; the improvement of *job design* to avoid work overload and ensure that work provide an appropriate degree of autonomy; the improvement of *workload* to avoid overtime

or too long hours of work; and the development and maintenance of an *organizational culture* centered on respect, trust, and dignity. Additionally, the *design of workplaces* should ensure adequate working space including a place for personnel to relax.

For its part, secondary prevention aims at early detection and intervention (Diem & Moyer, 2005). In the context of workplace violence management, secondary prevention aims at managing low intensity episodes of aggression, such as workplace incivility. Examples of secondary prevention strategies at the *individual* level include: encouraging employees to informally discuss the issue with the parties involved. If not possible, managers should get involved, meet individually with both parties to better understand the issue, and respond to the situation by enforcing the zero-violence policy; and disciplining by providing a verbal warning, a letter to file and even a suspension, as needed.

Finally, tertiary prevention is described as the limitation of disability and rehabilitation (Diem & Moyer, 2005). When used for the management of workplace violence, tertiary prevention serves to respond to medium to high intensity incidents of aggression and their consequences. As such, tertiary prevention strategies can include the termination of employment. It is important to remember that as part of both secondary and tertiary prevention strategies, managers should not only focus on the perpetrator of violence but must also ensure that the victim is able to deal with the situation. As such, managers should recommend the use of resources such as support/counselling by occupational health services and/or the employees' assistance program, as needed.

In summary, the purpose of the current study was to broaden the understanding of the management of intra/inter professional aggression. The three main findings of this research can be recapitulated as:

- 1) aggression management is a non linear process involving managing perceptions, emotions and the actual aggressive act, which are all influenced by omnipresent and insidious power relations;
- 2) aggression management is not solely the responsibility of managers but must involve several actors including the aggressive individual, peers, human resources department and unions; and
- 3) each individual needs to play an active role in aggression management and be held responsible and accountable for his/her actions.

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Appendix A
**Summary Table of Definitions and Typologies
Used to Define Workplace Aggression and Violence**

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
Alexy, E.M. & Hutchins, J.A. (2006)			Several definitions provided but none agreed upon. Using the typology suggested by the UIIPRC (2001).		
Andersson & Pearson (1999)					<u>Typology of workplace mistreatment</u> p. 456 <ul style="list-style-type: none"> • <i>Antisocial behaviour</i> (behaviour that harms organization and/or members) • <i>Deviant behaviour</i> (antisocial behaviour that violates norms) • <i>Aggression</i> (deviant behaviour with intent to harm – includes violence and some forms of incivility) • <i>Incivility</i> (low intensity deviant behaviour with ambiguous intent to harm) • <i>Violence</i> (high intensity, physically aggressive behaviour).

* Health care literature

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
Baron & Richardson (1994)	<p>“Any form of behaviour directed toward the goal of harming or injuring another living being who is motivated to avoid such treatment” p.7.</p> <p><u>Distinction between:</u></p> <ul style="list-style-type: none"> • <i>Hostile</i>(goal is to harm)/<i>instrumental</i> (mean of obtaining non injurious goals) aggression • <i>Reactive</i> (retaliation to provocation) /<i>proactive</i> (aggression initiated without apparent provocation) aggression 				

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
Buss (1961)	<p>“A response that delivers noxious stimuli to another organism” p.1.</p> <p><u>Typology:</u></p> <ul style="list-style-type: none"> • <i>Physical</i> (assault by means of a body part or weapon)-<i>verbal</i> (use of word to inflict harm) • Direct (delivered without an intermediary) -indirect (expressed when victim not present - e.g. vandalism) • Active (actually performing a behaviour)-passive (withholding actions or information) 				

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
CCOHS (2005)			“Any act in which a person is abused, threatened, intimidated or assaulted in his or her employment” including threatening behaviour, verbal or written threats, harassment, verbal abuse and physical attack		
*CNA (2005)			No actual definition provided <u>Typology:</u> <ul style="list-style-type: none"> • Verbal and emotional abuse • Physical violence • Sexual harassment 		

* Health Care Literature

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
Courcy & Savoie (2003) and Courcy (2004)		<p>“Behaviour by a member or ex-member of an organization going against the organization’s current norms with the intent to harm or coerce another member” 2003 - p. 20. (free translation)</p>	<p>Two forms:</p> <ul style="list-style-type: none"> • “Intentional physical aggression perpetrated by an attacker” 2003 - p. 20 (free translation) • “Coercion carried out by a perpetrator to bring the target to act against his/her will” 2003 - p.20 (free translation) <p><u>Categories (2004):</u> (free translation)</p> <ul style="list-style-type: none"> • Criminal (someone outside the organization commits a crime – e.g. hold-up) • Occupational (client who perpetrates an act of violence toward staff) 	<p>“Act of aggression, repeated over time” 2003 - p. 20. (free translation)</p> <p><u>Typology (2004):</u> (free translation)</p> <ul style="list-style-type: none"> • Bullying (often comes from co-workers – aim at isolating by ostracizing or ridiculing the victim) • Mobbing (often carried out by immediate supervisor and aims at discrediting the victim) • Abuse of power (behaviours that are above and beyond the legitimate power granted by the organization) 	

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
Courcy & Savoie (2003) and Courcy (2004) – Cont'd			<ul style="list-style-type: none"> • Domestic (perpetrator of violence comes to workplace to assault a specific worker to whom he/she has or has had a personal relationship with) • Workplace (co-worker perpetrate violence towards another co-worker) <p><u>Typology (2004):</u></p> <ul style="list-style-type: none"> • Psychological (can have an effect on person's self esteem or self confidence) • Physical (encompass injury to the body and/or damage to objects belonging to the victim) 		

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
Courcy & Savoie (2003) and Courcy (2004) – Cont'd			<ul style="list-style-type: none"> • Sexual (includes sexual harassment, sexual discrimination and sexist remarks) • Financial (victim's financial well being compromised – e.g. not paid to what is due or in a timely fashion) 		
Engel (2004)			<p>“An act or a continuum of behaviours that jeopardizes one's physical and/or psychological well-being. A threat or a perceived threat to one's life and/or a risk to one's safety, health or integrity. An act of verbal, psychological, sexual and/or physical abuse. Can be an attack on one's person or personal</p>		

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
Engel (2004) Cont'd			beliefs or an attack on one's property. The intent is to control or dominate, to injure or destroy, or to deprive a person of dignity" p.50.		
*Farrell et al. (2006)		No actual definition provided <u>Typology:</u> <ul style="list-style-type: none"> • Verbal abuse • Physical abuse 			
*Gerberich et al. (2004);			<u>Work related violence</u> "any activities associated with the job or events that occur in the work environment involving the intentional use of physical force or emotional abuse against an employee resulting in physical		

* Health Care Literature

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
*Gerberich et al. (2004) Cont'd			or emotional injury and consequences” p. 496. <u>Typology:</u> <ul style="list-style-type: none"> • Physical assault • Non-physical forms of violence 		
Griffin & Lopez (2005)					<u>Bad behaviour in organization</u> “Any form of intentional (as opposed to accidental) behaviour that is potentially injurious to the organization and/or to individuals within the organization” p.988 <u>Typology:</u> <ul style="list-style-type: none"> • <i>dysfunctional behaviour</i> (intended to have negative consequences for another individual and/or group and/or the organization itself)

* Health Care Literature

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
Griffin & Lopez (2005) Cont'd					<ul style="list-style-type: none"> • <i>workplace deviance</i> (behaviours that differ from social norms - can be either destructive or constructive). • <i>workplace aggression</i> (highly assertive non-physical behaviour directed toward a person or object (can either be destructive or constructive). • <i>workplace violence</i> (highly assertive physical behaviour directed toward a person or object - can either be toward person(s) or object(s)). • <i>antisocial behaviour</i> (alternative term for dysfunctional behaviour - should use dysfunctional behaviour whenever possible).

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
*Hesketh et al. (2002); Ducan et al. (2001)			No actual definition provided. <u>Typology:</u> <ul style="list-style-type: none"> • Physical assault • Threat of assault • Emotional abuse • Verbal sexual harassment • Sexual assault 		
*Hutton (2006)			No actual definition – just a distinction from workplace incivility: “when there is a clear intent to harm” p. 22		<u>Workplace incivility</u> “Low –level, deviant behaviour in the workplace” p. 22 Differs from workplace violence “in that it has an ambiguous intent to harm” p.22
ILO et al. (2002)			“Incidents where staff are abused, threatened or assaulted in circumstances related to their work, including commuting to and from work,		

* Health Care Literature

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
ILO et al. (2002) Cont'd			involving an explicit or implicit challenge to their safety, well-being or health" p.3.		
Neuman & Baron (1998)		<p>"Efforts by individuals to harm others with whom they work, or have worked, or the organizations in which they are presently, or were previously, employed" p.395.</p> <p><u>Typology:</u></p> <ul style="list-style-type: none"> • <i>Expression of hostility</i> (behaviours which are verbal or symbolic in nature) • <i>Obstructionism</i> (behaviours that impede the target's ability to perform effectively his/her job or with an organization's ability to meet its objectives) 	"Refers only to instances involving direct physical assaults" p. 393.		

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
Neuman & Baron (1998) Cont'd		<ul style="list-style-type: none"> • <i>Overt aggression</i> (typically associated with workplace violence such as physical attack, theft, destruction of property). 			
*Mason & Chandley (1999)		<p>“Disposition to show hostility towards becoming violent” ... “An extreme negative tendency towards becoming assaultive” p.6.</p>	<p>“Harmful and unlawful use of force or strength; or caused by physical assault” ... “on another person either with or without the use of weapons” p. 6.</p>		
O’Leary-Kelly, Griffin and Glew (1996)		<p><u>Organization-motivated aggression</u> “attempted injurious or destructive behaviour initiated by either an organizational insider or outsider that is instigated by some factor in the organizational context” p.229.</p>	<p><u>Organization-motivated violence</u> “significant negative effects on person or property that occur as a result of organization-motivated aggression. p.229.</p>		

* Health Care Literature

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
*Rippon (2000)		<p><u>Aggression</u> (in general) “is a behaviour with intent that is directed at doing harm to a living being whether harm result or not, or with wilful blindness as to whether harm would result ... Can occur with or without a weapon, can incorporate psychological and emotional tactics such as depriving or withholding nourishment in the form of food, love or affection ... Can be the manifestation of anger and can be directed either toward oneself or other persons. Can also occur in the absence of anger” p. 456.</p>	<p><u>Violence</u> (in general) “reserved for those acts of aggression that are particularly intense, and are more heinous, infamous or reprehensible” p. 456.</p>		

* Health Care Literature

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
*Rippon (2000) Cont'd		<u>Typology:</u> Based on Buss (1961) <ul style="list-style-type: none"> • Physical/verbal • Active/passive • Direct/indirect 			
Robinson & Bennett (1995)					<u>Deviant Behaviours</u> “voluntary behaviour that violates significant organizational norms and in doing so threatens the well-being of an organization, its members, or both” <u>Typology</u> <ul style="list-style-type: none"> • <i>Production deviance</i> (behaviours that violates the formally proscribed norms delineating the minimal quality and quantity of work to be accomplished) • <i>Political deviance</i> (engagement in social interaction that puts other individuals at a personal or political disadvantage)

* Health Care Literature

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
Robinson & Bennett (1995) Cont'd					<ul style="list-style-type: none"> • <i>Property deviance</i> (instances where employees acquire or damage the tangible property or assets of the work organization without authorization) • <i>Personal aggression</i> (behaving in an aggressive or hostile manner toward other individuals)
University of Iowa Injury Prevention Research Center (UIIPRC) (2001)			<u>Typology</u> <ul style="list-style-type: none"> • Type I – <i>criminal intent</i>: perpetrator has no legitimate relationship to the business or its employees, and is usually committing a crime in conjunction with the violence. • Type II – <i>customer/ client</i>: perpetrator has a legitimate relationship with 		

	Human aggression	Workplace aggression	Workplace violence	Workplace harassment	Others
University of Iowa Injury Prevention Research Center (UIIPRC) (2001) Cont'd			<p>the business and becomes violent while being served by the business.</p> <ul style="list-style-type: none"> • Type III – <i>Worker on worker</i>: perpetrator is an employee or past employee of the business who attacks or threatens another employee(s) or past employee(s) in the workplace. • Type IV – <i>Personal relationship</i>: perpetrator does not usually have a relationship with the business but has a personal relationship with the intended victim. 		

Appendix B
Information Letter and Consent Form
Interview Participant

Understanding the Management of Intra/Inter Professional Aggression: A Critical Nursing Ethnography

Principal Investigator

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School of Nursing, University of Ottawa

Thesis Supervisor

Dave Holmes, RN, PhD
Professor, School of Nursing, University of Ottawa

INFORMATION LETTER AND CONSENT FORM INTERVIEW PARTICIPANT

Introduction

You are invited to participate in a study which will contribute to the partial fulfillment of the requirements for a degree of Doctor of Philosophy. The purpose of this study is to broaden the understanding of how nursing managers respond to and deal with intra/inter professional aggression. The role of the organization will also be examined as part of the study. Before you decide to participate, it is important that you understand the content of this consent form, the risks and benefits to make an informed decision, and ask any questions if there is anything that you do not understand. Please read this entire consent form and take your time to make a decision. If you decide to participate in this study, you will be asked to sign this informed consent form.

Study objectives

The study will serve to answer the following questions:

1. Which aspects of organizational/unit culture, structures and systems influence the management of intra/inter professional aggression by nurse managers?
 - 1.1 How do factors in the organizational environment play a role in the management of intra/inter professional aggression?
 - 1.2 How can nurse managers be supported when having to manage intra/inter professional aggression?
2. What are the strategies deployed by nurse managers to deal with intra/inter professional aggression?
 - 2.1 What are the specific actions taken by nurse managers, when managing intra/inter professional aggression on their units?
 - 2.2 How do the type of perpetrator and the type of aggression play a role in the choice of action taken?

Implications of your participation in this study

Your participation in this study will consist of participating in an individual semi structured interview that expected to take one hour, but no longer than one and a half hours, unless mutually agreed upon by the researcher and participant. Additionally, you may be contacted again to clarify some of the information received or to discuss findings. This may require approximately thirty minutes, but no longer than one hour.

Your participation in this study is voluntary. If you agree to participate, you are free to withdraw from the study at any time without penalty of any kind. You may also decline to answer a particular question or questions, and/or request that the digital recorder be turned off at any point during the interview.

Risks and benefits

While no foreseeable risks are associated with participation in this study, answering some of the questions may cause you some psychological discomfort if you wish to indicate negative opinion as part of the interview. You will receive no direct benefit from your participation. However, the data collected from this study may contribute to the development of aggression prevention and management strategies targeted to the specific themes that will emerge from the study findings.

Confidentiality

All the information you provide will remain strictly confidential. All appropriate measures will be taken during the study to ensure that the confidentiality of the data collected about you is maintained. Only an identification number will appear on the interview transcript; your name will not appear in any report. Only the researcher will have access to the list of names and identification numbers. *Under no circumstances will your personal results be sent to your employer or to other employees.* All the information will be kept locked away in the office of the researcher. In the event that study results are published, measures will be taken to make it impossible to identify any individual.

Questions

Information regarding your rights as a participant may be addressed to the Protocol Officer for Ethics in Research, University of Ottawa, Tabaret Hall, 550 Cumberland Street, Room 159, Ottawa, ON K1N 6N5; Tel.: (613) 562-5841; Email: ethics@uottawa.ca

If you have any questions regarding this research project, you can contact the researcher or her supervisor

Supervisor

Professor Dave Holmes, PhD
Faculty of Health Sciences
School of Nursing
University of Ottawa
451 Smyth Rd.

Researcher

Isabelle St-Pierre, PhD (cand.)
Faculty of Health Sciences
School of Nursing
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I acknowledge that I have read and understood this consent form, particularly as it concerns the nature of my participation in the research project. I acknowledge that the project has been explained to me, that all my questions have been answered and that I have had the time I needed to make a decision. I freely and voluntarily consent to participate in this project. I will be given a signed copy of this form.

Name of participant: _____
Signature _____ Date: ____/____/____
Yr/ Mo/Day

Name of researcher: _____
Signature _____ Date: ____/____/____
Yr/ Mo/Day

Comprendre la gestion de l'agression intra- et interprofessionnelle : une ethnographie critique en soins infirmiers

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LETTRE D'INFORMATION ET FORMULAIRE DE CONSENTEMENT ÉCLAIRÉ DU PARTICIPANT À L'ENTREVUE

Introduction

Vous êtes invité(e) à prendre part à une étude s'inscrivant dans le cadre des exigences d'un diplôme de Docteur en philosophie. Cette étude a pour but d'acquérir une meilleure compréhension de la façon dont le personnel cadre infirmier traite l'agression intra- et interprofessionnelle. Le rôle de l'organisation sera également examiné dans le cadre de l'étude. Avant de prendre une décision quant à votre participation à cette étude, il est important pour vous de comprendre le contenu du présent formulaire de consentement, de connaître les risques et les bienfaits associés à l'étude afin de pouvoir prendre une décision éclairée, et de poser des questions s'il y a quoi que ce soit que vous ne comprenez pas. Veuillez lire ce document au complet et prendre le temps d'y réfléchir. Si vous décidez de participer à l'étude, on vous demandera de signer le présent formulaire de consentement éclairé.

Objectifs de l'étude

L'étude a pour but de répondre aux questions suivantes :

1. Quels sont les aspects de la culture de l'organisation/unité, des structures et des systèmes qui influent sur la gestion de l'agression intra- et interprofessionnelle par le personnel cadre infirmier?
 - 1.1 De quelle façon les facteurs présents dans le milieu organisationnel influencent-ils la gestion de l'agression intra- et interprofessionnelle?
 - 1.2 Comment le personnel cadre infirmier peut-il être appuyé dans la gestion de l'agression intra- et interprofessionnelle?
2. Quelles sont les stratégies déployées par le personnel cadre infirmier pour faire face à l'agression intra- et interprofessionnelle?

- 2.1 Quelles sont les mesures prises par le personnel cadre infirmier dans le but précis de gérer l'agression intra- et interprofessionnel au sein de son unité?
- 2.2 En quoi le type d'agresseur et le type d'agression influencent-ils le choix de la mesure prise?

Interventions prévues dans le cadre de l'étude

Dans le cadre de votre participation à cette étude, on vous demandera de prendre part à une entrevue individuelle semi-structurée, dont la durée prévue est de 1 heure, mais qui pourrait durer jusqu'à 1 heure et demie au maximum, à moins d'un commun accord entre la chercheuse et le participant. De plus, on pourrait vous contacter de nouveau afin de clarifier certains des renseignements fournis ou de discuter des résultats. Cela pourrait prendre environ 30 minutes, mais pas plus de 1 heure.

Votre participation à cette étude est volontaire. Si vous acceptez d'y participer, vous pouvez vous en retirer à n'importe quel moment sans subir quelque pénalité que ce soit. Vous avez également le droit de refuser de répondre à une ou des questions en particulier et/ou de demander que l'on interrompe l'enregistrement à n'importe quel moment durant l'entrevue.

Risques et bienfaits

Bien qu'aucun risque prévisible ne soit associé à la participation à cette étude, le fait de répondre à certaines questions pourrait vous mettre psychologiquement mal à l'aise si vous désirez émettre une opinion défavorable durant l'entrevue. Votre participation à l'étude ne vous apportera aucun bienfait direct. Toutefois, les données recueillies au cours de l'étude pourraient contribuer à la mise en œuvre de stratégies de prévention et de gestion de l'agression axées sur les thèmes qui seront mis en évidence dans les résultats.

Confidentialité

Toute l'information que vous nous fournirez sera traitée de manière strictement confidentielle. Toutes les mesures appropriées seront déployées durant l'étude afin d'assurer le maintien de la confidentialité des données recueillies à votre sujet. Seul un numéro d'identification figurera sur la transcription de l'entrevue; aucune mention de votre nom ne sera faite dans quelque rapport que ce soit. Seule la chercheuse aura accès à la liste des noms et des numéros d'identification. *Vos résultats personnels ne seront en aucun cas présentés à votre employeur ou à d'autres employés.* Toute l'information sera gardée sous clef dans le bureau de la chercheuse. Si les résultats de l'étude sont publiés, des dispositions seront prises afin que toute identification des sujets soit impossible.

Questions

Vous pouvez obtenir de l'information concernant vos droits en tant que participant auprès du Responsable de l'éthique en recherche, Université d'Ottawa, Pavillon Tabaret, 550, rue Cumberland, salle 159, Ottawa, ON K1N 6N5 ; Tél.: (613) 562-5841 ; Courriel : ethics@uottawa.ca

Si vous avez des questions au sujet de ce projet de recherche, veuillez communiquer avec la chercheuse ou son superviseur.

Superviseur

Professeur Dave Holmes, Ph.D.
Faculté des sciences de la santé
École des sciences infirmières
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451, chemin Smyth

Chercheuse

Isabelle St-Pierre, PhD (candidate)
Faculté des sciences de la santé
École des sciences infirmières
Université d'Ottawa
451, chemin Smyth

Je reconnais avoir lu et compris le présent formulaire de consentement, particulièrement en ce qui a trait à ma participation au projet de recherche. Je reconnais que le projet m'a été expliqué, que j'ai obtenu réponse à toutes mes questions et que j'ai disposé du temps nécessaire pour prendre une décision. Je consens librement et volontairement à participer à ce projet. Je recevrai une copie signée du présent formulaire.

Nom du participant : _____
Signature _____ Date : ____/____/____
année/mois/jour

Nom de la chercheuse : _____
Signature _____ Date : ____/____/____
année/mois/jour

Appendix C
Self Administered Socio-Demographic Questionnaire

Self Administered Socio-Demographic Questionnaire

Date : ____/____/____ 200__

I.D. number : _____

Day/Month/Year

Please answer the following questions by marking in the space provided.

1. How many years have you been employed in nursing?

- less than a year
- a year or more, but less than five years
- five years or more, but less than ten years
- ten years or more, but less than 20
- 20 years or more

2. How many years have you been employed as a nursing manager?

- less than a year
- a year or more, but less than five years
- five years or more, but less than ten years
- ten years or more, but less than 20
- 20 years or more

3. How many years have you been employed in this hospital?

- less than a year
- a year or more, but less than five years
- five years or more, but less than ten years
- ten years or more, but less than 20
- 20 years or more

4. How many years have you been employed on this/these unit(s)?

- less than a year
- a year or more, but less than five years
- five years or more, but less than ten years
- ten years or more, but less than 20
- 20 years or more

5. How many units do you manage?

- 1
- 2
- 3
- 4
- more than 4, please specify: _____

6. How many employees report to you (span of control)?

- less than ten
- ten or more, but less than 20
- 20 or more, but less than 30
- 30 or more, but less than 40
- 40 or more, but less than 50
- 50 or more, please specify: _____

7. What is your highest level of educational preparation (in nursing or other)?

- College/CEGEP
- University: Certificat/Dipl.
- BSc
- MSc
- PhD
- Fellowship

8. Have you ever received formal training on
- Conflict management/resolution
 - Violence/aggression management

9. What is your age group?
- Less than 25 years old
 - 25 to 35 years old
 - 36 to 45 years old
 - 46 to 55 years old
 - 56 to 65 years old
 - Over 65 years old

10. Are you?
- Female Male

Questionnaire auto-administré portant sur les caractéristiques socio-démographiques

Date : ____ / ____ /200____
jour/mois/année

Numéro d'ident. : _____

Veillez répondre aux questions suivantes en cochant la case qui se trouve vis-à-vis votre réponse.

1. Depuis combien d'années travaillez-vous dans le domaine des soins infirmiers?

- Moins de 1 an
- 1 an et plus, mais moins de 5 ans
- 5 ans et plus, mais moins de 10 ans
- 10 ans et plus, mais moins de 20 ans
- 20 ans et plus

2. Depuis combien d'années êtes-vous membre du personnel cadre infirmier?

- Moins de 1 an
- 1 an et plus, mais moins de 5 ans
- 5 ans et plus, mais moins de 10 ans
- 10 ans et plus, mais moins de 20 ans
- 20 ans et plus

3. Depuis combien d'années travaillez-vous à cet hôpital?

- Moins de 1 an
- 1 an et plus, mais moins de 5 ans
- 5 ans et plus, mais moins de 10 ans
- 10 ans et plus, mais moins de 20 ans
- 20 ans et plus

4. Depuis combien d'années travaillez-vous à cette unité/à ces unités?

- Moins de 1 an
- 1 an et plus, mais moins de 5 ans
- 5 ans et plus, mais moins de 10 ans
- 10 ans et plus, mais moins de 20 ans
- 20 ans et plus

5. Combien d'unités gérez-vous?

- 1
- 2
- 3
- 4
- Plus de 4, veuillez préciser : _____

6. Combien avez-vous d'employés sous votre direction (étendue des responsabilités)?

- Moins de 10
- 10 ou plus, mais moins de 20
- 20 ou plus, mais moins de 30
- 30 ou plus, mais moins de 40
- 40 ou plus, mais moins de 50
- 50 ou plus, veuillez préciser : _____

7. Quel est votre degré de scolarité (études en soins infirmiers ou autre)?

- Collège/cégep
- Université : certificat/dipl.
- B. Sc.
- M. Sc.
- Ph. D.
- Boursier(ère)

8. Avez-vous déjà reçu une formation en :

gestion/résolution des conflits

gestion de la violence/agression

9. À quel groupe d'âge appartenez-vous?

Moins de 25 ans

De 25 à 35 ans

De 36 à 45 ans

De 46 à 55 ans

De 56 à 65 ans

Plus de 65 ans

10. Êtes-vous :

une femme?

un homme?

Appendix D
Focused Interview Guide

Semi-Structured Interview Guide

Pre interview steps

Welcome and introduction

Thank you for taking the time to participate in this interview, my name is ...

Brief review of context for interview

The purpose of this study is to broaden the understanding of how nursing managers respond to and deal with intra/inter professional aggression, and will contribute to my PhD research. The role of the organization will also be examined as part of the study. More specifically, the study will serve to answer the following questions:

1. Which aspects of organizational/unit culture, structures and systems influence the management of intra/inter professional aggression by nurse managers?
 - 1.1 How do factors in the organizational environment play a role in the management of intra/inter professional aggression?
 - 1.2 How can nurse managers be supported when having to manage intra/inter professional aggression?
2. What are the strategies deployed by nurse managers to deal with intra/inter professional aggression?
 - 2.1 What are the specific actions taken by nurse managers, when managing intra/inter professional aggression on their units?
 - 2.2 How do the type of perpetrator and the type of aggression play a role in the choice of action taken?

In order to answer these research questions, I will conduct several individual semi-structured interviews with managers from your organization.

Review and signing of informed consent form by participant (a signed copy of consent will be given to participant)

Caution prior to interview beginning

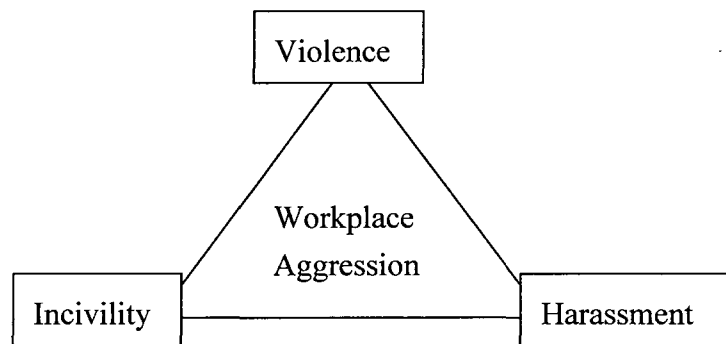
- I will be taking notes during the interview.
- I will sometimes look at the digital recorder during the interview to ensure that it is recording (if participant allows the interview to be recorded).

Questions prior to interview beginning

Do you have any questions before we begin the interview, either pertaining to the interview or to the research project?

Provide participant with definition of workplace aggression and validate his/her understanding of definition.

Before we start, I would like to clarify what is intended by the term workplace aggression. In the context of this study, **Workplace aggression** is a broad concept which encompasses three sub concepts: incivility, harassment and violence. Workplace incivility is defined as low-intensity aggression and includes behaviours such as waiting uninvited impatiently by someone engaged in a conversation, leaving the supply cart empty and not telling anyone. Workplace violence, defined as high-intensity physically aggressive behaviour, includes actions such as being bitten, scratched, spat on and punched. For its part, workplace harassment, is defined as an act of aggression repeated over time and includes bullying, mobbing and abuse of power.



Types of aggression

Four types of aggression have been identified:

- Physical
- Psychological (including verbal, harassment: bullying, mobbing and abuse of power)
- Sexual
- Financial

***Topic Domain 1: Management of Workplace Aggression
from the Managers' Perspective***

- 1 You expressed an interest in participating in this study because as a manager, you had to manage an act of intra/inter professional aggression. Please tell me the title of the victim and the title of the perpetrator.**

Think back to that event:

- 2 What was the type of aggression (physical, psychological...)?**
- 3 What was the context in which the incident took place?**
- 4 Did you or someone else intervene when the aggressive act took place (during the event)? If yes, who and what did they do?**
- 5 Following the event, which specific action did you take to manage the aggressive act?**

Probes

With the:

- victim,
- perpetrator,
- environment (both physical and social)

- 6 Were you satisfied with the outcome of your intervention? If no, what would you have liked to have seen happen differently?**
- 7 Did you previously have to intervene for a similar event (pre-event)? If so, how?**

***Topic Domain 2: Support needed when having to respond to and deal with
intra/inter professional aggression***

8. How well prepared do you feel for your role in managing intra/inter professional aggression?
9. What type of support did you initially receive to prepare you to manage intra/inter professional aggression?

Probes

- Formal training
- Orientation to code of conduct/ to organizational policy
- Orientation to organizational processes
- Provided literature/documentation on the subject

- 10 What are your current sources of support when having to manage intra/inter professional aggression?

Probes

- Peers
- Direct report manager (own boss)
- Human Resources Department
- Literature: books, articles

- 11 What would you need to help support you when having to manage intra/inter professional aggression?

Topic Domain 3: Organizational Factors that can Facilitate or Impede the Management of Intra/Inter Professional Aggression

12. To your knowledge, did factor(s) in the physical environment facilitate or impede the way you managed the event? If so, how?

13. To your knowledge, did factor(s) in the social environment (i.e. culture, structures – policies and procedures) facilitate or impede the way you managed the event? If so how?

Probes

-
- Mission statement
- Organizational documents and processes
- Access to information
- Appraisal and reward systems
- Restructuring, downsizing, change in management
- Leadership
- Perception of fairness

14. Does your organization have policy on workplace aggression or violence? If so

14.1 When was it implemented?

14.2 How was it implemented?

14.3 To your knowledge, how useful has it been?

14.4 Does the policy include a specific section to address intra/inter professional aggression?

15. Beside the policy (if one is available) what other structure or process are currently in place in this organization to facilitate the management of intra/inter professional aggression?

<i>Closing Remarks</i>

16. Are there other subject matter or questions you would have liked to discuss?

Thanking of participant

Informing of the next steps of the research process:

- Transcription and analysis of all interviews;
- Presentation of results to the advisory committee;
Dissemination of research findings at conferences and in scientific journals

Guide d'entrevue semi-structurée

Étapes préalables à l'entrevue

Accueil et introduction

Je vous remercie de prendre le temps de participer à cette entrevue. Je m'appelle ...

Brève revue du contexte dans lequel se situe l'entrevue

Cette étude, qui a pour but d'acquérir une meilleure compréhension de la façon dont le personnel cadre infirmier traite l'agression intra- et interprofessionnelle, s'insère dans le cadre de ma recherche de doctorat (Ph. D.) Le rôle de l'organisation sera également examiné dans le cadre de l'étude. En termes plus précis, l'étude vise à répondre aux questions suivantes :

1. Quels sont les aspects de la culture de l'organisation/unité, des structures et des systèmes qui influent sur la gestion de l'agression intra- et interprofessionnelle par le personnel cadre infirmier?
 - 1.1 De quelle façon les facteurs présents dans le milieu organisationnel influencent-ils la gestion de l'agression intra- et interprofessionnelle?
 - 1.2 Comment le personnel cadre infirmier peut-il être appuyé dans la gestion de l'agression intra- et interprofessionnelle?
2. Quelles sont les stratégies déployées par le personnel cadre infirmier pour faire face à l'agression intra- et interprofessionnelle?
 - 2.1 Quelles sont les mesures prises par le personnel cadre infirmier dans le but précis de gérer l'agression intra- et interprofessionnel au sein de son unité?
 - 2.2 En quoi le type d'agresseur et le type d'agression influencent-ils le choix de la mesure prise?

Pour répondre à ces questions de recherche, je réaliserai plusieurs entrevues individuelles semi-structurées avec des membres du personnel cadre de votre organisation.

Revue et signature du formulaire de consentement éclairé par le participant (une copie signée du formulaire de consentement sera remise au participant)

Avertissements au sujet du déroulement de l'entrevue

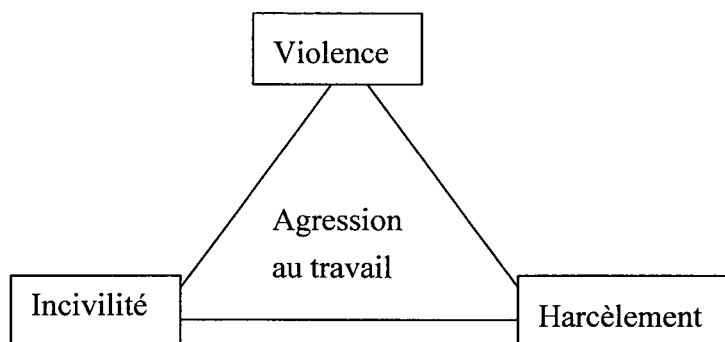
- Je prendrai des notes durant l'entrevue.
- Durant l'entrevue, je jetterai parfois un coup d'œil au magnétophone numérique pour m'assurer qu'il enregistre (si le participant consent à ce que l'entrevue soit enregistrée).

Questions du participant

Avant de commencer, avez-vous des questions au sujet de l'entrevue ou du projet de recherche?

Définition de l'agression au travail et validation de la compréhension de cette définition par le participant

Avant de commencer, j'aimerais vous expliquer clairement ce que signifie le terme *agression au travail*. Dans le contexte de la présente étude, l'**agression au travail** est un concept vaste qui englobe 3 sous-concepts, c'est-à-dire le manque de civilité, le harcèlement et la violence. Le manque de civilité au travail se définit comme étant une agression de faible intensité se manifestant par des comportements tels que rester à côté d'une personne engagée dans une conversation pour l'attendre en manifestant des signes d'impatience ou laisser le chariot à fournitures vide sans le dire à personne. La violence au travail désigne un comportement comportant un niveau élevé d'agression physique, comme mordre, griffer, cracher et donner des coups. Le harcèlement au travail, quant à lui, désigne une répétition d'actes hostiles au cours d'une période de temps et comprend l'intimidation, la persécution collective et l'abus de pouvoir.



Types d'agression

Quatre types d'agression ont été cernés :

- Physique
- Psychologique (y compris la violence verbale et le harcèlement : intimidation, persécution collective et abus de pouvoir)
- Sexuel
- Financier

**Domaine thématique 1 : Gestion de l'agression au travail
du point de vue du personnel cadre**

1. Vous avez manifesté de l'intérêt pour la participation à cette étude parce que, en tant que cadre, vous avez déjà été appelé(e) à gérer un acte d'agression intra- ou interprofessionnelle. Veuillez me donner le titre de la victime et celui de l'agresseur.

Rappelez-vous de ce qui s'est passé :

2. De quel type d'agression s'agissait-il (physique, psychologique...)?
3. Dans quel contexte l'incident est-il survenu?
4. Quelqu'un (vous ou une autre personne) est-il intervenu au moment de l'agression (durant l'incident)? Si oui, qui est-ce qui est intervenu et qu'a-t-il ou qu'a-t-elle fait?
5. Après l'incident, quelle mesure avez-vous prise dans le but précis de gérer cet acte d'agression?

Précisions

Auprès de :

- la victime,
- l'agresseur.
- Au sein du milieu (physique et social)

6. Étiez-vous satisfait(e) du résultat de votre intervention? Si non, qu'auriez-vous aimé obtenir comme résultat?
7. Avez-vous déjà été appelé(e) à intervenir dans un incident semblable (avant celui dont nous parlons)? Si oui, de quelle façon êtes-vous intervenu?

**Domaine thématique 2 : Soutien requis au moment de traiter un cas
d'agression intra- ou interprofessionnelle**

8. Dans quelle mesure vous sentez-vous bien préparé(e) à assumer votre rôle de gestion de l'agression intra- ou interprofessionnelle?
9. Quel genre de soutien avez-vous obtenu initialement pour vous préparer à gérer l'agression intra- ou interprofessionnelle?

Précisions

- Formation officielle
- Orientation définie par le code de conduite/la politique organisationnelle
- Orientation définie par les processus organisationnels
- Littérature/documentation sur le sujet

10. Quelles sont vos sources actuelles de soutien lorsque vous devez gérer un cas d'agression intra- ou interprofessionnelle?

Précisions

- Pairs
- Supérieur direct (votre propre patron)
- Service des ressources humaines
- Documentation : livres, articles

11. De quel genre de soutien auriez-vous besoin pour gérer l'agression intra- ou interprofessionnelle?

Domaine thématique 3 : Facteurs organisationnels pouvant aider ou nuire à la gestion de l'agression intra- ou interprofessionnelle

12. À votre connaissance, un ou des facteurs présents dans le milieu physique ont-ils aidé ou nuit à la façon dont vous avez géré l'incident? Si oui, dites pourquoi?
13. À votre connaissance, un ou des facteurs présents dans le milieu social (culture, structures – politiques et marches à suivre) ont-ils aidé ou nuit à la façon dont vous avez géré l'incident? Si oui, dites pourquoi?

Précisions

-
- Énoncé de mission
- Documents et processus organisationnels
- Accès à l'information
- Systèmes d'évaluation et de récompense
- Restructuration, rationalisation, changement de gestion
- Leadership
- Perception d'équité

14. Votre organisation s'est-elle dotée d'une politique sur l'agression ou la violence au travail? Si oui :
- 14.1 Quand a-t-elle été mise en œuvre?
- 14.2 De quelle façon a-t-elle été mise en œuvre?
- 14.3 À votre connaissance, dans quelle mesure s'est-elle révélée utile?
- 14.4 La politique comporte-t-elle une section qui traite spécifiquement de l'agression intra- ou interprofessionnelle?
15. Outre la politique (s'il y en a une), quelle autre structure ou quels autres processus sont actuellement en place au sein de l'organisation pour faciliter la gestion de l'agression intra- ou interprofessionnelle?

<i>Mot de la fin</i>

16. Y a-t-il d'autres points ou questions que vous aimeriez aborder?

Remercier le participant

L'informer des étapes suivantes du processus de recherche :

- Transcription et analyse de toutes les entrevues;
- Présentation des résultats au comité consultatif;
- Diffusion des résultats de recherche dans le cadre de conférences et dans les revues scientifiques.

Appendix E
Data Collection Grid
Elements of Policy on Workplace Aggression

Data Collection Grid
Elements of Policy on Workplace Aggression

Elements of policy	Included
• Introduction or context for policy	
• Statement reflecting organization's vision pertaining to workplace aggression	
• Date when policy became effective	
• Legal context	
• Purpose or objective	
• Scope and application	
• Guiding principles	
• Definition of workplace aggression	
• Responsibilities of stakeholders	
• Processes to prevent incidents of workplace aggression	
• Procedures to report incidents of workplace aggression	
• Statement pertaining to the need to report all incidents (ensuring confidentiality and protection from reprisals)	
• Procedures to investigate and resolve complaints	
• Statement on organizational commitment to support victims of aggression (protection, support)	
• Consequence(s) of policy violation	
• Statement on commitment to offer training and education on aggression prevention to all employees of the organization	
• Cross-reference, when appropriate, with other related policies such as sexual harassment and disability management	
• Timeframe for revision of policy	

Based on the work of Chamberland (2004) and French & Morgan (2002)

How was the policy implemented?

Appendix F
Data Collection Grid
Job Description of Nursing Managers

Appendix G
Data Collection Grid
Recording Template - Review of Minutes of Meetings

Data Collection Grid

Recording Template - Review of Minutes of Meeting

Date of minutes: _____

Type of meeting:

- Occupational Health & Safety Committee
- Unit Other: _____

How was the issue related to “worker on worker” aggression?

What was done about the issue? Who was in charge of doing it (title)?

Was there any follow up done?

Comments:

Appendix H
Data Collection Grid
Recording Template for Direct Observation

Data Collection Grid
Recording Template for Direct Observation

Category of Observation	Points to Observe
Inventory of objects, tools and instruments required for action and their usage	Presence (or not) of surveillance camera, access to computer
Rules, both formal and informal	Mission and vision, policies and procedures, code of conduct, posters, signs, incident reports.
Professionals	Professional affiliation of people, hierarchy, division of labour, dress code.
Users	Number of bed, number of clients.
Site and environment	Neighbourhood, type of establishment, physical access, part of health care network

Adapted by Isabelle St-Pierre (2008) from Peretz H. (1998). *Les méthodes en sociologie. L'observation*. Paris : La Découverte.

Appendix I
Summary Tables
Socio-Demographic Data

	less than a year	a year or more, but less than five years	five years or more, but less than 10 years	ten years or more, but less than 20	20 years or more	Total
How many years have you been employed in nursing?	0	1	0	3	14	18*
How many years have you been employed as a nursing manager?	2	8	4	4	1	19
How many years have you been employed in this hospital?	2	6	2	2	7	19
How many years have you been employed on this/these unit(s)?	5	3	4	1	5	18**

	1	2	3	4	More than 4	Total
How many units do you manage?	5	3	4	1	5	18**

	less than ten	ten or more, but less than 20	20 or more, but less than 30	30 or more, but less than 40	40 or more, but less than 50	50 or more	Total
How many employees report to you (span of control)?	3	0	0	1	1	14	19

	College/ Cegep	Bacc (in progress)	Bacc (completed)	Masters (in progress)	Masters (completed)	PhD	Total
What is your highest level of educational preparation (in nursing or other)?	3	2	8	2	4	0	19

Based on 19 participants (7 directors and 12 nurse-managers)

* One participant was a non-nurse

** One missing variable

	Conflict management /resolution	Violence/ aggression management
Have you ever received formal training on:	17	8

	< 25	25-35	36-45	46-55	56-65	> 65	Total
What is your age group?	0	1	3	12	3	0	19

	Female	Male	Total
Are you?	16	3	19

Based on 19 participants (7 directors and 12 nurse-managers)

Appendix J
Data Saturation Table

Data Saturation Table

Themes (and sub-themes)	Participants																							
	1	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2	2	2	2	2		
	1	1	1	1	1	1	1	1	1	2	2	1	1	1	1	1	1	2	2	2	2	2		
	1	2	3	4	5	6	7	8	9	0	1	1	2	3	4	5	6	1	2	3	4	5	7	
										*	*						*	*						
Theme 1 - Perceptions		◆	◆	◆		◆	◆	◆	◆				◆			◆		◆	◆	◆		◆	◆	
Intent			◆	◆				◆					◆							◆		◆	◆	
Awareness		◆	◆	◆		◆	◆	◆	◆							◆		◆	◆			◆	◆	
Differences				◆				◆											◆			◆	◆	
In education					◆			◆							◆			◆						
In practice					◆				◆		◆	◆	◆	◆							◆	◆		
In management style			◆			◆				◆													◆	
In roles & responsibilities	◆						◆							◆	◆								◆	
Representation				◆				◆									◆			◆				
Expectations	◆			◆	◆	◆		◆		◆			◆	◆	◆					◆			◆	◆
Assumptions				◆												◆				◆				
Taking it personal		◆						◆			◆	◆											◆	

Each number represents a participant.

- Participant number 120, 121, 216 and 221 were key informants.
- Participant number 216 and 224 do not have transcripts as the interviews were not recorded.

The symbol “◆” in a cell indicate that the participant spoke about the theme or sub theme during the interview.

Themes (and sub-themes)	Participants																						
	1	1	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2	2	2	2	
	1	1	1	1	1	1	1	1	1	2	2	1	1	1	1	1	1	2	2	2	2	2	
	1	2	3	4	5	6	7	8	9	0	1	1	2	3	4	5	6	1	2	3	4	5	7
										*	*						*	*					
Theme 2 - Emotions	◆		◆	◆		◆						◆	◆	◆		◆			◆			◆	◆
Fear	◆											◆	◆	◆		◆						◆	◆
Frustration			◆	◆		◆														◆			
Mistrust			◆											◆									
Theme 3 - Aggression	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆
Etiology	◆	◆	◆		◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	
Environments	◆		◆		◆	◆	◆	◆		◆	◆	◆					◆		◆		◆		◆
Physical environment	◆		◆	◆		◆	◆		◆	◆	◆		◆		◆	◆	◆	◆	◆				◆
Social/cultural environment	◆	◆	◆	◆		◆	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆		◆	◆		◆	◆
Boundaries	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆		
Players		◆		◆		◆	◆		◆		◆	◆	◆					◆		◆			

Each number represents a participant.

- Participant number 120, 121, 216 and 221 were key informants.
- Participant number 216 and 224 do not have transcripts as the interviews were not recorded.

The symbol “◆” in a cell indicate that the participant spoke about the theme or sub theme during the interview.

Themes (and sub-themes)	Participants																							
	1	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2	2	2	2	2		
	1	1	1	1	1	1	1	1	1	1	2	2	2	2	2	2	2	2	2	2	2	2		
	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	1	2	3	4	5	7		
Theme 4 - Management	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆		
Modus Operandi	◆	◆	◆	◆	◆	◆			◆	◆	◆	◆			◆	◆			◆	◆		◆	◆	
Timing	◆	◆	◆	◆					◆				◆		◆	◆			◆			◆	◆	
Actors		◆				◆						◆												
Individual				◆				◆					◆				◆					◆		
Peers			◆				◆						◆				◆				◆			
Managers	◆		◆	◆	◆	◆	◆	◆	◆		◆	◆	◆	◆	◆	◆		◆	◆			◆	◆	
Human Resources	◆			◆		◆	◆			◆		◆		◆	◆	◆	◆	◆		◆				
Unions						◆				◆	◆	◆	◆	◆	◆	◆	◆	◆				◆	◆	
Support	◆	◆	◆	◆		◆	◆		◆	◆		◆		◆	◆	◆	◆	◆	◆				◆	
Sources of support	◆	◆	◆	◆	◆	◆	◆	◆	◆	◆				◆	◆	◆	◆	◆	◆	◆	◆	◆	◆	
Responsibility/accountability	◆			◆	◆								◆		◆				◆			◆	◆	
Theme 5 - Power			◆	◆	◆	◆			◆			◆	◆	◆	◆	◆	◆		◆			◆	◆	◆
Hierarchy					◆	◆			◆			◆	◆		◆				◆			◆	◆	
Agenda						◆																◆		

Each number represents a participant.

- Participant number 120, 121, 216 and 221 were key informants.
- Participant number 216 and 224 do not have transcripts as the interviews were not recorded.

The symbol “◆” in a cell indicate that the participant spoke about the theme or sub theme during the interview.

Appendix K
Ethics Approval Notice

File Number: H03-09-07

Date (mm/dd/yyyy): 05/28/2009



Université d'Ottawa University of Ottawa
 Service de subventions de recherche et déontologie Research Grants and Ethics Services

Ethics Approval Notice

Health Sciences and Science REB

Principal Investigator / Supervisor / Co-investigator(s) / Student(s)

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Dave	Holmes	Health Sciences / Nursingy	Supervisor
Isabelle	St-Pierre	Health Sciences / Nursingy	Student Researcher

File Number: H03-09-07

Type of Project: PhD Thesis

Title: Understanding the Management of Intra/Inter Professional Aggression: A Critical Nursing Ethnography

Approval Date (mm/dd/yyyy)	Expiry Date (mm/dd/yyyy)	Approval Type
05/28/2009	05/27/2010	Ia

(Ia: Approval, Ib: Approval for initial stage only)

Special Conditions / Comments:

N/A

File Number: H03-09-07

Date (mm/dd/yyyy): 05/28/2009



Université d'Ottawa **University of Ottawa**
 Service de subventions de recherche et déontologie Research Grants and Ethics Services

This is to confirm that the University of Ottawa Research Ethics Board identified above, which operates in accordance with the Tri-Council Policy Statement and other applicable laws and regulations in Ontario, has examined and approved the application for ethical approval for the above named research project as of the Ethics Approval Date indicated for the period above and subject to the conditions listed the section above entitled "Special Conditions / Comments".

During the course of the study the protocol may not be modified without prior written approval from the REB except when necessary to remove subjects from immediate endangerment or when the modification(s) pertain to only administrative or logistical components of the study (e.g. change of telephone number). Investigators must also promptly alert the REB of any changes which increase the risk to participant(s), any changes which considerably affect the conduct of the project, all unanticipated and harmful events that occur, and new information that may negatively affect the conduct of the project and safety of the participant(s). Modifications to the project, information/consent documentation, and/or recruitment documentation, should be submitted to this office for approval using the "Modification to research project" form available at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

Please submit an annual status report to the Protocol Officer 4 weeks before the above-referenced expiry date to either close the file or request a renewal of ethics approval. This document can be found at:
http://www.rges.uottawa.ca/ethics/application_dwn.asp

If you have any questions, please do not hesitate to contact the Ethics Office at extension 5841 or by e-mail at: ethics@uOttawa.ca.

Germain Zongo
 Assistant Director, Ethics (Interim)
 For Dr. Daniel Lagarec, Chair of the Health Sciences and Sciences REB