VIOLENCE IN NURSING: COMPETING DISCOURSES OF POWER, CARE AND RESPONSIBILITY

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Declaration

I declare that *Violence in Nursing: Competing Discourses of power, care and responsibility* is my own work, that it has not been submitted before for any degree or examination at any other university, and that all the sources I have used or quoted have been indicated and acknowledged as complete references.

Naomi Myburgh March 2007

Signed: _____

Abstract

Much research has focused on the social and psychological dimensions of nursing; yet we have not identified the thoughts and feelings of health care professionals as a priority in trying to understand a variety of nursing phenomena. There is a need to explore how nurses understand their social and psychological worlds, specifically with regards to the phenomena of violence, abuse and neglect within health care. Therefore, this study has attempted to answer the following research question: How do nurses understand and talk about the occurrence of violence towards patients?

The research question demanded the use of qualitative methods to collect and analyse data. In-depth interviews, consisting of open-ended questions were conducted. 11 female participants were enlisted from a tertiary hospital labour ward in Cape Town by means of convenience sampling. Data were transcribed and analysed using a combination of methods. In addition to more traditional methods, I have also included autoethnography in this thesis.

The following themes were identified: a culture of violence in nursing in South Africa; a split in the voice of nursing; changing and contradictory role expectations; a changing definition of violence within nursing discourse; emotional detachment; an appraisal of patients in the development of violent or abusive interactions; and competing and contradictory discourses that influence beliefs and practices around violence, abuse and neglect in care-giving. Furthermore, violence was found to involve contradictory discourses and definitions that served to simultaneously legitimise and prohibit the perpetration of abuse, violence and neglect in health care provision. Violent behaviour was described as collective action, involving insiders who adopt the collective way of thinking and behaving (Douglas, 1986, Whitaker, 2000) or outsiders who are isolated and powerless. Emotional detachment and appraisal of the patient were found to play a central role in allowing nurses to employ violent or abusive behaviour to exert power and control over patients.

This research highlighted the difficult circumstances in which nursing is practised in South African hospitals today. The lack of resources, time, money and support; along with continuous changes in policy exacerbate the difficulties experienced in health care, and influence care-giving. This study has not attempted to provide clear answers to the broad question of why patients are abused, neglected and generally mistreated, and nurses' understanding of the occurrence of violence against patients has proved to be more than a simple problem with clearly identifiable causes that may be addressed with the development and refinement of codes of conduct, regulatory measures and disciplinary procedures.

Opsomming

Heelwat navorsing het al klem gelê op die sosiale en sielkundige dimensies van verpleegkunde. Nietemin het ons nog nie die denke en gevoelens van gesondheidsorg werknemers voorop gestel in ‘n poging om ‘n verskeidenheid van verskynsels in verpleegkunde te verstaan nie. ‘n Behoefte bestaan om ondersoek in te stel na hoe verpleegsters hulle sosiale en sielkundige wêrelde vestaan, met spesifieke verwysing na geweld, mishandeling en die afskeep van pasiënte. Hierdie ondersoek poog om die volgende navorsingsvraag te beantwoord: Hoe verstaan en praat verpleegspersoneel oor die voorkoms van geweld teenoor pasiënte.

Die navorsingsvraag het vereis dat kwalitatiewe metodes aangewend word om data te versamel en analiseer. In-diepte onderhoude betsaande uit oop vrae is gevoer. Elf vroulike deelnemers van ‘n tersiêre hospitaal in Kaapstad se kraamafdeling is by die studie betrek deur middel van ’n gerieflikheids-steekproef. ‘n Kombinasie van metodes is gebruik om die data te transkribeer en te ontleed. Bo en behalwe meer tradisionele metodes het ek ook autoetnografie by hierdie tesis ingesluit.

Die volgende temas is geïdentifiseer: ‘n kultuur van geweld in verpleegkunde in Suid Afrika; verdeelheid in die diskoers oor verpleging; veranderende en teenstrydige rolverwagtinge; ‘n veranderende definisie van geweld in verplegingsdiskoers; emosionele afstomping; evaluasie van pasiënte gedurende die ontwikkeling van geweldadige of mishandelende optrede; en mededingende en teenstrydige diskoers wat beskouings met betrekking tot geweld, mishandeling en die afskeep van pasiënte in gesondheidsorg beïnvloed. Verder is daar gevind dat geweld teenstrydige diskoerse en definisies betrek met die gevolg dat dit terselfdertyd legitimiteit verleen aan en ‘n verbod plaas op mishandeling, geweld en afskeping. Geweldadige gedrag is beskryf as kolletiewe optrede wat binnestaanders by ‘n kollektiewe manier van dink en doen betrek (Douglas, 1986; Whitaker, 2000) of buitestaanders isoleer en magteloos laat. Daar is gevind dat emosionele afstomping en evaluasie van die pasient ‘n sentrale rol daarin speel om verpleegsters toe te laat om geweldadige of mishandelende gedrag aan te wend om mag en beheer oor pasiënte uit te oefen.

Hierdie navorsing het die moeilike omstandinghede waaronder verpleging in vandag se Suid-Afrikaanse hospitale beoefen word onder die soeklig gestel. ‘n Tekort aan hulpbronne, tyd, geld en ondersteuning, asook voortdurende beleidsveranderinge, vererger die moeilikhede wat in gesondheidsorg ervaar word en beïnvloed die aard van sorg. Hierdie studie het nie gepoog om duidelike antwoorde op die breë vraag oor hoekom pasiente mishandel, afgeskeep en swak versorg word te gee nie. Hoe verpleegspersoneel die voorkoms van geweld teenoor pasiënte vestaan blyk om meer as ‘n eenvoudige problem met maklik identifiseerbare oorsake te wees.

Thanks

I dedicate this thesis to my mother whose experiences had sparked this investigation, and without whom I would never have been able to complete it.

Thanks to my partner, Heinie Pretorius, who has provided immeasurable support.

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Lastly, I thank the participants of this study, who have most obligingly shared their thoughts and experiences with me and have consequently made this research possible.

She learned to hold her tongue, and prudently suppressed the treasure of her prodigious flow of fables until I gave her the opportunity to unloose the torrent of words stored within her.

Isabel Allende

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Preamble

Nursing research is an important field of study and the occurrence of violence within the nurse-patient relationship is a particularly neglected area of empirical research (Jewkes, Abrahams & Mvo, 1998a). This is especially the case in South Africa where little research has been conducted on the nurse-patient relationship, and the way in which issues of violence, power and identity influence this relationship need further attention so that we may more fully understand the social world of nursing (Blaauw et al., 2003). We know little about nurses' perceptions of patients (Roos, 2005), their personal experiences and their complex world of work. Yet, nurses play a pivotal role in the provision of health care and are arguably the most important constituents in positive health care outcomes. Thus we need to develop our understanding of nursing practice in all of its complexities. For the same reason, Penn-Kekana, Blaauw and Schneider (2004) argue that "the practice of health care workers (can) only be understood in the context of their individual lives, the health system as a whole, and the cultural, political and economic environment in South Africa" (p.i72).

Nursing plays a central role in the provision of health care services and is often the primary or sole contact with the patient in times of illness. It is generally perceived to involve caring behaviour and the South African Nursing Council stipulates its vision for nursing as being: "committed to excellence in quality humane nursing care for all" (2006), but contrary to this, instances of humiliation, neglect and abuse of patients have been reported. In spite of the fact that violence against patients has been reported to be a widespread problem in developing countries, there is very little published work on the subject (Jewkes et al., 1998a). In addition to this, Jewkes et al. (1998a) established that the South African Nursing Council (SANC) and the South African Nursing Association (SANA) had not yet at that time recognised the abuse and neglect of patients as a problem in need of attention. Furthermore, cases of neglect or abuse are rarely reported by nursing staff or by patients, but the presence of abuse or neglect has become clear through a variety of sources.

[*]I have personally observed neglect and abuse in both private and public hospitals where I have been a regular visitor. My observations have led to conclusions about the presence of overt or covert aggressive and violent behaviour towards patients; and have been the motivation for this research at the inception of my thesis. My observations were reinforced by my involvement in the Women's Mental Health Research Project, run by Professor Kruger at the University of Stellenbosch that investigated the experiences of mothers during pregnancy; media reports that

[*] I have intentionally used the first person at times in this thesis. Although I am aware that this may not follow traditional convention, I have provided a full exposition of my reasons for doing this in the Research Methodology section. Moreover, Henning, Gravett and van Rensburg (2005) argue that, in keeping with the "American Psychology Association (1994:29) … it can seem contrived to refer to oneself as 'the author' or 'the researcher'", that first person writing reduces the use of the passive form and it "does not impact on the formality or the persuasive character of the writing" (p. 92).

confirmed my own suspicions and observations; and the study conducted by Jewkes et al. (1998a) that identified abuse and neglect in maternity services.

Interviews with women who have given birth have exposed narratives of neglect; and verbal and physical abuse by maternity ward staff (Abrahams, Jewkes & Mvo, 2001; Jewkes et al. 1998a). Jewkes et al. (1998a) found abuse in the maternity services in South Africa and reported "neglect, verbal and physical abuse ... which was at times reactive, and at others ritualised in nature" (p. 1781).

Reports of violence in the media have predominantly involved mistreatment and malpractice in nursing homes and abortion clinics. A television programme on the *M-Net* programme secretly recorded video footage where patients had to remove their own foetuses from their bodies in 2002 after they had undergone an abortion at a health care facility (Ke Nene, 2002). It is unsettling to consider this kind of treatment of patients in our medical institutions, but what is important for the purpose of this study in referring to the media, is the fact that such reports confirm the occurrence of this problem in more than one health care setting.

Pattinson (2004) argues that South Africa is a country wherein issues of infant mortality, treatment seeking behaviour, treatment adherence and violence are closely related to nursing. Furthermore, maternity services are faced with the responsibility of improving maternal health, providing safe delivery sites and practices; and of becoming a reliable, predictable source of services (Pattinson, 2004). The relationship between the nurse and her patient affects treatment at all levels and problems in the care of women have been reported in more than half of maternal death cases (Pattinson, 2004). Unprofessional conduct, involving the refusal to attend to patients when called, not doing observations as prescribed, poor diagnosis, failure to follow standard protocols and poor quality of care have been identified as problems associated with maternal health care practices (Jewkes et al., 1998a; Parkhurst et al., 2005; Pattinson, 2004).

I argue that the problem of violence perpetrated against patients is not only a personal issue relating to a particular nurse, it is also an institutional and social issue relating to the medical organisation. Therefore, I have approached the topic of this thesis by focusing on both the personal and the organisational aspects of the phenomenon so that I may offer a more comprehensive view of identity, practice and violence in nursing. The social world of nursing has been explored in terms of discourse in order to illuminate the ways in which "socially produced ideas and objects that populate the (nursing) world are maintained and created" (Philips, 2003, p.222). Schwartz (1999) argues that organisations produce actions that may seem to make sense to those involved, but that "underneath the appearance of stability and order, an appearance often cultivated with great care by organisational leaders, lie tension, conflict and flux, always threatening to change the order of things" (p.1). Underneath the order, routine and task-orientated care associated with care-giving in

the hospital, there may be issues of power, care and responsibility that threaten to "change the order of things" and may play a role in our understanding of violence towards patients (Schwartz, 1999; Van der Walt, 2002; Van der Walt & Swartz, 1999).

I undertook the current study with the issues of violence, abuse and neglect in maternity services as its point of departure. The occurrence of violence in health care is reportedly a wide-spread problem and I strongly believe that it involves negative consequences for the well-being of both nurses and patients. Violence perpetrated against patients has been reported in many types of health care settings, although this study has been conducted with a focus on maternal health care services. I adopted this focus for the following reasons: my earlier involvement with the Kylemore project in which I developed an understanding of the impact of violence during labour on the participants; former research that revealed the occurrence of violence in maternity services; and lastly as a result of the overarching study under which this research was conducted. This thesis forms part of a larger research project on violence in the nursing profession, conducted by Professor Khalil at the University of Cape Town. This study focused on the occurrence of violence perpetrated towards nurses by patients and other staff members. My role was to do an exploratory study of violence perpetrated against patients. Hence I was granted access to the sample via this study and the maternity ward was decided upon as the most suitable setting for my part of the research.

This thesis consists of five chapters. The first provides an introduction to the research question, objectives and motivation. It also consists of a literature review in which I have aimed to provide a comprehensive view of nursing in South Africa, focusing particularly on maternity services and violence. The research question that I have attempted to answer in this thesis is: how do nurses understand and talk about violence against patients by nurses? I have used qualitative research methods to address this question, since they proved to be the most appropriate. The research methods have been discussed in chapter 2. Since I have used more than one method to analyse the data, chapters 3 and 4 will provide the results. Chapter 5 contains the discussion of the study; including a consideration of its limitations, and the conclusion.

CHAPTER 1

1.1 The Problem and Motivation for the Research

Violence perpetrated by nurses against patients is a problem of great importance that needs to be addressed. In maternity services, for example, patients have reported that they fail to seek treatment or avoid certain health care facilities, since they fear that they will be badly treated there (Abrahams et al., 2001). This, in turn, influences maternal mortality rates (Abrahams et al., 2001).

Nursing is associated with caring behaviour towards patients and the profession is geared towards taking care of the patient. In addition, the development of the nursing profession is historically based on the belief that it is a suitable profession for women, since they are believed to possess intrinsic values of virtue and care-giving (Marks, 1994). Because nurses are expected to be 'naturally' caring women (and nursing remains a female-dominated profession, infused with idealised images of female caring, Marks, 1994**)**, any experience that nurses may have of anger or hostility towards patients or colleagues, or frustration and anxiety with their work, may be viewed as illegitimate (Menzies Lyth, 1988, Schoombee, 2004). Nurses may struggle to find socially sanctioned outlets for feelings of anger, frustration or anxiety, since they are expected to possess the inviolable capacity for limitless patience and caring.

Notwithstanding this expectation of caring, nursing involves great personal, emotional, physical and professional demands (Menzies Lyth, 1988). What is less clear is how nurses themselves understand these demands, and what nurses say about their experiences of them. Though much is written about nursing as a taxing profession, nurses themselves who work daily with patients seem, in keeping with their implied social role as idealised female carers, to be almost voiceless in a profession where much depends on their attitude and behaviour towards patients and work. Furthermore, despite the fact that much has been written about the issue of violence and neglect in the nurse-patient relationship for example, we know surprisingly little about how nurses themselves speak about and understand this violence and neglect**.** Importantly, this study forms part of a growing literature which attempts to address this imbalance in knowledge.

1.2 Broad Aims of this Research

This study aims to provide an understanding of the reality of a nurse's everyday experiences of and explanations for violent behaviour towards patients. Violence is an issue which is generally found to be kept behind 'closed doors' as a consequence of its very sensitive nature, a problem which is confounded in the nursing profession, since nurses have adopted an approach of silence about problematic issues (Gilson et al., 2003).

The broad aims of this thesis were therefore to:

- explore and describe the experiences of nurses regarding the occurrence of violence towards patients;
- develop an understanding of the phenomenon of violence perpetrated by nurses against patients;
- contribute to the growing literature about the experiences of nurses; and
- provide an exposition on how nurses talk about and understand the occurrence of violence against patients

These issues were studied in a particular context, which will be described in detail later.

1.3 Literature Overview

1.3.1 Nursing in Context

Nursing, as any other profession, is situated within a particular context which determines and is determined by the behaviour of the individuals within that profession. Therefore, in order to build an understanding of nursing practice and behaviour in South Africa, particularly with regards to violent practices or behaviour towards patients, it is important to understand the context in which nursing is practised in this country. Health care organizations will reflect the context – social, gender, political, historical or cultural - in which they find themselves (Blaauw et al., 2003). The organisation and the provision of services, attitudes, beliefs, and behaviour of the members of that organisation may be influenced by these contexts and vice versa.

Gender and politics have played a central role in the development of nursing as a profession world-wide and if we wish to understand nursing we need to know something of the specific gender and political contexts within which nursing practices occur. In South Africa, nursing has been viewed not only as an expression of caring, but also as one of many ways used to suppress and control marginalised groups under apartheid (Marks, 1994). The politically complex and culturally diverse society in which nursing is practised in South Africa today brings with it unavoidable conflict, misunderstanding and prejudice, which place the profession in a precarious and challenging context. This section of this thesis will provide an in-depth picture of the context of nursing in South Africa as it relates to our understanding of nursing attitudes and behaviour, particularly violent nursing behaviour.

1.3.1.1 A brief history of the genesis of nursing in South Africa with specific reference to gender.

Marks (1994) has argued that Stockdale, who founded nursing in South Africa, influenced nursing in a similar way to the Florence Nightingale ideal. According to Marks (1994) nurses were instilled with the belief that nursing encapsulated a special mission for women. Women who had other obligations towards their parents, children or husbands were not called on to serve this mission, since it would temper with their primary womanly duties. Marks (1994) stated that one of the dominant themes in nursing history was the tension between the assertion that nursing was a suitable profession for "refined and educated women" on the one hand, and the reality that nursing demanded a large amount of manual labour, on the other (Marks, 1994, p.9). The profession of nursing was based on inflexible ideas about gender and class and this caused a paradox within early nursing discourse, since this restrictive profession ironically provided women with a degree of freedom and autonomy. As Marks (1994) notes, in spite of the demands for self-sacrifice and strong patriarchal expectations of nurses, the profession historically has also offered women with the opportunity for a degree of independence and a sense of achievement within a gender repressive society.

In its early days in South Africa, nursing was a profession retained for the middle class 'lady' who would remain the ever friendly, feminine caregiver while attending to domestic and often unpleasant tasks. Marks (1994) has discussed the way in which nursing represented the power relations of the archetypal Victorian family. It involved the female nurse acting in subordination to the male doctor, and their joint dominion over the infantilised patient. This governance of the patient's well-being also implied control over the patient by the nurse who found herself in a hierarchy where she was stationed above the patient and below the doctor. Power relations between nurses and their patients were deeply ingrained into nursing practice within an ideology where the patient needed to be controlled and disciplined.

Henrietta Stockdale focussed on both the intellectual capacity and the moral and ethical character of her nursing students (Marks, 1994). She demanded strict discipline and self-sacrifice, values which remain implicit today in the profession in South Africa. Nurses were expected to dedicate themselves fully to the profession and the sisterhoods instilled physical distance, austerity, discipline and strict self-control. Luxury and self-indulgence were unacceptable. Rules were made in order to eliminate errors of judgement by young nurses and to protect the inexperienced from the "physical intimacy of nursing and its psychological associations with sex and death" (Marks, 1994, p.30). These rules were practised not only as a means of internal control and prevention of errors, but also assured the outside world of the competence and respectability of nurses.

Nursing practice in South Africa today is arguably still affected by this socio-historical construction of the nurse identity and the nurse-patient relationship (Jewkes et al., 1998a). Nurses

were historically instilled with a way of being that stipulated their hierarchical position, demanded self-sacrifice, control and discipline and followed the ideology of the 'perfect nurse', which are all issues relevant to nursing in South Africa today. The development and continuance of these nursing discourses and identities are important issues to be considered in this research, since they relate to the origin of practices still found in present-day nursing and are of importance when the issue of violence is considered.

1.3.1.2 The role of race and politics in the development of nursing in South Africa.

Similarly to the impact of gender and class issues on the development of nursing in South Africa, race and politics have played a fundamental role in the progression of the profession to what it is today. Therefore, it is important to consider the particular impact that the South African political history may have had on nursing practice today.

Early South African nursing mirrors gender and class divisions brought here by English 'lady nurses' (Marks, 1994). These distinctions eventually extended into ethnic divisions. Marks (1994) argued that the professionalisation of nursing in South Africa involved the assertion of control of white nurses over black nurses which caused nursing to become entangled in apartheid. The impact of apartheid on nursing was probably at its greatest in contributing to the role that nursing played in the development of the "black middle class" (Marks, 1994). The major focus of the development of nursing as a profession for African women was to instil black nurses with Western middle class values and to create the "new middle class elite" (Marks, 1994, p.208). Moreover, the socialisation and education of African nurses distanced them from their communities, and created a new identity for the nurse from which she was expected to "moralise and save the sick and not simply nurse them" (Marks, 1994, p.208). The black nurse found herself in a position of authority over her patients, and Marks (1994) argued that this had an impact on the relationship between nurses and their communities. This may be illustrated by the story of a particular nurse told by Marks (1994). She aspired to be trained as a nurse, but first had to overcome her anxiety that nurses were cruel and abusive towards their uncooperative patients (Marks, 1994). Importantly, this story illustrates that the abuse of patients has been a theme present in early nursing history.

The following quote from Marks (1994) illustrates the effect of political influences on the formation of nurses' identities and the relationship between patients and black nurses in South Africa:

> The hierarchy in the profession – what might be called the 'monstrous regimentation of women' – has put the black (female) patient at the bottom of

> the pecking order. Depoliticised by a training … many black nurses have imbibed the commonsense racist discourse of their white mentors and have the same 'blame the victim' attitude to their patients, accusing mothers of stupidity and neglect when they bring their malnourished infants to hospital. (p.209)

The statements made in the quote provided above are debatable, yet they propose a striking reality of the complexity of nursing history in South Africa. Importantly, the relationship between the nurse and the patient today; and the occurrence of violence against patients may be rooted within the very complex history of nursing which may have affected the nurse's image of herself, her duty and her patient, as well the image of the nurse in her community. It is clear that as a result of the particular history of nursing, nurses were continuously torn between two opposing forces. On the one hand the nurse was a powerful, educated, refined and respected member of the community. On the other hand, she was a repressed individual who was expected to be submissive to her superiors and doctors. This simultaneous experience of power and powerlessness remains today (Jewkes et al. 1998; Schoombee, 2004). These are important issues to be explored when we study present day relationships between nurses and their patients. It is crucial to keep in mind that the nurse-patient relationship may be political in nature and may serve purposes greater than the provision of care.

Presently, South African nursing is grounded in a multicultural society with its own political and relational challenges. Oosthuizen (2002) holds that the reality of transcultural nursing is an important aspect of the problem of patient-care. It is argued that nursing staff may find it difficult to provide quality care to patients who differ from them in terms of their beliefs, values and lifestyle, since this may cause problems in communication, evoke certain attitudes towards culturally different patients, and may lead to mistrust and prejudice. Miscommunication is unavoidable in a culturally-diverse community and the frustration that results from the nurse's inability to relate to the patient may adversely affect care-giving and may result in nurses showing a lack of empathy, respect and sensitivity towards patients (Henderson & Primeaux, 1981 cited in Oosthuizen, 2002). The end result may be an intellectual justification of violent behaviour towards patients. In a culturally diverse country such as South Africa, Oosthuizen (2002) argues that it is important for nurses to provide culturally appropriate care and for nurses to be aware of and educated about different cultures and how they may impact on their quality of care. Yet this ideal cannot be attained unless attention is given to the political history in which multicultural care-giving is situated as well current cultural issues regarding the nurse-patient relationship. Therefore medical culture in South Africa and the changes currently found in nursing will be addressed in the

following section in order to illuminate the role they play in the provision of care, and potentially the development of violent care-giving.

1.3.1.3 Medical Culture, Practice and Change.

Nursing forms part of a broader health system. Helman (1994) states that in order to understand any medical or health system, we need to have an appreciation of the context of the basic values, ideology, political organisation and economic system of the society from which it emerges.

We may argue that medical practice and hence nursing, "does not exist in a vacuum … it is an expression of and - to some extent - a miniature model of the values and social structure of the society from which it arises" (Helman, 1994, p.77). The health care system of any country and community will therefore reflect the same issues, problems, beliefs and attitudes as the society in which it functions. Helman (1994, 2001) further argues that the professional medical sector reflects some of the values, social structures and inequalities of its society, especially in terms of gender, social class and ethnic background. The behaviour of health care practitioners is therefore determined and endorsed by the society within which they operate. Importantly, nurses have been found to reproduce underlying prejudices present in society which may influence their understanding of "good" and "bad" behaviour (Helman, 1994; Van der Walt, 2002).Consequently, it is important to explore problems in our health system within South African society in order to fully contextualise the occurrence of violence that may endorse or allow violent acts within nursing.

Landy (1977), cited in Helman (1994), offers an explanation of how a health care system may determine behaviour. He argues that health care systems comprise two elements. The first is the cultural that involves basic concepts, theories, practices and shared ways of perceiving reality. The second is the social that involves different roles – patient or doctor - and rules that regulate relationships amongst these roles. When this view is applied to nursing practice, it could be argued that medical culture determines specific nursing theory, treatment, practice and shared realities for nurses. Patients and nurses become part of this medical culture that prescribes a certain kind of reality and socially determined roles that regulate interactions. Clearly, if we should adopt both Helman (1994, 2001) and Landy's (1977) perspectives, we could argue that our unique South African society may determine what our health care system looks like, which in turn influences the experiences and behaviour of our health care workers and patients. This theoretical perspective is illustrated in Khoza's (2005) research.

Khoza (2005) investigated the impact of organisational culture on the ability of newly-employed nurses to adapt to their new working environments. Khoza (2005) argued that adapting to a new working environment involves a "socialisation process inherent in the organisational culture" (p.46). However, newly-employed nurses were found to experience the existing norms of a new

organisation as ambiguous, perplexing and restrictive (Khoza, 2005). Organisational culture is defined by Harvey and Brown (1996), cited in Khoza (2005) as a "system of shared meanings including the language, dress, patterns of behaviour, value systems, feelings, attitudes, interactions, and group norms of the members" (p.47). Khoza (2005) argued that this culture is an invisible quality or a particular modus operandi that stabilises the environment of the organisation if it is perceived as correct and valid. New members of the organisation should be schooled in the way things are done and continuous interaction with a specific health care culture results in the development of shared ways of thinking and communicating (Khoza, 2005). It is evident that nursing culture may determine a particular way of making sense of the world and experiences at work. In addition to this, nursing culture may provide nurses and patients with particular roles and shared meanings that are not immediately understood and have to be taught to newcomers (Khoza, 2005). Hence, it may follow that the medical culture and prescriptive social roles in the health care system may produce difficulties in relationships and behaviour when individuals do not understand what is expected and do not know the rules of the medical or health care culture. This medical culture and its associated social roles are not static, and may be subject to change. In South Africa, changes in the broader society – the end of apartheid and the introduction of human rights – have resulted in changes in health care and therefore also changes in the organisational culture found in health care facilities.

Nursing practice has been argued to be strongly characterised by the culture of self-sacrifice, control, social distance and the drive to maintain the professional middle class (Jewkes et al., 1998a; Marks, 1994; Van der Walt & Swartz, 2002). Yet, with the end of apartheid, nursing practice has undergone various changes. The shift to primary health care and recent health care reforms, for example, have resulted in changes in the context in which nursing is practised, the role nursing plays in society, and the specific nursing culture in South Africa. To demonstrate this, Van Wyk et al. (2006) argue that health care during apartheid involved practices in which "life was compartmentalized" (p.11) and health care workers could focus on the medical, thereby not always being aware of their patients' social or emotional difficulties. This created a false sense of order and stability, amplified by hierarchical management, all of which provided social defences against anxiety (Van Wyk et al., 2006). With the changes in health care provision, nurses are still confronted with anxiety-provoking situations in the care of patients, but may have lost their social defences to protect them against these anxieties (Van Wyk et al., 2006). Therefore, it is clear that the changes found in South African society may have affected medical culture, social roles as well as the psychological dynamics of nursing practice. It is of great importance to explore how our changing society may be affecting the provision of health care – particularly in terms of violence in

the nurse-patient relationship (Van der Walt & Swartz, 2002). A closer look at present-day changes within nursing in South Africa follows.

1.3.1.4 The Impact of Change

Nursing practice is currently complicated by issues of staff shortages, major changes in the organisation of the provision of health care services, low income, long hours, little emotional or monetary support, hierarchies and power-relations (Gilson et al., 2004, Jewkes et al., 1998). These issues affect the well-being of nurses and their attitudes towards their profession and their patients. Set within a history and a society troubled by conflict, violence and uncertain identity, nursing is faced with challenges which may bring about frustration and dissatisfaction if not addressed. Nurses in the public sector often have to contend with extremely difficult and often unpleasant conditions, struggle with shortages of medical supplies, receive low incomes and are expected to provide a variety of services for which they have not received any training (Jewkes et al., 1998a). It is important to consider these contextual issues when investigating the issue of violence in nursing, since the broader context and experience of nursing plays a vital role in behaviour at work and relationships with colleagues and patients.

South Africa is still in the process of transformation and nursing is deeply affected by changes in public health policies which have an impact on salaries, resources, management and the structure of health provision (Gilson et al., 2004). The changes in the health care sector have had a notable influence on nursing practice. Changes in policies and practice have led to "transformation fatigue" (Gilson et al., 2004). Health care workers have reported that they feel that they are never consulted before any policy change and the resulting uncertainty about tasks, organisation and job security greatly affects their job satisfaction (Mclntyre & Klugman, 2003, cited in Gilson et al., 2004). Van der Walt (2002) stresses that since individuals are resistant to change, the change process in health care should be facilitated by managing the anxieties and resistance that accompany it. Moreover, James, Kotze and Van Rooyen (2005); and Penn-Kekana et al. (2004) have discussed declining nursing care standards as a consequence of the pressures created by changes in the health care system on political, socio-economic and technological levels. In addition to the proliferation of health reforms, health care personnel are faced with increasing demands to improve the quality of care provided (Gmeiner & Poggenpoel, 1996, cited in James et al., 2005) and are faced with a work environment in which their expectations are not being met (James et al., 2005). Some of the negative outcomes of these pressures are the breakdown of relationships with nurse managers who are responsible for the implementation of policy changes; and feelings of anger, pain, disillusionment and de-motivation (James et al., 2005).

Penn-Kekana et al. (2004) argued that these policy changes have "ignored the human resources issues and changing roles" brought about by these changes (p.i71). Consequently, the needs and rights of health care workers have not been addressed (Gilson, 2004). Penn-Kekana et al. (2004) further argue that poor quality care and abuse follow poor attitudes towards patients. These attitudes are rooted in nursing history (Marks, 1994, cited in Penn-Kekana et al., 2004) and are exacerbated by the new challenging environment created by changes in health care (Penn-Kekana et al., 2004). Too many successive policy changes are argued to have the unintended consequence that patients are not prioritised and badly treated (Penn-Kekana et al. 2004).

Blaauw et al. (2003) reason that macro-level changes in health care impact significantly on the micro-level, everyday organisational reality of health systems. They argue that changes and perspectives regarding problems in health care are approached as technical and structural interventions, rather than from social and human dimensions, an approach which they believe has contributed to the failure of recent initiatives to significantly improve health system performance. It is rare that changes aimed at improving the functioning of our health care system focus on health care worker attitudes and behaviour (Blaauw et al., 2003). Consequently, nurses at the grassroots level are faced with changes in policies and service delivery, which impact greatly on their everyday functioning, with little attention being paid to their personal and social responses to these changes or to the social origins of problems which may be better solved with social interventions (Blaauw et al., 2003).

The relationship between nurses and patients has experienced changes that run parallel with the changes in society. The medical view of care-giving stems from a socio-cultural perspective where care-giving is depersonalised, prescriptive and determined by rules and social roles (Helman, 1994) . Van der Walt and Swartz (2002) suggested that we need to find ways to humanise the delivery of health care services for the psychological benefit of both nurses and patients. The relationship between nurses and patients has been affected by the introduction of the patients' rights charter which has been adopted in an attempt to regulate the care provided to patients. It stipulates that patients have the right to be treated with dignity, respect, patience, empathy, courtesy, tolerance and a positive attitude (Gilson et al., 2004). Gilson et al. (2004) argue that the charter aims to rectify the apartheid legacy in nursing, in which the patient unquestioningly accepts the service provided within nursing practice that is linked to authoritarian attitudes which seek to create a status difference to the patient. Patients have become more demanding, question nursing staff and expect free and competent medical treatment as a result of their increased awareness of their rights, particularly the right to verbalise demands (Gilson et al., 2004, Van Wyk et al., 2006). This has resulted in conflict between the professional and her patient, both of whom struggle to understand their new roles in a changing medical world.

Importantly, nurses have indicated that they feel that their rights have been ignored as the rights of patients have been established and protected (Mclntyre & Klugman, 2003; Walker & Gilson, 2004; cited in Gilson et al., 2004). Nurses see this as a resulting in patients having no respect for them, misusing the health care system, and being abusive towards them (Walker & Gilson, 2004). Nurses have been found to feel that even though patient care has improved with new health care policies, nurses' conditions have worsened. Therefore, as patients have been empowered, nurses experience a sense of disempowerment (Van Wyk et al., 2006, Walker & Gilson, 2004). Walker and Gilson (2004) explored nurse's attitudes towards and experiences of policy changes in nursing; and nurses revealed that they do not feel as respected by their patients and communities as they were during apartheid, and that they expected much after 1994, but now feel that their circumstances may have been better then. In addition to this, managers feel that the changes in the health care system are politically motivated and do not consider the practical limitations to implement these changes (Van Wyk et al., 2006). Through the development and implementation of changes in the health care system, greater pressure is placed on health care professionals while "new health policies exacerbate the situation by empowering patients and stripping health care workers of their status as professionals" (van Wyk et al., 2006, p.8).

From the discussion of culture, practice and change in the South African health care system, it seems that the culture of nursing as we know it is historically embedded in a socio-cultural context (Helman, 1994). Medical culture and indeed nursing culture have undergone many changes since the introduction of formal health care in South Africa. Health care culture and consequent care-giving and roles are learnt by those who interact with it (Khoza, 2005) and it is imperative to our understanding of nursing to pay attention the effect that changes have on this aspect of health care.. Changes in South African health care have been found to play a role in the disintegration of nurse-patient relationships and the development of violence. Therefore, this context of nursing has been an important consideration throughout this thesis in terms of the discourses that underlie the occurrence of violence against patients.

1.3.1.5 Hospital Culture and Behaviour.

The following study by Zaman (2004) illustrates the role of culture in health care. Zaman (2004) undertook an ethnographic study in Bangladesh in order to understand hospital culture in the context of Bangladeshi society at large. It was argued that that the life and work in a particular ward resulted in a culture that was created by its inhabitants and the conditions in which they found themselves. The study showed that biomedical practice is an outcome of specific social

circumstances and that the hospital mirrors characteristics of its society (Zaman, 2004). The study addressed the issue of how medical practice is shaped by its particular social context, in this case an understaffed, under-resourced and poorly financed hospital in a low-income country. The study created a picture which proved to have many similarities to South African hospitals where staff shortages and the lack of resources are everyday problems that nursing staff have to contend with.

King (1962) cited in Zaman (2004) described the hospital as a cultural setting which involves a particular way of life where the everyday customs, behaviours and relationships can be considered as a subculture existing within the greater society. Zaman (2004) argued that this subculture within a hospital does not exist in isolation, but as a microcosm of the larger culture. He observed hierarchies within the hospital where the patient became a passive observer of his or her treatment. There was no discussion with the patient. Patients were seen to receive scolding from all staff members and this seemed to have become an integral part of ward life. Staff seemed to exercise a high level of power and control within the ward over both patients and their family members, yet expressed high levels of professional frustration. Patients were generally ignored and humiliated by staff. Zaman (2004) argued that these observations reflected the value placed on hierarchy in the greater Bangladeshi society. The staff in wards demonstrated concern with the maintenance of inequalities between doctors, different ranks of staff and patients. The patients remained the most vulnerable within this hierarchy. These observations are similar to those described by Jewkes et al. (1998a, 1998b) in their study on abuse and neglect of patients in South Africa.

Clearly, nursing behaviour and the occurrence of violence towards patients cannot be researched without consideration for the broader context in which is occurs. Working conditions, salaries, patient-staff ratios and other practical demands of the job contribute to the overall experience of nursing. Next one can consider the particular relationship between the nurse and her patient as it is both culturally and socially determined (Landy, 1977 cited in Helman, 1994). All of this is set within a particular socio-historical context that determines the ideologies, theories, discourses and practices drawn from to develop a particular hospital culture. This hospital culture may reflect inequalities and violent practices, present in the broader society that have become the norm in nursing practice. In addition to this, medical practice in South Africa has undergone changes (for example - in policies) that run parallel with changes in society, thereby creating new, conflicting and confusing contexts and experiences for nurses to contend with. These aspects of nursing have been important in the development of this thesis, since they provide an illustration of the context in which violence may be allowed to occur. They are taken as a theoretical point of departure in the exploration of violence towards patients, as it may occur in a specific South African governmental hospital that may have developed a specific care-giving culture determined by history, politics, society and change.

1.3.2 The Experience of Care

Within the context of nursing described in the previous section, the care-giver and patient also have personal experiences of care giving and receiving that may influence their relationship and behaviour. This is illustrated by Blaauw et al. (2003)) who found that the nurse-patient relationship is a central component of patients' health-seeking behaviour and resulting treatment outcomes. Jewkes et al. (1998b) indicated that a poor nurse-patient relationship is a highly complex problem for which multiple solutions are required. Another important aspect of the experience of care-giving is the care that nurses receive from colleagues and nurse managers. It follows that a discussion of relevant issues involved in the experience of care-giving; and indeed care-receiving will be provided in order to illuminate possible problems experienced by nurses that may contribute to the understanding of the phenomenon of violence towards patients.

1.3.2.1 Poor patient care and the nurse-patient relationship.

O'Donoghue, Jooste and Botes (2004) argued that poor patient care is tantamount to unethical behaviour. *Quality of care can also have life and death implications. Negative and non-caring staff attitudes towards patients contribute greatly to poor care, and results in neglect in homes for elder patients (O'Donoghue et al., 2004). Between April 1979 and March 1994, 171 cases of neglect and 21 cases of assault in nursing homes were reported to the South African Nursing Council. (O'Donoghue et al., 2004). O'Donoghue et al. (2004) argue that quality care involves ethical care, and that the drop in standards of care-giving results in unethical behaviour. Unethical behaviour has also been related to poor job satisfaction, which is seen to be relevant when addressing patient care (Biton & Tabak, 2003). The implementation of moral and ethical codes of conduct is seen by Biton and Tabak (2003) as one of the biggest challenges facing nursing today, and Jewkes et al. (1998a) argue that the occurrence of violence towards patients is a result of nursing leaders' failure to enforce a system of ethics. It becomes increasingly evident that violence against patients is seen not only to be an occupational and personal issue relating to the nurse, but also an ethical problem within the health care services.

O'Donoghue et al. (2004) have found that management difficulties, long work hours, not knowing what is expected, and high patient-staff ratios seem to be important correlates of unethical behaviour towards patients. They recommended procedure manuals and management styles that encourage ethical behaviour and create a sense of belonging to a team as ways to address this problem. The problem of poor patient care and violence towards patients can be approached from

such an ethical perspective, but there are certainly more dimensions to this problem than a classification of 'good' and 'bad' behaviour followed by the addition of a prescriptive manual stipulating acceptable behaviour. Occupational and emotional stressors play as important a role in the provision of health care and affect care-giving negatively. The correlates of unethical behaviour – work-related pressures and management difficulties cannot be completely solved by the development of procedure manuals. James et al. (2005) argue that quality care is impossible when the necessary resources to provide this care are not available. Management styles, however, may play an important role in the development of ethical and quality care. Sikma (2006) argues that there is an association between feeling cared for and care-giving, since being supported by colleagues and management have been associated with family satisfaction, improved quality of care and a decreased risk of patient abuse. Nurses who feel supported in the work environment and feel comfortable with colleagues, have been found to excel in their jobs and maintain higher levels of patient-care (AbuAlRub, 2004).

The nurse-patient relationship, and consequently patient care, may suffer as a result of the social environment in which care is provided. Gilson (2004) reports that discourtesy by staff towards their patients has negatively affected service access, since patients fail to seek treatment where they fear they will be badly treated (Jewkes et al., 1998a). This problem is proposed by Gilson (2004) to be related to working conditions that include issues of staff shortages, concerns for staff safety and remuneration (Mclntyre & Klugman 2000, cited in Gilson, 2004), a lack of resources and insufficient training for dealing with circumstances in rural and under-resourced areas (Gilson, 2004). Lazarus (1994) cited in Jewkes et al. (1998a) similarly argues that poor nurse-patient relationships are barriers to access to care. Gilson (2004) investigated the trust that patients have in their health care workers, and found that many have trust in health care workers in general, but not in those with whom they have regular contact. Gilson (2004) further identified a common theme in many interviews with regards to this trust - the concern about the arbitrary nature of the care patients would receive. Interviewees reported that they may be treated badly by some nurses; or treated badly by the same nurse at times; and could not predict if they would receive care that would not involve scolding, treating them like children or not explaining treatment. Therefore, being badly treated by nursing staff was identified as a prominent theme in patient discourse; and it has had an impact on the trust communities have in individual nurses, certain facilities, the understanding of treatment, and decisions of where and if treatment will be sought (Gilson, 2004).

Besides the impact that poor quality care may have on patients' feelings of security and trust, the quality of patient-care has been linked to feelings of professional insecurity amongst nurses (Jewkes et al., 1998a). Jewkes et al. (1998a) argue that the professional security of nurses in South Africa is linked to status and power that are experienced to be undermined by patients. Nurses are

argued to be actively involved in a struggle to maintain their middle class status (Jewkes et al., 1998a). This is done by creating social distance from their patients that may result in lack of compassion and eventually in violence against patients (Jewkes et al., 1998a). *Quality of care has also been found to play great role in treatment adherence and maternal death rates (Adar & Stevens, 2001; Gilson et al., 2004). More than half of maternal deaths have been reported to involve problems with the care provided (Parkhurst et al. 2005).

Johnson and Webb (1995) cited in Roos (2005) argue that nurses make vague social appraisals of their patients. Patients are given evaluative labels that are inflexible and impact on the relationship between the nurse and patient. In light of this, Roos (2005) claims that we know little of how nurses perceive their patients –especially difficult patients - in South Africa. Roos (2005) further argues that when a patient is seen as difficult, the relationship with the patient can be affected negatively. Three categories that influence how nurses perceive patients were identified by Roos (2005) – patient factors, nursing factors and situational factors. One of the most important findings of the research conducted by Roos (2005) is that nurses report that they do not want to be questioned by their patients. Breeze and Repper (1998) cited in Roos (2005) argue that nurses see patients as difficult "when they pose a threat to the control and competence of the nurse" (p.58). From the findings reported by Roos (2005), it can be argued that the label of being 'difficult' may not always be related to the behaviour of the patient, but to how patients are perceived by nurses. Therefore, the relationship between nurses and patients needs to be carefully investigated in terms of the occurrence of violence against patients.

Rask (2002) found that nurses felt that improving their relationship with patients is relative to the development of interpersonal relationships that are based on empathy, respect, trust and responsibility in addition to in-service training that improves skills in treatment administration and development of relationships. The nurse-patient relationship is arguably the most important aspect of care-giving and positive health care outcomes. Yet, it remains a complex interaction, which can pose many interpersonal, professional, personal and health challenges. A variety of views with regards to this relationship, and how it may be related to poor health care or violence, has been offered in this section. Poor patient care is unethical, and is rooted in a variety of work-related issues that affect the nurse-patient relationship. A need exists for further exploration of these issues and specifically of ways to improve care-giving. The development of better interpersonal relationships and codes of conduct should be complemented by policies based on a more holistic understanding of the nursing experience. The more demanding aspects of the nursing experience affects care-givers personally and impacts negatively on care. Therefore, I have considered, in detail, other aspects of nursing practice that may influence care-giving and play a role in violent care-giving.

1.3.2.2 Job satisfaction, burnout and patient care.

Rad and Yarmohammadian (2006) define job satisfaction as the attitude that individuals have towards their jobs and the organisations within which they work; as well as other inherent and extrinsic elements of their profession. Job satisfaction has been found to be one of the main factors related to the quality of patient care (Biton & Tabak, 2003). Biton and Tabak (2003) argue for the importance of an individual's emotional evaluation of work experiences, and maintain that job satisfaction is derived from such evaluations being positive. It is further argued that job satisfaction is related to the experience of autonomy, workload, remuneration and relationships with colleagues, superiors and patients (Biton & Tabak, 2003). Job dissatisfaction, on the other hand, may lead to low morale, high turnover and poor job performance, which negatively affect the quality of patient care (AbuAlRub, 2004; Laschinger, Shamian & Thomson, 2001). Nurses are reported to be apathetic towards their jobs, because they are overworked, lack sufficient nursing staff and have to work with agency staff who may not be orientated to the particular clinical setting where they are placed (Abrahams, 2002).

Shortage of staff is an important problem facing the nursing profession (Laschinger et al., 2001). Staff shortages threaten the quality of patient care, since work satisfaction is compromised when nurses are unable to satisfy their own care standards (Newman, Maylor & Chansarker, 2004). If nurses are taken care of, it is argued that patients will receive proper care. Newman et al. (2004) argued that nurses who are not satisfied, and feel undermined and undervalued are more likely to neglect their duties towards patients. A definite link has been found between job satisfaction and the quality of care given to the patient (Newman et al., 2004). A supportive working environment has been linked to higher quality of patient care (Laschinger et al., 2001).

Nurses sometimes have to do their jobs against overwhelming circumstances and this may result in a feeling of loss of control over their professional and personal lives. Similarly, Havens (1996) cited in Jewkes et al. (1998a) found that job satisfaction is strongly related to empowerment and locus of control (autonomy). The lack of autonomy or locus of control at work may lead to the need to assert control and the most common ways to do this is through anger, aggression and violence (Morrison, 1992, cited in Morrison et al., 2000). Violence against patients may thus be linked to job dissatisfaction and the need to assert autonomy and control over work environments. Therefore job satisfaction, and its effect on the quality of care provided to patients, is of the utmost importance. Results show that if quality care is provided, the mortality rates in hospitals decrease, patients are more satisfied, and there are fewer adverse effects, such as medication errors, patient

falls, infection rates, inadequate discharge rates and hospital readmissions (Laschinger et al., 2001). Job dissatisfaction may be linked to burnout, which affects care-givers negatively.

Burnout is a work-related hazard in the care-giving professions that has a significant impact on patient-care. McGrath, Reid and Boore (2003) identified various sources of stress: workload, patient care, interpersonal relationships with colleagues, knowledge of nursing and bureaucratic issues. Burnout has been described as a condition where professionals become depersonalized and lose all their emotional concern and feeling for people they work with, and consequently treat them in a dehumanized and detached way (Cronin-Stubbs & Rooks, 1985 cited in McGrath et al., 2003). Burnout is a physical, emotional and psychological response to job-related stress and may present symptoms of fatigue, low energy, weakness and weariness; as well as depression, helplessness and hopelessness (McGrath et al. 2003). Laschinger et al. (2001) argue that it is characterised by detachment from patients, intellectualization of stress, and withdrawal from patients and co-workers in the caring professions. Chapman (1997) cited in Potter (2006) argued that burnout involves emotional exhaustion that results in a lack of competence and a sense of failure.

In contrast, Billeter-Kopenen et al. (2005) cited in Potter (2006) concluded that nurses suffer from lasting stress and burn-out, caused by decision-making and reorganisations that did not take nurses' knowledge and experience into account. Nurse-patient relationships were deemed as central to care and nurses stated that this relationship was not affected negatively as a result of tiredness, but as a result of being powerless to meet the needs of patients and to secure quality care (Billeter-Kopenen et al., 2005, cited in Potter, 2006). Staff felt that the only way to cope with these problems was to go on sick leave. Rowe (2005) argues that the emotional relationship between the nurse and her patient has been based on the feeling of empathy for the patient's survival. Emotions are, according to Mark (2005), important in health care as they relate to the survival of both patients and nurses. Emotion, in this sense, is defined as the meaning we attach to our survival as a person. Nurses need to survive their occupation in order to be able to provide care to all their patients. It may therefore be that burnout involves caring too much and not having the ability to survive the emotional demands of the job, rather than not caring at all. Potter (2006) discovered that earlier detection of burnout may be of utmost importance in ameliorating its damaging effects and suggested that the health care community should deal with burnout by caring for patients and caregivers.

The inability to survive nursing emotionally seems to be common, and it can have devastating consequences for nurse-patient interactions and relationships, and ultimately patient care. It has been linked to negative patient ratings of quality care and may be related to the occurrence of violence as a symptom of being unable to cope effectively (Laschinger et al., 2001). Positive working conditions are associated with lower rates of burnout and it is important to create positive

and supportive environments for the benefit of both nurses and patients (Laschinger et al., 2001). Creating such environments may be difficult in the face of other, more demanding challenges in nursing. The association between burnout and violence towards patients is of importance, especially when we investigate violence in a setting where great emotional and environmental demands have been reported to affect patient care. The emotional side of nursing is easily forgotten when we explore violent behaviour of care-givers, yet it is integral to our understanding of the provision of care.

1.3.2.3 Emotion and care.

El-Nemer, Downe and Small (2006) found in their study of nursing in Egypt that there is a distinction between two kinds of care nurses provide to birthing women. They categorised care in terms of hospital care epistemology "characterised by 'technical touch'" and women's birth epistemology "characterised by 'helping from the heart'" (p.81). They discovered that the emphasis on the technical and the medical in care-giving failed to provide quality, safe care for patients. Some nurses were seen to be merely in attendance and doing their jobs, but others were involved with the birth on a personal level, providing empathy and creating an emotional connection. The prominent way of caring was observed to be 'technical touch' that "… was therefore about helping women to endure the constraints that resulted from (a) philosophical approach" that visualises birth as an event that is "predictable and should conform to standard rules" (El-Nemer et al., 2006, pp. 84-85). 'Technical touch' involves caring that "appears to be almost completely divorced from the woman as person" (El-Nemer et al., 2006, p.85). 'Caring from the heart' on the other hand involves the emotional aspect of care-giving in which comfort and support is provided.

El-Nemer et al. (2006) found that 'caring from the heart' was to a great extent missing in hospitals, which raises the question of why nurses would distance themselves emotionally from patients and focus only on the medical condition. Burnout has been discussed in the previous section as one explanation for the emotional detachment of nurses from their patients. El-Nemer et al. (2006) conversely argue that this emotionally-detached form of care-giving originates in the application of a western technical model that "constructs women's bodies as flawed and in need of correction" (p.89) and that it is therefore not a consequence of the overwhelming demands of the job. El-Nemer et al. (2006) further observed care that involved unnecessarily high rates of technological and pharmacological interventions, and interactions with patients that focused on technical tasks, and included only commands and criticisms. Comfort was provided only to help women to accept interventions. El-Nemer et al. (2006) argue that the way of knowing about and doing birth should include "concepts such as love, respect, trust … skill and knowledge" (p. 90).

They conclude that the absence of emotional care is a consequence of the epistemology of care that medicalises the process of birth and they suggest that this could be rectified in terms of a new epistemology involving "skilled help form the heart" (El-Nemer et al., 2006, p. 90). It seems therefore that the nature of westernised medical care-giving itself may inhibit the provision of care and contribute to the experience of poor care. Therefore, the approach to care-giving may be contributing to negative experiences of care. The question that follows is: what other purpose could this depersonalised care serve and how could it relate to the development of violent care-giving.

Van der Walt and Swartz (2002) argue that task orientation is an aspect of patient-care that involves nursing care provided to the patient being divided into discreet sets of tasks performed by different care-givers. Lewin, Greene and Daniels (2000) cited in Van der Walt and Swartz (2002) argue that one of the consequences of task orientation is that the care provided becomes depersonalised, but it allows nurse managers to exercise maximum control over their work force. It also serves to place the nurse at a particular distance from the patient in order to protect against the full impact of what nursing entails (Van der Walt & Swartz, 2002). Nurses need to shield themselves from emotional invasion by their patients when they are not strong enough to provide this emotional care. Task-orientated care-giving provides nurses with a practical defence against the overwhelming anxiety that may accompany care-giving (Menzies Lyth, 1988; Van der Walt & Swartz, 2002). As I have noted earlier, nursing is a demanding and stressful occupation. Many of the tasks are mundane and unrewarding and may be experienced as disgusting, degrading and even frightening (McGrath et al., 2003, Menzies Lyth, 1988). McGrath et al. (2003) found that a nurse's emotional involvement with patients becomes limited by various anxiety-evoking stressors in the hospital environment, such as the nurse hierarchy and relationships with colleagues. Menzies Lyth (1988) argued that a "task-orientated, fragmented pattern of care spread the responsibility and limited nurses' emotional involvement with patients, thus reducing anxiety" (McGrath et al., 2003, p. 565).

In other words, nurses may be inadequately prepared to deal with the complexities involved in patient care, such as pain, substance abuse, anger, manipulation and non-compliance (Morrison, 2000). Some may not have the psychological or life skills necessary to work in the health care environment (Morrison, 2000) and may therefore divide their contact with patients into smaller, task-orientated or avoidable fragments (Van der Walt & Swartz, 2002). Van der Walt and Swartz (2002) explain that this task-orientated form of care-giving has a "long tradition in nursing" (p. 1001) that may have originated in attempts to "overcome the constraints of time and personnel shortages" (p. 1006). Furthermore, Van der Walt and Swartz (2002), agree with Menzies Lyth's (1988) view that nursing involves the development of defences or coping mechanisms that enable nurses to manage anxiety present in nursing practice.

Nursing may entail a certain level of trauma and suffering; and Frenkel (2002) posed the question of how nurses and doctors learn to deal with these experiences. Frenkel (2002) found that health care professionals generally responded that one "gets used to it" and subsequently argued that staff develop a "protective skin" in order to cope with the stressors of their profession. This "protective skin", however, is not complete and it is argued that health care professionals never truly get used to trauma and suffering by normalising these events (Frenkel, 2002). Therefore, socially sanctioned defences are developed within the nursing profession in order to protect against anxiety and trauma experienced daily (Frenkel, 2002; Menzies Lyth, 1960). Frenkel (2002) had observed that eye contact and interaction with the suffering patient have been minimised, except to tease or reprimand. The patient then becomes an object from which the nurse is detached and depersonalised. This may cause nurses to work efficiently and methodically in a task-orientated way in order to deny their own feelings (Frenkel, 2002; Menzies Lyth, 1988; Van der Walt & Swartz, 2002). Obholzer (2005) cited in Mark (2005) suggests that what we see as dysfunctional in health care settings may be a result of the defence mechanisms that are elicited by the health care environment. Perhaps, then, focusing on the technical and medical aspect of care-giving; and violence towards patients could be consequences of the defences developed to protect against the 'typical' anxiety involved in providing care. These defences against overwhelming emotion are not only individually developed, but organisationally determined.

The emotional well-being of health care providers is clearly related to a variety of factors: organisational factors, such as workload, resources, nurse-patient ratios; environmental factors, management, culture, and expectations; psychological factors, such as burn-out and anxiety; and personal factors. Mark (2005) suggests that there exists a dynamic relationship amongst emotion, individuals and organisations in health care. Importantly, Rowe (2005) argues that emotion plays a very important role in the survival of both patients and professionals. For the professional, survival is argued to be linked to validation of the individual and professional; as well as the nurse's ability to provide consecutive care to patients (McLaughlin, 2003, cited in Mark, 2005). Within the nursing profession, emotion plays a crucial role in the provision of care, and as we have seen in the literature, emotion is not only a personal issue, but an organisational one in the medical world. In fact, the care provided to patients by nurses may be crucial to their well-being and it may be adversely affected by their emotional well-being. Surely, then, we may argue that health care workers are also in need of care.

Khoza (1996) cited in James et al. (2005) stated that "we tend to focus on caring for the patients, clients and their families, but we forget to care for ourselves and colleagues in the nursing profession" (p. 5). To add to this, Pera and van Tonder (1996), cited in James et al. (2005) argue that nurses have a professional responsibility to care for and support one another. They discovered a

variety of emotional manifestations of feeling uncared for and unsupported by nurse managers. These emotions included feelings such as: anger, frustration, sadness, loss of hope, bitterness, loneliness, insecurity and alienation to name a few. Sikma (2006) found that nurses working in nursing homes often feel used, mistreated and burned out as apposed to feeling cared for. Tellis-Nayak (1989) cited in Sikma (2006) argues that if we focus on the human needs of nurses, we will simultaneously be enhancing the well-being of patients. Care-givers need to experience caring and support; open communication; trust; and safety, since these allow them to feel safer when they are in a weak position and reduce the environment of defensiveness (Sikma, 2006). Health care workers report that when they feel cared for, they are satisfied, proud, and productive; and the quality of care provided improves (Sikma, 2006). On the flip side, when health care workers do not feel supported, they feel frustrated, exhausted and risk burnout; and may treat patients severely or become abusive towards them (Sikma, 2006). Emotion within the organisation plays an important role in our understanding of nursing practice.

1.3.2.4 Emotion within the organisation

Schwartz (1999) argues that organisational theory can benefit from exploring "irrational, symbolic and emotional forces in accounting for the behaviours of individuals and groups in organisations" (p.2). This approach can enable us to look at the motives and meanings attached to behaviour that are not always openly acknowledged (Schwartz, 1999). Schwartz (1999) further argues that the individual's experience of their social reality is not neutral, but shaped by feelings of anxiety and pain that may be too painful to deal with. In agreement with the views proposed by Frenkel (2002), Menzies Lyth (1988), and Van der Walt and Swartz (2002), Schwartz (1999) argues that individuals then develop defences to address the emotional demands of the organisation. Nursing, in particular, involves many emotional demands that may require defences to reduce anxiety (Frenkel, 2002; Menzies Lyth, 1960 cited in Frenkel, 2002). Therefore, emotion in care-giving is debatably of the utmost importance when exploring the experience and understanding of violence against patients, since the relationship with the patient lies at the heart of care-giving and the associated feelings of anxiety (Menzies Lyth, 1988).

Brunton (2005) argues that health organisations have a complex emotional life, despite the tradition of rationality imposed by organisational theory. Brunton (2005) maintains that the relationship between health care workers and patients involves a variety of emotions - for example: anxiety, fear, happiness or anger - that play an important role in the creation of meaning. In this context, health care workers may demonstrate authentic empathic emotion during care-giving, but the main focus of the organisation remains on service-delivery (Brunton, 2005). Hereby, "emotional

labour" (Hochschild, 2003, cited in Brunton, 2005) is found within a "service culture" (Brunton, 2005) that requires the emotional boundaries between nurses and patients to be "managed" (Brunton, 2005, p.341). This results in the necessity of adjusting one's real emotional responses in order to meet conventional social or occupational norms. These norms determine how much emotion one is allowed to display. Mann (2005) argues that health care professionals invariably develop strategies to manage emotions as a result of the uncertainty and repression of feelings associated with care-giving. Nurses may then be placed within a framework for care-giving in which they have to draw on "emotional labour" when "they do not feel as they think they ought to in a particular situation" (Mann, 2005, p. 306). Therefore, health care workers are expected to display organisationally determined emotions, rather than those that they truly experience, in order to meet the needs of the clients (Brunton, 2005). Mann (2005) argues that health care professionals may not feel the expectation for emotionally-appropriate care from only the organisation, but may also have the personal desire to provide 'emotional labour'. Yet, it is not always possible to feel genuine feelings of kindness, sincerity or empathy; and nurses may suffer in terms of their mental well-being when they are expected to provide such care (Mann, 2005).

An important aspect of emotional labour is that "health professionals must not only empathize and support clients, but also, when deemed appropriate, separate themselves from the emotional transactions which may be occurring …" (Hosking & Fineman, 1990, cited in Brunton, 2005, p. 341). Brunton (2005) discovered that nurses used the "rational framework of biomedicine … to construct a protective frame to emotionally 're-code' the work to help to protect them from higher levels of stress" (p.351). Ironically, the excessive and continuous demand for such emotional 'management' seems to have the opposite effect of creating a stressful environment that may lead to burnout (Brunton, 2005), in addition to having a negative impact on health care worker's health (Schaubroeck & Jones, 2000 cited in Brunton, 2005). Importantly, Mark (2005) indicates that this split or separation between rationality and emotion in health care provision, with the dominance of rationality, may "provide the cognitive means by which emotionally unacceptable procedures and activities are allowed to occur to individuals as patients" (p. 279). It may be, then, that if violence or abuse are rationalised as aspects of health care, they may be allowed to occur to patients. Obviously, the "tradition of rationality" may involve negative outcomes for patients as well as nurses when the importance of emotion in care-giving is underestimated (Mark, 2005).

Mackintosh (2006) conducted research on how nurses protect "the self" within the emotionally charged profession of nursing. Mackintosh (2006) argued that nurses emotionally distance or detach themselves from patients as a result of the cognitive dissonance (Festinger, 1957, cited in Mackintosh, 2006) embedded in the emotionally distressing circumstances that health care workers may find themselves. Cognitive dissonance is a "process by which individuals actively

seek consistency of opinions, attitudes, knowledge and values, and where this consistency is not present a dissonance exists" (Mackintosh, 2006, p. 3). Interestingly, Mackintosh (2006) argues for the resultant existence of a dichotomy between the nurse's personal and professional levels of being, which may cause moral distress. Consequently, there may exist a difference between what the individual would perceive as morally correct; and what a professional would. Furthermore, Mackintosh (2006) argues that emotional labour may present similar a dichotomy, where there is a difference between what the individual feels and how the professional behaves, which may lead to emotional detachment. Mackintosh (2006) discovered that nurses report the necessity to "switch off" to alleviate the stress involved in care-giving (p. 7). Moreover, nurses revealed that they develop a "work persona" that determines the type of relationship developed with the patient, and promoted the development of coping skills of "hardness and switching off" (Mackintosh, 2006, p. 7). Of great significance, Mackintosh (2006) discovered that the "work persona" of the nurses in her study included features similar to "switching off or withdrawal, a loss of caring beyond a certain acceptable level, and depersonalisation" that are all "symptoms of burnout" (p. 7). Hagbaghery, Salsali and Ahmadi (2004) similarly found that role conflicts between what nurses feel is professional and what the organisation determines may lead to avoidance of care-giving in order to alleviate the tension.

It becomes apparent, as I review the literature, that the presence of a socially and organisationally determined nursing culture that prescribes social roles for patients and nurses; as well as nursing practice is closely associated with nurse-patient relationships and care-giving. The organisationally determined expectations placed on care-givers affect them emotionally and psychologically, and may be involved in the development of defensive behaviour. This may, in turn, be involved with violent behaviour towards patients. An understanding of both the context and experience of care-giving are critical to our understanding of the relationship between the individual, organisation and emotion in the development of violence.

The previous sections have focused on creating a general, yet comprehensive picture of health care issues in South Africa. The following two sections will focus on the particular context within which this research has been conducted, and the particular area of interest. Therefore, I have included the following two sections: *Maternity services in South Africa*; and *Violence in the health care profession*.

1.3.3 Maternity Services in South Africa

The maternal health outcomes of a country are a good indicator of whether the health system in that particular country is well or not, since it is argued that maternal health care depends on the entire health care system (Penn-Kekana et al., 2004; Parkhurst, 2005). With a functioning health system, the majority of maternal deaths can be averted (Graham, 2002, cited in Penn-Kekana & Blaauw, 2002). Penn-Kekana et al. (2004) identified health care provider behaviour to be an important issue related to the "wellness" of the South African health system, with poor provider practice being related to the majority of maternal deaths. Although South Africa reveals high levels of antenatal care (ANC) utilisation, Penn-Kekana et al. (2004) suggest that these figures mask great inequalities in our service provision and that more research is needed to understand the relationship between health-seeking behaviour, access, quality of care and utilisation as barriers to treatment in maternity services. One of these barriers is that women, especially poor women, have been found to avoid seeking treatment, since they cannot access facilities and are unsure of the kind of treatment they will receive there (Penn-Kekana et al., 2004). An investigation into avoidable factors concerned with high mortality rates conducted as part of the Saving Mother's Reports (1998), identified a delay in health-seeking behaviour. Jewkes et al. (1998a) argued that many women do not seek help from their clinics as a consequence of negative relationships with nurses.

Penn-Kekana et al. (2004) argued that more research is needed to understand how maternal health care services are affected by the major reforms taking place in South Africa. Parkhurst et al. (2005) have identified the most common systems issues impacting on maternal health care in South Africa to be: human resources structures, the public - private mix of services, and changes in health sector reforms. Health sector reforms entail the decentralisation of administration and funding; integration of formerly separate health services; privatisation of services; and financial reforms (Parkhurst et al., 2005). These reforms have a significant effect on maternal health care, especially since they may affect the provision of maternity services negatively with a decline in quality care where the needs of health care workers have not been taken into account (Bosman, 2002 cited in Penn-Kekana at al., 2004; Parkhurst et al., 2005). The negative impact of health care reforms is specifically caused by the burden they place on relationships and the workload that they create for health care workers (McIntyre & Klugman, 2003; Oliff et al., 2003; Orubuloye & Oni, 1996 cited in Parkhurst et al., 2005). One of the major health care reforms in South Africa has been the provision of comprehensive free primary health care in an effort to negate the impact of apartheid on health care provision (Penn-Kekana et al. 2004).

Schneider and Gilson (1999) have found that health care providers have powerful beliefs and opinions regarding the policies of free maternal health care. Free care is seen to encourage the

'abuse' of services; and the combination of abortion-on-demand, and free care is believed to encourage women to become pregnant (Schneider & Gilson, 1999). Jewkes et al. (1998b) argued that the occurrence of abuse of women in maternity services may be linked to negative attitudes towards patients and their social worth. Schneider and Gilson (1999) further discovered that health care workers rated pregnant women low on the list of groups deserving free care. Penn-Kekana et al. (2004) highlighted that poor attitudes towards patients have originated in the historical roots of nursing in South Africa, particularly in the apartheid era (Marks, 1994). The training of providers under a conservative, apartheid regime has resulted in the socialisation of many health care providers into perceiving particular categories of patients, for example poor pregnant women, as morally defective and that use of facilities by such patients could even be experienced as a sort of harassment (Schneider & Gilson, 1999). This history has contributed to the development of particular beliefs and attitudes regarding their patients. Schneider and Gilson (1999) suggested that maternal health care pay particular attention to programmes that address health care providers' attitudes toward their patients, and the development of more women-friendly health care environments. This is of great importance, particularly when we are faced with issues of abuse and violence perpetrated against patients.

Jewkes et al. (1998a) assert that dysfunctional relationships between nurses and patients are present in South Africa and internationally. They discovered the following problems related to the nurse-patient relationship in maternity services: nurses feel that they should and can moralise patients, poor staff communication skills, limited bio-medical knowledge, a lack of respect for patients and a belief that beating patients is sanctioned within nursing practice. To add to the seriousness of the problems in nurse-patient relationships, Jewkes et al. (1998b) observed that "the manner in which staff responded to patients created obstetric risk and five women delivered on their own" (p.3).

The South African Health Review (2004) has indicated that the standard of care during pregnancy has gradually deteriorated (Smit et al., 2004). Problems within maternal and perinatal care have been identified and recommendations to improve the quality of care and to reduce mortality rates associated with pregnancy have been made. These recommendations include: the training of staff, development of technology and improvement of resources (Smit et al., 2004). Smit et al. (2004) argue that more needs to be done in order to avoid maternal mortality and morbidity, as well as to improve women's experiences of giving birth. The Reproductive Health Steering Committee has prioritised women's dignity as a major focus in service delivery, but research and the media have indicated that more needs to be done to achieve this (Smit et al., 2004).

Poor health care worker performance in maternity services have been identified in more than half of the cases of maternal deaths, of which the majority occurred at primary health care levels

(Smit et al., 2004). The failure to follow standard protocols was identified as a key problem in the occurrence of poor performance (Smit et al., 2004). Similarly, Ghandi, Welz and Ronsmans (2004) discovered inadequate monitoring and delays in treatment or referral to be related to severe acute maternal morbidity in an audit conducted in a South African hospital. The Saving Mothers Reports (1998) indicated that poor quality of patient care can partially be attributed to a shortage of staff, since skilled staff is leaving the public health sector and the country, which leaves remaining staff de-motivated and overworked. Interestingly, Parkhurst et al. (2005) argue that maternal health outcomes are not only dependent on skilled attendance rates, but that "the context in which staff work, the quality of human resource management, and issues around health care worker motivation are as important whether staff are present or not" (p.101). The development of staffing norms, addressing staff shortages, reviewing training and how nurses relate to patients were identified as essential to improving technical and human quality of care in the maternity services (Smit et al., 2004). However, these interventions may not affect the quality of care positively if they place more stress on health care workers.

Schneider and Gilson (2000) report that maternal mortality rates are high in South Africa, especially for African women who have figures of 156 to 250 deaths per 100 000 births in comparison to 3 to 8 death per 100 000 for white women. The four main causes of maternal mortality are: hypertension, non-pregnancy related infections (mainly AIDS), obstetric haemorrhage and early pregnancy losses – mainly septic abortions. Schneider and Gilson (2000) argue that in spite of the fact that we do have the basic infrastructure in place, many gaps in the quality of care provided exist. Access to services, such as supervised delivery and emergency referrals are low for many women. In addition to this, communities complain about judgemental and hostile attitudes from providers, which create further barriers to service provision and health seeking behaviour. Adar and Stevens (2001) argue that a great percentage of maternal deaths can be prevented with good, quality care, management, protocols, proper referral systems, better communication and more frequent in-service training.

Another aspect of maternal health care is the way in which pregnancy and birth are understood from the perspective of the health care system. This may influence the care provided to birthing women. Within the Western approach to birthing, there is a tendency to 'medicalise' a normal birth by changing it into a medical problem (Helman, 1994). According to Davis-Floyd (1987), cited in Helman (1994) obstetrics communicates some of society's values concerning women in labour – her powerlessness in the face of patriarchy, the 'defectiveness' of her female body, the need of medicine to control her natural processes, her dependence on science and technology and the enduring importance of institutions and machines over individual beliefs and meaning. Smith and Brown (2002) cited in Smit et al. (2004) found that women are subjected to

uncomfortable and degrading procedures during delivery from which they received no benefit. These practices may be linked to the medical view of birth; and may affect the type of care women receive in hospitals. Furthermore, studies have identified harsh and abusive behaviour towards birthing women in South Africa (Smith & Brown, 2002; Fawcus et al., 2002; Fonn, 1998 cited Smit et al., 2004; Jewkes et al., 1998a) that may be linked to the above-mentioned view of the 'defectiveness' of their bodies, and the need to control the birthing process.

Maternity services in South Africa are faced with particular problems in the provision of care to birthing mothers. In addition to problems with resources and care, violence and abuse have been reported. Maternal death rates are high and related to inadequate provision of care. Moreover, practices that may contribute to such problems in care-giving have been found to be rooted in attitudes towards patients and birth. It is evident, then, that maternity services in South Africa have been identified as a problematic area of care-giving with devastating consequences of death and violence. A closer look at violence in health care may bring me closer to the issue of violence in nursing.

1.3.4 Violence in the Health Care Profession

Violence at work is described by Hoel et al. (1999) cited in Marais (2003) as destructive behaviour towards another person or object which is expressed in physical assault, homicide, verbal abuse, bullying, sexual harassment and acts leading to mental stress. Marais et al. (2003) argue that violence in the workplace is a manifestation of a more general and pervasive pattern of violence in society at large. Health care workers, amongst other service providers, are argued to be amongst the most likely to experience workplace violence.

Marais et al. (2003) investigated violence in the workplace and identified three consequences on the delivery of services. These consequences were: negative service delivery, including lowering the quality of care provided; internalised responses, including depression and anxiety; and creative adaptation, avoidance strategies and coping mechanisms. In the study conducted by Marais et al. (2003), 59% of health care workers reported that health care workers are also perpetrators of violence towards patients. Violent behaviour towards patients was explained to be a reaction to provocation by patients or deliberate strategies to control or punish patients. Some respondents felt that such violence was the result of unprofessional behaviour.

Certain subgroups of clients are particularly vulnerable to violence perpetrated by caregivers, e.g. children, the aged, mentally ill patients, people with disabilities, and women (Workcover, 2002). Shaw (1998), cited in Workcover, 2002; and Jewkes et al. (1998b) divide abusive behaviour in the health care profession into two categories: sadistic and reactive. Sadistic abusers methodically

and intentionally abuse patients with no feelings of remorse. Reactive abusers are unable to control their impulses and act without thinking. Shaw (1998) cited in Workcover (2002) argues that individuals who do not abuse patients are able to develop psychological immunity to the demands and abuse from their patients and are therefore able to cope and eventually feel positive about their work. They realise their own value, the value of their patients; and are able to maintain resilience and patience (Shaw, 1998, cited in Workcover 2002).

Shaw (1998) further states that violent reactions to patients result from the financially driven medical model that places productivity and efficiency above human relationships and care. This theory is supported by findings by Gilson et al. (2004) who argue that problems in the health system are viewed and solved from predominantly technical and structural perspectives that ignore the 'human', social dimensions of health care provision. Workcover (2002) argues that our understanding of the phenomenon of workplace violence is limited and must be developed.

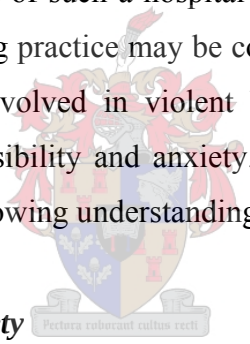
Jewkes, et al. (1998a) interpreted their findings of patient abuse as the result of nurses' attempts to assert their middle class and professional identities by creating a social distance and maintaining fantasies of power through the abuse and neglect of patients. Abusive behaviour was found to be the direct consequence of the social sanctioning of coercive and punitive measures to assert control, an underpinning ideology of patient inferiority, the absence of influential ideologies of care-giving and ethics; and the lack of accountability and action taken against such nursing practices on both nursing and managerial levels (Jewkes et al., 1998a).

Nursing practice in South Africa is dominated by rigid staff hierarchies between ranks, which bring about distinct power-relations. These power-relations result in feelings of insecurity, inferiority in some and superiority in others, and may play an important role in how nurses relate to their patients (Jewkes et al., 1998a). The hierarchy stretches from those who provide simple care to those who are highly qualified and paid (Makoni & Grainger, 2002). These hierarchies extend to the patients and there are clear power discrepancies between nurses and poor, often illiterate or semi-literate patients (Jewkes et al., 1998a). It is then interesting that nurses at the lower ends of the hierarchy have been found to have harsher attitudes towards patients (Jewkes et al., 1998a)

Jewkes et al. (1998a) describe a preoccupation with controlling the work environment and instances where nurses hold onto rigid organization in order to control patients and maintain the power-relations discussed above. Nurses provided the following reasons for the need for control and the consequent abusive behaviour: eroded morale as a result of being overworked and unfairly blamed; the unpredictable nature of the birthing process; experiences of abuse and hostility from patients and the community at large; and moral evaluations of patients. The booking system described by Jewkes et al. (1998a) is a clear illustration – women are expected to arrive at the clinic at a specified time in order to make a booking for delivery. The nursing staff insist on women

arriving a number of hours before the clinic is opened at 8:30 and those who do not arrive early enough are not seen and cannot make bookings. Women who do not abide by the rules of the clinic are not attended to and are perceived as difficult and defiant. Abusive behaviour towards patients who are regarded as difficult or deviant follows when they are birthing. Dysfunctional relationships between nurses and patients exist in the health system, where staff share societal norms and beliefs regarding the rights of women, which according to Adar and Stevens (2001) further legitimises and perpetuates the problem of violence against women.

Jewkes et al. (1998a) argued that violence towards patients results partially from a social sanctioning of such behaviour. Staff did not always see their verbal or physical abuse as being abusive behaviour. This behaviour was legitimised through a supposed agreement where staff believed it to be their duty to obtain compliance from pregnant women in order to ensure the delivery of a healthy baby. The failure of patients to comply was found to be a justification for refusing to provide help during birth. Jewkes et al. (1998a) argued that the sanctioning of this behaviour was clear from the willingness of staff to discuss such strategies and the ritualised nature of this kind of abuse. The development of such a hospital culture in South Africa where violence and neglect have become part of nursing practice may be contributing to this important problem. A deeper exploration of the elements involved in violent behaviour towards patients involves a discussion of issues of control, responsibility and anxiety. I will also pay attention to discourse, power and identity as they relate to a growing understanding of violence in nursing.



1.3.5 Control, Responsibility and Anxiety

The problem of violence towards patients, including abuse and neglect, is without a doubt an important issue in the health care profession that almost certainly has an effect on care-giving, and the well-being of both nurses and patients. Yet, it is still difficult to gauge at this point how nurses themselves understand and experience the process by which it occurs. As discussed in section 1.3.5, Jewkes et al. (1998b) interpreted their findings of patient abuse as the result of the social sanctioning of coercive and punitive measures in an attempt to assert insecure middle class and professional identities. This was done by creating a social distance, and maintaining fantasies of power through the abuse and neglect of patients. Furthermore, staff hierarchies were argued to bring about power-relations that affect how nurses relate to patients. In addition to this, Jewkes et al. (1998b) argued that existing preoccupation with controlling those patients and their environment influenced the relationship with patients.

In this context, Jewkes et al. (1998a) explored staff perceptions of control and responsibility; and found that nurses working in maternity services were aware of significant responsibilities

associated with their positions. These responsibilities were indicated to be linked to the unpredictable nature of labour, good outcomes being dependent on the acquiescence of pregnant women, and heavy workloads. Significantly, all of these perceived responsibilities may be outside the control of the nurse; yet nurses indicated concerns with controlling their work environment and workload, and inherent to this control is the control over the behaviour of their pregnant patients (Jewkes et al., 1998b). Along with this control and responsibility, nurses have been found to desire and enforce order (Jewkes et al., 1998a). This, in turn, affects their relationship with the patient which is "governed by an implicit contract, with clear responsibilities on both sides" (Jewkes et al., 1998a, p. 38). Therefore, control strategies that are employed to prevent negative outcomes are influenced by nurses' assessments of patients and this implicit contract. Jewkes et al. (1998a) learned that tensions would arise when nurses felt anxieties about their ability to meet their responsibilities or when patients did not adhere to the 'contract'. It may be, then, that violence results from anxieties evoked by the birthing process when nurses are responsible for positive outcomes, which implies the need for control, but they are not able to control their environment or their patients.

Menzies Lyth (1988) provides a different explanation of the need to control the environment, and the dynamics of the nurse-patient relationship. Her extensive research on nursing organization has led to a deeper understanding of the structure of nursing practice and how this affects both the nurse and the nurse-patient relationship. As has been established, nursing may involve a great deal of tension, distress and anxiety for nurses, which can become difficult to endure. These may result in a withdrawal from duty.

Menzies Lyth (1988) explained that the nurse's primary task is to care for the patient, but this involves being confronted with the threat and reality of suffering and death. The nurse may carry the full weight of the stresses involved in caring for the patient and may be expected to carry the physical, emotional and psychological problems of her colleagues, the patient, and his or her family members. Furthermore, nurses may experience very strong and mixed feelings, like: pity, compassion, love, guilt, anxiety, hatred, resentment of patients who arouse these feelings, and envy of the care given to patients. Menzies Lyth (1988) further argued that patients may become demanding and envy the nurse's health. In this case, the nurse's own, inner anxiety is compounded by the expectation for her to allow the projection of the patient's feelings of anxiety, fear, depression, and disgust. Patients and their families may treat nurses in such a way that nurses experience feelings that patients are supposed to feel themselves, thus forcing the responsibility and anxiety involved with the illness onto the nurse (Menzies Lyth, 1988).

Therefore, Menzies Lyth (1988) explained, the nature of the profession continually threatens to flood the nurse with intense, unmanageable anxiety. The core of this anxiety that the nurse

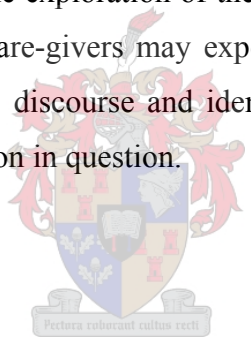
experiences, is her relationship with patients. The nature of the organisation of nurses involves certain defences which are unconsciously developed and aimed at minimising this experience of anxiety (Menzies Lyth, 1988). The nurse has the need to shield herself from this level of involvement with the patient, since she is not strong enough to provide the emotional support demanded of her (Van der Walt & Swartz, 2002). Thus, defences may be developed. These defences become part of the structure of nursing and are an expected way of dealing with patients and the emotions evoked by the practice of nursing (Menzies Lyth, 1988). Menzies Lyth (1988) further explained that these defences have been socially structured and involve behaviour through which nurses have to evade, rather than deal with anxiety. These primitive defences are aggressive and primitive ways of dealing with anxiety (Menzies Lyth, 1988), and may be linked to the development of violent behaviour towards patients. They prevent the development of effective methods of alleviating anxiety, which in itself causes a secondary anxiety (Menzies Lyth, 1988).

The nurse protects herself from the anxieties of the nurse-patient relationship by splitting up her contact with the patients. Each nurse performs certain isolated tasks for the patients, hence minimising intimate contact with any one of the patients (Menzies Lyth, 1988, Van der Walt & Swartz, 2002). A professional detachment is developed and nurses interact on a very impersonal level with parts of patients, never whole patients (Menzies Lyth, 1988; Van der Walt & Swartz, 2002; Van der Walt, 2002).

Projection of the responsible self onto superiors and the irresponsible self onto juniors occurs as a means of reducing the stress of making decisions and taking responsibility (Menzies Lyth, 1988). Seniors are expected to treat a nurse with the harshness that she would have towards her own irresponsible self and juniors are treated in the same way (Menzies Lyth, 1988). The same process has been seen to present itself with regard to patients where nurses have been found to split off their own ‘irresponsible’ compulsions that are then ascribed to patients (Van der Walt & Swartz, 1999). Klein (1946) cited in Frenkel (2002) explains that an individual projects his or her vulnerability into another person in order to attack it, which brings about a sense of triumph. Therefore, it may be part of the desire to triumph over her own anxieties about the loss of control or being overwhelmed that causes the nurse to project vulnerabilities into the patient, resulting in the necessary attack in order to overcome it. Nurses then treat patients harshly and strictly as they are expected to be irresponsible and that aspect of the patient needs to be eliminated. Patients become symbolic of the “irresponsible” and negative aspects of the projected self and should therefore be controlled and punished, since the inability to control them would reflect an inability to control the fantasy situation within the nurse also (Klein, 1946 cited in Frenkel, 2002).

The research conducted by both Menzies Lyth (1988) and Jewkes et al. (1998b) reflect the rigid organisational practices and hierarchies within nursing; and explore how these relate to the

need for power, control and reduction of anxiety. Anxiety and insecurity is seen to be caused mainly by the relationship with patients; and the great emotional and psychological demands of these interpersonal relationships. In addition to this, responsibility plays a central role in the development of this relationship and in the way in which nurses behave and respond to their environment. Both Jewkes et al. (1998b) and Menzies Lyth (1988) have found that patients are perceived to be irresponsible or uncooperative. Whether this perception is as a result of projection (Menzies Lyth, 1988) or the patient's refusal to adhere to the 'contract' (Jewkes et al., 1998a), it may cause the need for the nurse to attack and triumph over (Menzies Lyth, 1988); or to control, discipline and punish (Jewkes et al., 1998a) what the patient represents. It is therefore argued that the patient is the main cause of overwhelming anxiety that results in the development of coping mechanisms to prevent being overwhelmed or negative outcomes (Menzies Lyth, 1988). It may be argued, then, that nurses experience the patient and the uncontrollable work environment as precursors to efforts to regain control; and that these efforts may involve violence perpetrated against patients. These views of nursing experiences of control, responsibility and anxiety as they relate to violence serve as a theoretical point of departure for the exploration of the research question, since they provide a basis from which to investigate how care-givers may experience violent care-giving. Underlying these experiences, are issues of power, discourse and identity that arguably provide a secondary level of understanding of the phenomenon in question.



1.3.6 Power, Discourse and Identity

Gilbert (1995) argues that the problem with the subject of power in nursing is that we focus on the existence of power in the minds and actions of individuals; therefore we disregard how individuals are "themselves the product of power, and how their identity is located within the material conditions of their lives and the social practices which operate there" (Gilbert, 1995, p.866). From this point of view, we can argue that power and the nursing identity do not exist merely in the minds or actions of individuals (in this study – thoughts and actions of nurses), but within the nursing environment and social practices that are located there. Therefore, the nursing identity can be proposed to be a product of power instead of power merely existing in the minds and actions of nurses. Lukes (1974), cited in Gilbert (1995), proposes a three dimensional model to understand power in terms of conflict. This model of power suggests that power is a means of preventing the development of conflict. Power, from this view, constructs the experiences, thoughts and preferences of individuals in such a way that they unquestioningly accept certain social practices and roles as normal (Lukes, 1974, cited in Gilbert, 1995). The result may be that conflict is avoided, since individuals do not consider other options or possibilities to the ones that have been integrated

into their social realities and the identities that they assume when they are practising within these realities (Lukes, 1974, cited in Gilbert, 1995). Conversely, I argue that conflict may be addressed in terms of certain accepted, seemingly normal social practices (that may involve violence) to which alternatives might not exist. Therefore, I agree with the more popular points of view that focus on the overt influences of power in the caring profession; yet I propose that we should take cognisance of the insidious nature of power within organisations; and its effect on relationships and actions within these organisations.

Gilbert (1995) raises the question of how the concept of power can be understood specifically in nursing and turns to Foucault for further discussion. Foucault (1984), cited in Gilbert (1995), investigated how knowledge, truth and power produce certain identities and social practices – in this study this is applicable to nursing identities and practices. He argues that power is not only repressive in nature, but also productive, since it constructs "new ways of seeing and speaking" – a perceived truth in a specific society (Gilbert, 1995, p. 867). Foucault (1979), cited in Gilbert, 1995) further argues that disciplinary power produces individuals as both subjects and objects. Gilbert (1995) argues that the nursing process contains all the elements of objectification as described by Foucault (1979). Power produces individuals through the effects of three processes: hierarchical observation, normalising judgements and the examination (Foucault, 1979, cited in Gilbert, 1995). Hierarchical observation by nurses takes the form of what Foucault describes as a constant gaze carried out by an array of observers and it is a form of surveillance that underlies society without members of society being aware of it (Gilbert, 1995). The watchers – those higher in the nursing hierarchy – also become the watched (Gilbert, 1995). The normalising gaze is a process whereby individuals are compared to certain norms and judged according to their level of compliance with these norms. Through this gaze, examination allows for evaluation, recording and intervention (Gilbert, 1995). Both nurses and patients may become objects of nursing practice. The nurse must comply with the expected norm of the nurse identity; the patient must comply with that of the patient in order for both to be judged as "normal". The patient is subjected to the examination, during which nurses determine the degree to which the patient complies with the prescribed identity. Through the examination, individuals are also constructed as subjects (Foucault, 1979, cited in Gilbert, 1995).

Foucault (1980c), cited in Gilbert (1995), explains the concept of subjectification as it is related to power. Subjectification is argued to be a process through which an individual restricts part of the self as an object of moral practice. This part of the self then becomes a representation of the individual's identity. The consequence is that an individual may define him/herself within a specific discursive structure, for example, as the good nurse (Gilbert, 1995). This identity will define how the individual will behave in order to fulfil the moral practice and involves self-discipline and

continual self-monitoring (McDonald, 2005). Therefore, we can explore how the identity of the perfect or good nurse may become a means of fulfilling her organisationally determined moral practice. Similarly, patients may also become subjects of power, since the patient may be defined in terms of a specific discursive construction, for example: the good patient or the bad patient. These constructions of the patient's identity may determine what a nurse may expect from the patient in terms of his or her behaviour. Yet, an individual is not merely a blind follower of rules implemented on the organisational level; and has the freedom to make a choice with regards to behaviour (McDonald, 2005). Consequently, power is understood as a process whereby individuals become the subjects and objects of power; yet also have the ability to offer resistance to this power. In order to clarify the role of behaviour, Foucault (cited in McDonald, 2005) describes power in terms of moral codes and technologies of the self. Moral codes stipulate behaviour and attributes that one should strive to. Technologies of the self are the methods used to change oneself into the object of moral practice (McDonald, 2005).

Foucault's (1972, 1979) analysis of the effect of power on what he called 'docile bodies' and his exploration of state regulation of the population has been applied to the nursing context (Deveaux, 1994). Patients are expected to personify the role of the 'docile body' over which self-regulation and power will be exercised (Deveaux, 1994). The 'docile bodies' are subjected to 'surveillance' which involves a 'normalising gaze'. Within the health care system, this would ideally create circumstances under which no force or coercion would be necessary to ensure that patients comply with the expectation of behaviour. It has been proposed that nurses also govern their own and colleagues' behaviour in similar ways within the hospital. Nursing stations and the set-up within a ward are constructed in such a way that surveillance of both patients and nurses may take place. There is no need for coercion, since the normalising gaze is extended to a point where it becomes internalised and each individual supervises and examines his/her own behaviour (Foucault, cited in Deveaux, 1994). Yet, the possibility of resistance to this surveillance poses a potential problem. What we may need to clarify is to what extent this aspect of power (as described by Foucault) allows nurses to attach moral expectations to their patients' behaviour; and what happens when patients resist their organisationally sanctioned power to produce certain 'patient identities'. "… [I]ndividuals contest fixed identities and relations in ongoing and sometimes subtle ways" (Deveaux, 1994, p. 231). It is then possible to investigate the role of the patient in this neatly ordered practice of power and control. The patient may not be as easily accepting of the expectation of self-regulation and control and may therefore offer resistance to this. This resistance to power (which can also of course occur amongst nurses) may be an important element to consider in the exploration of the nurse-patient relationship and violence in the health care profession.

Kettinnen, Poskiparta and Gerlander (2002) maintain that the relationship between nurses and patients is always based on power relations. They argue that "patients' submissive position is based on the function of the socially defined roles of a client, patient, or professional and on their status imbalances" (p.101). They argued that professionals find their power in their professional or medical knowledge and implement this power through persuasion, rewarding, controlling information, verbal messages, questioning and interrupting (Kettinnen et al., 2002). Furthermore, Kettinnen et al. (2002) propose that the popular view of the nurse-patient relationship which perceives patients as "helpless and passive recipients of knowledge" (p.102), who give over their control, seldom ask questions or want explanations; and rely on staff to take care of them, ignores the significant role that patients play in constructing the nurse-patient relationship. Since patients hold their own power, they may certainly affect their relationship with nurses (Kettinnen, 2002).

May (1992) adds to our understanding of Foucault's theories as they relate to nurses' engagement with the patient as a body and as a subject. He argues that the nurse-patient relationship is not merely a social interaction between a nurse and a patient, but also a form of work. The patient, as the body, enters the hospital as the unknown and will not be known by any one individual. Consequentially, the body is seen in terms of many detached identities and is treated according to a pattern of signs and symbols (May, 1992). May (1992) suggests that the patient becomes the object of medical knowledge and the site of action. Patients are further defined in terms of their power to disrupt or comply with the demands that the nurse makes; and are objectified as the medical body. Yet, the patient can also be experienced as a subject - as a social being (May, 1992). The clinical gaze therefore extends beyond the body into the social as a site of power-relations. Surveillance then becomes a necessary part of medical therapy, since it is a productive aspect of power and the nurse is able to diagnose and treat the patient as more than just the body (May, 1992).

The nurse-patient interaction may also be viewed from an institutional discourse analysis perspective. Grainger (2004) argues that it would seem that the institutional discourse found in the hospital is continually open to negotiation between concepts of power and solidarity. This results from the fact that nursing behaviour is "inherently both controlling (requiring the exertion of power) and caring (requiring the formation of solidary relationships). *Solidary relationships involve the absence of power and are defined as interactions between equals and intimates. Nurses, Grainger (2004) argues, are subject to domination by others in the medical hierarchy, but with regards to their interactions with patients, they have a great degree of expertise and control over information and resources. This places the nurse in a particular position of power over the patient. Similar to

* It is understood that the word "solidary" is not grammatically correct, but it is used in this adjectival form in the original text, and has therefore been kept. The meaning of the term as it is to be understood is clarified in the main text.

Foucault (1980)'s analysis of power, Grainger (2004) contends that since patients have the power of "service users" and are in hospital to be helped, they have the power not to cooperate and can wilfully deter nurses from doing their job. Grainger (2004) argues that the hospital setting consequently has a particular context where solidarity and power have to be continually negotiated. Therefore, the spoken discourse is argued to be instrumental in constructing a particular reality for both the patient and the nurse. The nurse's understanding of her power or solidarity with regards to a particular patient will direct her interaction with the patient. Solidarity is seen as a lack of social distance and a familiarity with patients, where power entails a greater social distance and formality, which Grainger (2004) argues results in a greater need for 'politeness'. The need to assert social distance and power over the patient is seen by Jewkes et al. (1998a, 1998b) as a major contributor to violent behaviour towards patient and the theory discussed by Grainger (2004) may offer insights into inner workings that underlie this need.

1.4 Definitions

Given the nature of the phenomenon to be studied and the research question that has been posed, I have chosen to define only four concepts that have been part of this investigation. The general lack of literature and theory with regards to the specific issue of violence towards patients precludes limited and preconceived ideas related to patient abuse and neglect. Other ideas and possible concepts that may be related to this phenomenon have been discussed in detail in the literature review, but will not be stipulated as concepts to be explored.

1.4.1 Violence Against Patients

Violence may be understood in a variety of ways. Therefore, I have defined it as it will be seen in this study. Violence is defined as a physical force intended to hurt or damage someone or something, and may indicate the strength of an emotion (South African Concise Oxford Dictionary, 2002). The definition of what constitutes violence against patients is clearly stated by various researchers of elder abuse and may be applicable to all areas where patients are abused by health care professionals. Importantly, violence will be defined not only as physical force, but as verbal and emotional abuse as well. Any force, therefore, that is emotionally determined and results in an act that is damaging to the recipient will be defined as violence.

Physical abuse is believed to be a form of violence that involves hitting, slapping, kicking, punching, pulling hair, beating, and physical or sexual assault. It thus involves a physical form of violence which causes bodily harm (Abrahams et al., 2001; Jewkes et al., 1998a). Emotional abuse

may involve harassment that could cause emotional or psychological harm, such as ridiculing, demeaning behaviour, making derogatory remarks, cursing at or threatening patients with physical and emotional harm (Hodge, 1998).

Violence may also involve verbal abuse that is hurtful in nature. Verbal abuse involves shouting, scolding, threatening, rudeness and sarcasm towards patients when they irritate or defy nurses (Abrahams et al., 2001; Jewkes et al., 1998a). Nurses have been found to direct this type of abuse towards patients in an attempt to change their behaviour or as purely punitive measures (Jewkes et al., 1998a).

1.4.2 Institutional Violence

According to Whitaker (2000) an institution in itself suggests some conformity to a group ethos. He argued that there is a perception that individuals experience a form of inhibition when acting within the confines of the institution, but that these inhibitions are not necessarily against violence. Conformity to the "group ethos" may pressure individuals into relinquish their personal behaviour and values; therefore instilling the institution's "ethnocentrism, a habitual disposition to judge foreign individuals or groups by the standards and practices of [the organisational] culture" (Whitaker, 2000, p.73). He described the concept of inhibition in three ways: a formal forbidding of something, social or cultural restraints of spontaneous impulses and internal restraining forces. Internal inhibition is connected to feelings of guilt and empathy or fear of retaliation. This conception of the development of violence is closely linked to Foucault's (1980) analysis of institutions and power discussed in section 1.3.9. Whitaker (2000) suggests the implementation of the "normalising gaze" (Foucault) through monitoring and developing of inhibitions –external and internal- to prevent violence. Foucault (cited in Gilbert, 1995), on the other hand, discusses the power relations and resistance resulting from institutional discourses of violence.

Institutions have a greater potential for violence than individuals acting alone (Whitaker, 2000). The dynamic of violence in the institution is one in which "externally directed violence begets internally directed violence by modelling uncaring, violent relationships or through resultant tendencies to harbor guilt which may be reacted to by means of denial, projection, or self-punishment" (Whitaker, 2000, p. 73). The feelings of resentment toward the institution and the "insiders" who take part in violence are displaced onto the "outsiders" as individuals conform. This view of violence places this phenomenon within the greater context of the organisation, which may play an important role in the development of violence towards patients.

1.4.3 Patient Neglect

Neglect is defined as the failure to provide any treatment, care, goods or services necessary, to implement a doctor's treatment plan, and to observe and report changes in the patient's health status (Hodge, 1998). It also involves the failure to meet other physical needs, such as toileting, bathing, feeding, safety needs, empathy and understanding (Hodge, 1998). Where this failure is deliberate with the intention to harm or "punish" patients, it is also seen to be violent in nature. One way to define the neglect of patients may be in terms of passive-aggressive behaviour. Passive-aggressive behaviour is a pattern of behaviour in which aggression is displayed, but in a passive manner. It is more common amongst individuals who have relatively low power positions and fear reprisals for overt aggressive actions (Reber, 1995). Therefore, covert actions of violence may rather be employed than physically or verbally abusing patients.

1.4.4 Patient Care

Makoni and Grainger (2002) state that patient care is interactionally accomplished and there may be regimes of care that undermine the integrity of the recipients and place heavy burdens on care-givers. The care of patients involves at least two dimensions, the physical and the affective (Makoni & Grainger, 2002). The physical act of caring is defined as helping the patient and doing for him or her that which he or she cannot. It involves bathing, feeding, providing medication, watching and monitoring the patient's condition, and providing any assistance needed by the patient. Affective caring involves looking after the patient's emotional and psychological needs, being kind and empathetic, establishing rapport, motivating and listening.

1.5 Research Question

After a review of the relevant literature and a consideration of what we need to know about nursing and violence towards patients, I had decided on the following research question: *How do nurses understand and talk about violence against patients by nurses?*

This research question has evolved from literature and research that have provided much-needed knowledge about nursing issues, particularly about violence in nursing. Yet the absence of the voice of the nurse – the care-giver's perspective about this phenomenon - has created a gap in our knowledge of this very important health care issue. Therefore, within the context that has been created in the literature review (that explains violence on a social, cultural, interpersonal, organisational and psychological level), I have turned to the subject itself – the nurse – for answers

and new insights into the occurrence of violence towards patients. Considering that qualitative methods have been chosen to address the research question, I have not relied on theoretical or research-based concepts stated in the literature review, since the aim would be to find new knowledge and insights without preconceived ideas of what this knowledge would mean. .

CHAPTER 2
Methodology

This research was conducted at Groote Schuur hospital and served as an independent study under a larger self-initiated research project conducted by Professor Khalil at the Division of Nursing and Midwifery, School of Health and Rehabilitation at the University of Cape Town. Professor Khalil had conducted her research in collaboration with the director of nursing at Groote Schuur hospital, and with the assistant director of nursing. The overarching research project had conducted a survey of the nursing staff at Groote Schuur and intends to broaden its reach to the whole of the Western Cape. The survey focused on the occurrence of violence within nursing as experienced on three levels: violence experienced from patients, violence experienced amongst colleagues, and violence perpetrated against patients. My role was to precede the survey's third area of interest with qualitative interviews that were conducted with a selected group of nurses in the midwifery wards. We had hoped that my part of the research would identify additional aspects of the problem to be explored during further interviewing that would be conducted through the overarching project; and that a triangulation of methodologies could be achieved.

2.1 Setting

Groote Schuur is an academic training hospital. A key emphasis in this hospital is on teaching, training and learning. In addition to this, the hospital provides tertiary level services to a wide area of the Western Cape; and deals with referrals from primary and secondary level institutions. Consequently, the setting of data collection is believed to have influenced the type of data that was gathered. It is important to bear in mind that the data obtained from this setting may not be representative of the broader medical community, since this hospital may not represent the norm in South African hospitals or maternity services. The data were collected in the first stage maternity ward, which did not include women in the last stages of labour. The ward was, as most South African government hospital wards, in the form of a long aisle, with the nurse's station near the middle. The interviews were conducted in the Sister in Charge's office, which was allocated for the specific purpose of interviewing. It was chosen by the Sister in Charge, since it was conveniently out of the way, quiet, and had no telephone that could interrupt interviewing. All three days, during which interviewing was done, were uncharacteristically quiet and allowed for longer, more relaxed interviews. Atkinson and Delamont (2003) argue that the physical location of data collection is of the utmost importance; and that we tend to offer "… sketchy descriptions of the built environment within which social events and encounters take place" (p. 827). Atkinson and Delamont (2003)

further argue that public environments represent cultural assumptions about professional communication and interaction, the categorisation of individuals, political practices; and that they symbolize figurative and literal boundaries, shared recollections, and personal and emotional work. It is therefore necessary to pay attention to the role that the setting may play in the occurrence of the phenomenon; and to provide a thick description of both the setting and the data. For this purpose, I have included a more detailed description of the setting in section 3.1 in Chapter 3.

2.2 The Sample

The sample was obtained from the overarching research project conducted by Professor Khalil at the nursing department at the University of Cape Town. Staff were approached individually by the Sister in Charge; and those who agreed to participate were brought to the office where I would commence with the interviewing process. This method of participant selection did not allow me to gather data from those who refused to participate; yet it was the only means available to access participants. Therefore, this sampling method may have influenced data gathered, since there was no information available on who refused to participate and why they refused. Also, the sample was dependent on who the Sister in Charge approached, which may have led to the exclusion of potential participants. Since the focus of this research was transparent, and confidentiality was guaranteed (see ethics section), recruitment was a sensitive matter and cooperation maintained at the cost of sample selection. This may have affected the validity of the data gathered. Ten participants were interviewed, and this sample included two ward managers, four sisters (professional nurses), three nurses and a student nurse. The participants ranged from age 23 to 59. Most were English speaking and three were Afrikaans speaking. Even though participants were offered the use of pseudonyms, none opted for this choice. Therefore each participant was given a number for the sake of confidentiality. The participants all indicated that they were happy with this system of coding their identities, and did not mind using their own names. There was a relatively equal distribution of white and coloured participants; and there were two African participants. I informed the participants about the nature of the research and requested that each participant read and sign the written form of consent, which further clarified the intention of the study. The consent form included the right to withdraw from the study, the central purpose of the study, a description of the procedures to be used in data collection, assurance of the protection of confidentiality, a statement of known risks associated with participation in the study and the expected benefits (Cresswell, 1998). See Appendix B. The confidentiality and anonymity of the participants were ensured and maintained. Respondents were requested to participate in the study, they were offered the option to decline; and no inducements or coercive methods were used to obtain their cooperation. The participants completed

a list of demographics (see Appendix C) and the information provided has been tabulated (see Appendix E).

2.3 Research Design

Silverman (1993) maintains that "there is no standard approach among qualitative researchers" (p.23). The approach chosen is determined by the research question, the data required to answer the question, and the suitability of the methodology to provide the researcher with a means toward the end of successful analysis (Silverman, 1993). Qualitative research is seen by Hammersley (1992) cited in Silverman (1993) as a method which prefers meaning to behaviour, words to numbers and a hypothesis-generating activity to a hypothesis-testing activity. Given the nature of the research question, as well as the lack of a substantial research on the topic, I had decided that the research objectives would be best met by using qualitative methods. Therefore qualitative research methodology was chosen for this research, since it could allow me to contribute to a lacking base of knowledge, question how the participants make meaning of their life experiences, and contribute to the larger academic conversation about the phenomenon, rather than provide definitive answers. I had chosen to make a commitment to this time-consuming and complex type of research as a result of the personal encounters with the problem and the relevance that I believe it holds for a large vocational community, and the society that it serves. Qualitative research is commonly undertaken in the natural setting, in this case the hospital where the researcher becomes the research instrument by means of observation (Silverman, 1993). In addition to this, qualitative research allows a description and interpretation of a phenomenon in the context in which it is experienced and understood from the participant's point of view (Mash & Woolfe, 2002). Appropriately then, the objective of this study was to explore the phenomenon as it is experienced by the participants; and the focus for data collection was on interview material, which is consistent with qualitative research practice.

2.3.1 The interviews.

Qualitative interviews were used to collect the data. According to a principle of interactionism, participants in the interviewing process construct their social worlds in collaboration with the researcher (Silverman, 1993). Therefore, it was my aim to elicit data that provided "an authentic insight into people's experiences" (Silverman, 1993, p.91). This was attempted by using interviews that were semi-structured and consisted of open-ended questions that permitted and encouraged the participants to elaborate on their answers. The aim of data collection by means of interviewing was

to gain rich, detailed accounts of nursing experience and particularly of experiences of violence. The respondents were asked to answer the questions in their own words, thus conveying their subjective experiences and their understanding of these experiences. The questions were designed to elicit conversation from the participants, rather than to create a question-answer type of interaction. The questions were developed with the aim of gaining insight into and an understanding of nursing, which is experienced on a professional, personal, social, and emotional level.

As the questions were generated by both a review of relevant literature concerning nursing in general, and according to the systematic steps of data analysis, I understood that the questions might change as the research progressed and that I may be led into new directions or themes that may not have entered into the proposal as possible themes to be explored. The interview schedule was designed to allow for the development of a sense of safety, rapport and trust. This was achieved by clearly stating the purpose of the study; allowing for personal reactions to the research question; providing opportunities for participants to elaborate on issues not directly connected to the research question, and ensuring that participants were aware of their right to withdraw from the study at any stage. Thus, participants were given the opportunity to speak about a variety of issues that they may have had the need to discuss, and were questioned on more general aspects of work and nursing. Participants were encouraged to ask questions of their own and to voice concerns throughout the interviews to enhance the interviews and to preserve ethical standards of interviewing.

Silverman (1993) provided three reasons determined by Denzin (1970) for this type of interviewing:

1. It allows respondents to use their 'unique ways of defining the world'.
2. It assumes that no fixed sequence of questions is suitable to all respondents.
3. It allows respondents to 'raise important issues not contained in the schedule. (p. 95)

The interviews were recorded and transcribed, following the *Simplified Transcription Symbols* outlined in Silverman (1993, p.118) as a means to aid data analysis. I have adjusted this transcription convention slightly in order to fully convey the richness in tone that was present in the interviews (see Appendix D).

2.3.2 Data collection process.

The interviews were conducted in a completely private and discreet space set aside by the ward manager. This ensured confidentiality and aided the interviewing process, which touched on some sensitive issues. The room allocated for the purposes of the interviews was rarely disrupted during interviews, and participants could feel comfortable to speak without being overheard. The most

important aspect of data collection was establishing rapport with both the institution and the staff in order to ensure that the individuals disclose freely, and to maintain access to the sample. A more important consideration for developing and maintaining rapport with the participants was my intention to do no harm, to avoid taking advantage, and to ensure that participants were comfortable whilst sharing their personal narratives. I made three visits to the hospital in order to collect as much data as possible, and interviewing stopped when I had interviewed every willing participant in the ward. The process of data collection was restricted by the scope and time available for the project, since no follow-up interviews were possible, only ten participants were available, and opportunities for observation were limited.

2.4 Data Analysis

I approached the first step of my data analysis by using traditional qualitative techniques. These involved summarising, coding and categorising data in order to elucidate major themes (Coffey & Atkinson, 1996). Strauss (1987) argues that qualitative data analysis should always involve an initial perusal of the data – line for line, even word for word – in order to discover concepts that fit the data. This becomes an unrestricted, temporary analysis of the data that will illuminate categories and relationships that may, at first glance, not have been noticed by the researcher (Strauss, 1987). Strauss (1987) clarifies that "(t)he point is really that the potential is not so much in the document as in the relationship between it and the enquiring mind, and training of a researcher who vigorously and imaginatively engages in the open coding" (p. 28). Coding of the data compels the researcher to deconstruct the data (Strauss, 1987), yet it is not an alternative for analysis (Coffey & Atkinson, 1996). Once I had completed the initial coding, I revisited the data as a whole and checked the deconstructed elements in terms of the meaning found in the whole.

Steps of Initial Coding

1. Interviews were transcribed.
2. Transcribed interviews were read, re-read whilst listening to taped versions.
3. Potential categories / themes were identified.
4. Words, phrases and sections of speech were colour coded according to themes.
5. Words, phrases and sections were pasted to theme posters in order to provide a visual presentation of themes.
6. Themes were combined and adjusted.

7. Interviews were read again (as a whole) and themes were checked in terms of the meaning as a whole.
8. Themes were typed where further cutting and pasting took place until the researcher reached a point where the initial analysis seemed complete.
9. Contrasting and comparative cases were recorded under the various themes.

I proceeded by looking for contrasting and comparative cases, keeping the identified themes and patterns in mind. This initial analysis was used to develop a rich description of the data, using certain themes and categories to guide the description and interpretation. This was done with the intention to provide a portrayal of what the data said. Wolcott (1994) cited in Coffey & Atkinson (1996) split data analysis into three processes: description, analysis and interpretation. He argued that when researchers offer a description of a phenomenon, they "tell the story of the data" (p.9) and work from the point of view that data can speak for itself. Therefore, it is important to stay close to the original form of the data (Wolcott, 1994, cited in Coffey & Atkinson, 1996). Analysis follows the initial description of the data, and involves identification of major factors and relationships within the data. Therefore, it "expands and extends the data beyond a descriptive account" (Wolcott, 1994, cited in Coffey & Atkinson, 1996, p.9). Interpretation of data requires the researcher to attempt his/her own interpretation of what the data says (Wolcott, 1994, cited in Coffey & Atkinson, 1996). At this stage, the most important factors and relationships should be identified and interpreted in a free, unbounded and creative way; and the researcher must go beyond a description and analysis of the factual contained in the data to explore the meaning of the data (Wolcott, 1994, cited in Coffey & Atkinson, 1996). Data analysis does not simply involve writing up one's findings from the raw data, but rather a process through which the researcher constructs interpretations by creating a "field text" that consists of field notes, documents, and other forms of data (Denzin & Lincoln, 1994, p. 15). This "field text" is developed and reworked in order to create a working interpretation that will be used to produce the final analysis (Denzin & Lincoln, 1994). Description, analysis and interpretation are not seen by Wolcott (1994), cited in Coffey and Atkinson (1996) as mutually exclusive, but can be implemented in interaction with one another. Tesch (1990) cited in Coffey and Atkinson (1996) describes the key characteristics of qualitative data analysis:

> Analysis is a cyclical process and a reflexive activity; the analytic process should be comprehensive and systematic, but not rigid; the data are segmented and divided into meaningful units, but connection to the whole is maintained; and data are organised according to a system derived from the data themselves. (p. 10)

Data analysis is therefore argued to be an activity which is guided by the data and moves freely between description and analysis. As a result of the paradigm from which I have chosen to carry out my analysis, an eclectic mix of methods was used to analyse the data. Coffey and Atkinson (1996) confirm my choice by stating that qualitative researchers generally make use of multiple strategies and methods to analyze data.

> The qualitative researcher is like the dancer … seeking to describe, explain, and make understandable the familiar in a contextual, personal, and passionate way. As Goethe has told us, 'The hardest thing to see is what is in front of your eyes'. (Janesick, 1994, p. 217)

The quote above describes most simply the approach that I have chosen in my choice of topic, method of interviewing and method of data analysis. I have aimed to provide a simple exposition of the phenomenon in question while consistently contextualising the results within my own meta-realities and those of my participants. This resulted in a 'dance' involving the data, my self and the available methodologies in order to utilise the best that qualitative methods have to offer in a humble attempt to understand and explain a complex issue, which has social, professional and personal significance. The nature of the research topic and the very personal reasons for pursuing the phenomenon in question called for a sensitive and personal approach to the data; and an acknowledgement of the blinding effect that the familiarity of the phenomenon may have on me as a researcher. Consequently, I felt the need to disclose my own experiences and subjectivity, in the process of analysis, in an attempt to offer a contribution which is unique, sincere and trustworthy. This disclosure will be clarified and discussed in more detail in section 2.4.4.

2.4.1 The first step: basic descriptive and interpretive methods.

After the initial coding, which served to organize the data and to allow me to combine fragments of data along categories that have common characteristics (Coffey & Atkinson, 1996), I turned my focus to basic interpretation and description. This was done with the intention to provide a rich description and detailed exposition of what the participants chose to reveal in the interviews. Merriam (2002) explained that the researcher is interested in the meaning that the phenomenon has for the participants. Merriam (2002) further stated that this meaning is constructed as the individual interacts with his or her social world. The first step of my analysis therefore entailed an exploration of the meaning the participants constructed as they were confronted with a subject matter of a sensitive and social nature, namely violence in the nursing profession. Nursing and the issue in

question are both understood in terms of interactions with people. Nursing is a social profession guided by socially constructed meanings of experience. Therefore, I endeavoured to provide a platform, grounded in basic interpretation and description, from which to build further analyses. This involved a focus on: "(1) how people interpret their experiences, (2) how they construct their worlds, and (3) what meaning they attribute to their experiences" (Merriam, 2002, p. 38). Although I did not follow strict phenomenological or narrative analysis techniques, I drew on these approaches to enhance the descriptive and interpretive exposition of the phenomenon of violence in nursing.

Phenomenology is based on the principle that knowledge is grounded in experience (Holstein & Gubrium, 1994). Schutz cited in (Holstein and Gubrium (1994) argued that human beings approach life with a base of knowledge comprised of commonsense constructs and categories that are socially developed. This base of knowledge involves images, ideas, values and attitudes that are used to make meaning of, and to interpret experience (Holstein & Gubrium, 1994). Consequently, this knowledge also determines how individuals "grasp the intentions and motivation of others, achieve intersubjective understandings and coordinate actions" (Holstein & Gubrium, 1994, p. 263). Meaning structures may be internally organised, but they are influenced by social forces (Holstein & Gubrium, 1994). Therefore, as daily functioning is conducted within organised settings, such as the hospital, the creation of meaning becomes conditioned by socially promoted ways of making sense of experience. But individuals are not merely blind followers of organised thinking, they attach their own history, meaning and interpretation to experience (Holstein & Gubrium, 1994). Therefore, it followed that I approached the data conscious of these two experiential influences (personal and organisational) on the construction of meaning within nursing culture; and therefore used this methodological knowledge as a guide in data analysis. It became one lens through which to view the data and guide to interpretation.

Holstein and Gubrium (1994) assert that even though the description and interpretation of a phenomenon may seem familiar and simple, we must offer trustworthy and suitable analyses that "make sense" (p.266). Furthermore, Geertz (1973, 1983) cited in Holstein and Gubrium (1994) emphasise that interpretation "engages institutional frameworks, formal and informal categories, and long-standing cultural patterns – socially established structures of meaning" (p.266). These views of interpretation of data seemed to be particularly relevant to this research, since the meaning investigated and described was socially embedded within the institution of medical care in South Africa – therefore involving socially determined meaning structures. Durkheim (1964) cited in Holstein and Gubrium (1994) refers to "collective representations" of everyday, social facts or meanings that originate as regulated ideas that represent social order. Categories of meaning are argued to represent social organisation of individuals, and thus interpretation involves an exposition

of socially and experientially developed ways of making sense of everyday life (Schutz, 1970 cited in Holstein & Gubrium, 1994).

Clearly, I could not offer a basic description and interpretation of the data in this research without considering the social and organisational context of the data presented. The presentation of what individuals shared during the interviews would be incomplete without reference to the influence of the institution. Consequently, this step of my analysis was conducted with the focus on the meaning that my individual participants attached to their experiences, while keeping the organisational and social determinants of these meanings in mind. Once I had organised the various meaning structures, I continued my analysis of the data by exploring the ways in which this meaning was created. In order to examine the data on this level, I turned to narrative and discourse analysis methods.

2.4.2 Narrative analysis

The nature of the data allowed me to use narrative analysis as one of the tools for analysis. Mischenko (2005) argues that the use of narrative does not constitute a reality, but rather represent how we construct our realities. Hollway and Jefferson (2002) argue that we focus on the people who tell us stories, and that these stories are a means to understand our subjects better. Hollway and Jefferson (2002) further state that narratives are not intended to provide ultimate truths, yet they allow us to remain closer to the phenomenon in question than methods that obtain explanations. Stories are often used by members of a particular organisational group as a means to transmit a particular culture or way of thinking; and the way in which the story is constructed can tell us more about the nature of the data collected (Coffey & Atkinson, 1996). The structure of the story can illuminate why and how individuals tell stories; and consequently show us how the narrator reacts to events, and how they articulate their stories for the audience that is listening (Coffey & Atkinson, 1996).

Coffey and Atkinson (1996) further argue that narratives perform certain functions, since individual narratives are located within identifiable institutional discourses. Cortazzi (1993) cited in Coffey and Atkinson (1996) argues that institutional narratives provide a collective understanding of the rationale of an organisation. The nurses' narratives about violence in this study were therefore viewed in terms of the organizational function that they perform. They were investigated in terms of the cultural context they portray, and the institutional discourses reflected in the stories of violence. This was done in addition to the initial phases of data analysis, which focused on more traditional methods of coding and categorising. It facilitated the exploration of content in interviews and field notes; and it has allowed me to critically analyse the role of institutional discourse in the

development of personal narratives, meaning and behaviour. Coffey and Atkinson (1996) argue that when we use this kind of approach, we are able go beyond what the data says to explore how stories are socially and culturally constructed.

This process of evaluating how language is used to convey meaning can be approached in a variety of ways. The structure of stories and the use of figurative language illuminate what Coffey and Atkinson (1996) describe as "kinds of speech acts" (p. 84). Participants may share narratives with the intention to justify, legitimate, or excuse behaviour placed under scrutiny (Coffey & Atkinson, 1996). Mills (1940) cited in Coffey & Atkinson (1996) argues that individuals may use "vocabularies of motive" to explain social actions (p. 84), and that certain techniques may be used to provide a credible and articulate way of explaining experience and action. This method of data analysis allowed me to zoom in, so to speak, on the narratives provided in order to develop a thick description of the both the content and the context of the data. This provided me with the methodology with which to move beyond what has been said by the data to explore how the message was conveyed, and what function the narrative played in explaining or justifying experience and action.

Narrative analysis focuses on the study of individuals' lives from the narrator's experience. A distinct role that narrative analysis can play is to empower individuals by developing their understandings of their circumstances (Denzin & Lincoln, 1994). The perspective of the teller, rather than society can be emphasised. This is useful in the type of research that I have conducted, where it is the participant's point of view that takes precedence. On the other hand, organisational analysts emphasise the importance of stories in organisations, which are used to focus on the human or cultural aspect of organisational life, rather than to explore individual's personal lives (Holstein & Gubrium, 1994). Therefore narrative analysis can be a useful tool to use when investigating the more personal and cultural elements of the nursing experience, since it may shed light on how personal narratives are directed by organisational culture. This particular value of both personally and organisationally influenced narrative analysis brought me to the exploration of the role of "institutional thinking" in the data (Douglas, 1986 cited in Holstein & Gubrium, 1994). Douglas (1986) cited in Holstein and Gubrium (1994) argues that "human reason is organised and expressed through processes of 'institutional thinking'" (p. 268). She further argues that organised social institutions contain typical and routine representations of reality. Therefore, an analysis of the institutional thinking present in the data was an important level of analysis, since "contextually grounded discourses, vocabularies and categories form local interpretive structures or cultures for defining and classifying aspects of everyday life" (Holstein & Gubrium, 1994, p. 268). Therefore, I argue that the concepts explored in this research may be socially constructed within organisational (nursing) discourse, and have been analysed in terms of this discourse.

Specific steps followed:

1. Stories were identified.
2. Stories were then analysed literally, figuratively and structurally in order to enhance understanding of the descriptions provided.
3. The telling of the stories were compared and contrasted in order to find narratives that revealed shared ways of thinking amongst participants, ways in which meanings were created and how stories were told.
4. Step three was conducted whilst keeping theoretical perspectives on organisational and medical culture in mind. These concepts were critically reviewed as data was analysed in order to find potential cases of contradiction with existing theory and research.
5. Stories were then analysed in terms of the functions that they performed – I looked for speech acts that justify, legitimate or excuse the events or actions being described. This focus was chosen according to the kind of data gathered.
6. The narratives were then analysed in terms of personal meanings attached to stories. This was done in order to illuminate narratives that may not be organisationally determined, since the intention of the research was to give voice to the individual nurse's narratives about violence.

2.4.3 Discourse Analysis

After exploring personal and organisational narratives in terms of the functions that they perform, I proceeded with data analysis by means of discourse analysis. This method is complementary to narrative analysis, since the two methods combined can interpret the same data at various levels. Narrative analysis provides the tools to explore stories and how these stories are constructed to perform certain functions – excuse, explain, or justify. Discourse analysis provides the tools with which to explore the meta-narratives that inform the stories told. Therefore, simply put, the prior can explain 'why' and the latter can explain 'how' stories are constructed, both of which are important to the understanding of the creation of meaning within an organisation.

Macleod (2002) argues that there is no single method involved in discourse analysis, but that all methods used in this kind of analysis involve interpretive, reflexive techniques that focus on how meaning is constructed through the use of language. Parker (1990) cited in Macleod (2002) states that discourse is a coherent organisation of meaning. Moreover, discourse is constructive in nature, since it does not merely describe the world – it is the manner in which the world is assembled (Macleod, 2002). Fairclough (1992) cited in Macleod (2002) identified three aspects of the

constructive nature of discourse. Discourse constructs: "(1) 'social identities, 'subject positions' or 'types of self'; (2) social relationships between people; and (3) systems of knowledge and belief" (p.18). However, Macleod (2002) argues that discourse is not only constructive, but also restrictive. As it constructs aspects of reality, it also places limitations on "what [may] be known, said or experienced at any particular socio-historical moment" (p. 18). This is the point at which discourse analysis became particularly relevant to the data obtained in this research. The first level of analysis exposed that issues of control, power and responsibility were constructed by means of institutional discourse (see section 3.2), it also illustrated that discourse restricted what may be known or said. The duality of discourse to both construct and restrict is argued to be associated with knowledge and power (Macleod, 2002). Foucault (1978) cited in Macleod (2002) argues as follows: "discourse transmits and produces power; it reinforces it, but also undermines and exposes it, renders it fragile and makes it possible to thwart it" (p. 18). Therefore power in itself is both constructed and restricted by discourse and tension is constantly developed between the two extremes – the productive and the undermining levels of discourse. Parker (1992) cited in Macleod (2002) further explains that one discourse justifies or explains another through the contradictions contained within it. While it rejects contradictory discourses, it alludes to them and is destabilised by them (Parker, 1992, cited in Macleod, 2002).

Philips and Hardy (2002) argue for "the power of incomplete, ambiguous, and contradictory discourses to produce a social reality that we experience as solid and real" (pp. 1-2). They further state that what people say and what they are is the same thing. This view of discourse complements the concept of institutional thinking espoused by Douglas' (1986) cited in Holstein and Gubrium (1994), since what members of social group (institution) think and say; and what they are may also be argued to be the same thing. Therefore, the identities of the members of an organisation may be argued to "appear out of discourse" (Philips & Hardy, 2002, p. 2). Philips and Hardy (2002) further maintain that "(w)ithout discourse, there is no social reality, and without understanding discourse, we cannot understand our reality, our experiences, or ourselves" (p. 2); and they suggest that discourse analysis be applied to the investigation of the ways in which social organisational life is constructed. It therefore seemed fitting, if the research question of this study is kept in mind – how nurses understand violence perpetrated by nurses against patients – to turn to the organisational discourses that construct their understanding of this phenomenon.

Discourse is therefore argued to play a role in the construction of reality, and provides researchers with the ability to look critically at the meaning of this construction (Philips & Hardy, 2002). In addition to this, discourse may assist us in the investigation into what constitutes and sustains unequal power relations (Fairclough & Wodak, 1997, cited in Philips & Hardy, 2002). Discourse may "describe and explain how power abuse is enacted, reproduced or legitimised by the

talk and text of dominant groups and institutions" (van Dijk, 1996, cited in Philips & Hardy, 2002, p. 25). Power and discourse, then, are linked to the construction of professional identities through which social control is exercised and to which resistance may be offered. This may advantage some –those who hold power- at the expense of others through the development of taken-for-granted realities (Philips & Hardy, 2002). Philips and Hardy (2002) argue that critical discourse analysis offers us the opportunity to "study the discursive construction of identities and relations" (p.29). Philips (2003) further holds the view that discourse affects individuals' actions and that individuals similarly affect discourse and consequently the institutional sphere.

Discourse is a way of gaining an understanding of the conditions that produce accounts and the meaning produced from these accounts (Hollway, 1989, cited in Macleod, 2002). Therefore we should examine the conditions that allow for certain discourses and not for others to exist. We should challenge the taken for granted meanings in the telling and deconstruct the context within which these tellings are provided. The interaction during interviewing is an illustration of the speakers' culture, which allows us to interpret characteristics of his/her culture by exploring the text (Martin & Rose, 2002, cited in Slembrouck, 2005). In other words, interviews provide us with the narratives in which we can explore the discourses that produce these narratives. Atkinson and Delamont (2003) contend that medical professionals have narratives and explanations that are "constructed through various kinds of spoken performance … they use … recurrent rhetorical features of their professional talk … (and) characteristic devices to encode … collegial talk" (p. 830). In brief, Atkinson and Delamont (2003) further argue that even though we may feel that narratives are highly personal, they are culturally and socially constructed in this way. Philips and Hardy (2002) argue that these constructed social realities are taken for granted, while they advantage some and disadvantage others. "Foucauldian-informed work often focuses on unmasking the privileges inherent in particular discourse and emphasises its constraining effects" on particular actors, whereas Hardy, Palmer and Philips, 2000; Jackson, 2000; Philips and Hardy, 1997, cited in Philips & Hardy, 2002) argue that "actors use discourse as a resource to bring about certain outcomes" (Philips & Hardy, 2002, p. 21).

Specific steps followed:

1. The data were reviewed.
2. Statements that cluster around coherent, culturally available systems of meaning were identified. I stated these systems of meaning in the literature review and I consistently reviewed literature around these systems of meaning as they were identified during analysis.

3. I identified the following: social identities, subject positions, coherent systems of meaning and knowledge, ways of speaking about discourse, and historical and political locations of texts (consistent with Parker's (1992) criteria, cited in Macleod, 2002, p. 21)
4. Since the aim of the research was to identify nurse's voices, I adopted Foucault's (1972) "enunciative modalities to specify: (1) Who is speaking? Who is 'qualified' to use this type of language? and (2) the institutional sites from which the person speaks, e.g. the hospital …" (Macleod, 1992, p. 22).
5. Contradictory discourses were identified by identifying the points of incompatibility and uniformity.
6. The analysis was performed whilst reading and re-reading through the thematic analysis toward "engaging in the conceptual work required to do … discourse analysis" (Macleod, 2002, p. 21).
7. In order to analyse discourses of power, I explored practices in nursing that promote the power of some, whilst disadvantaging others. This was done by finding the following: who would benefit or lose from certain discourses, the construction of identities that would promote or discourage particular discourses, and who would resist the power of these discourses (Macleod, 1992).
8. Consistent with the method of using writing as a means of analysis and interpretation, my analysis changed as I wrote my chapters.
9. I continuously engaged with reading material "related to the broad areas covered in the thesis" (Macleod, 2002, p.21)

2.4.4 Foucauldian analysis: power and discourse.

Foucault (1980) defines power as something which is not destructive, but as productive that constructs reality. (Foucault, cited in Riley & Manias, 2002). Riley and Manias (2002) explains that one should analyse power from a Foucauldian perspective by exploring how mechanisms of power function at the micro-level of society. Therefore, power needs to be explored at the level of the maternity ward where it functions in order to analyse it. Unless this happens, we are at risk of "maintaining the illusion that power is only applied by those at the top of the nursing hierarchy" (Riley & Manias, 2002, p. 318). The movement towards Foucauldian analysis was a natural process guided by the data. After initial analysis, themes of power, control and discipline became more evident. Therefore, the addition of Foucauldian theory to the approaches discussed above complemented the methodology as well as the findings. Wilson (cited in Riley & Manias, 2002, p.

295) argues that Foucauldian analysis exposes the relationship between knowledge, power and language; therefore it complemented the already discussed methodology involving narrative and discourse analysis.

Macleod (2002) explains the role of the Foucauldian approach in discursive analysis. When working within this paradigm, we explore: "(1) what it is that people stand to gain … by invoking certain discourses … (2) the construction of the type of person … who would seek to promote or, alternatively, would seek to discourage the use of a certain discourse" (p. 23). This is followed by an investigation into power-relations and how they produce, regulate and normalise the subject. "We need to look at how certain forms of subjectivity are validated while others are marginalised" (Macleod, 2002, p. 23). Gilbert (1995) argues that the analysis of power should take into account the interaction between discourses and social practices. Foucault (1980), cited in Gilbert (1995), proposes that the analysis of power should be undertaken in the context of five methodological precautions:

> Firstly … should not be undertaken in the context of legal structures … there is a need to identify where the exercise of power exceeds the legitimate rights of an individual or group … [s]econdly [it] needs to identify the processes of ongoing subjectification … the aim is to establish the targets of power and to describe its effects …. [t]hird … indentif[y] individuals as the vehicles of power. They simultaneously undergo and exercise the effects of power … power circulates through a range of social institutions … [should] be undertaken bottom up … final[ly] … identify[y] the techniques through which knowledge is developed … (p. 869)

2.4.5 The issue of subjectivity and the use of autoethnography.

Bloom (2002) argues that subjectivity is a much debated topic in qualitative research and that the focus of the debate is typically on the subjectivity of the researcher. Subjectivity has undergone different phases as qualitative research has developed and changed. It has gone from being the adversary of scientific validity to being an inherent, inescapable component of inquiry (Bloom, 2002). Consequently, qualitative researchers may - accepting this aspect of research - attempt to analyse their own subjectivities in the research process. We, as researchers, undergo a process of analysing and exposing the racial, social, class, gender, religious, and personal values which influence the researcher-respondent relationship (Bloom, 2002). These same values influence the researcher's relationship with, and understanding of the data with which she/he is presented.

The process of data collection, data sorting, analysis and interpretation entails self-reflexivity which may commonly include the keeping of a diary, field notes, observation, and memos

(Merriam, 2002). The above-mentioned documents contain the researcher's personal and professional responses to respondents and data. The researcher arguably brings an element of subjectivity to the table. Following this argument, I found it impossible not to be self-reflexive during this research process, and have subsequently included interpretations of my own experiences, and by association revealed how I construct my world and the meaning I attach to it. This caused me to be profoundly aware of how my own positionality, values and motives for this research influenced data collection and my response to data. Leaving myself vulnerable as a novice researcher, I embraced the unknown, yet thrilling new way of understanding data. The continual questioning of my role in the process revealed the delicate 'dance' involved in qualitative research. The role of both the subject and the researcher may become interchangeable in the production of data and interpretation. Both add meaning to the data, and therefore both add a level of subjectivity to understanding and analysis. The relationship between researcher and participant; and researcher and data plays a vital role in the process of qualitative data.

Fine et al. (1994) argues that the relationship between the researcher and the researched subject is similar – by definition- to the relationship between the oppressor and the oppressed. "…it is the oppressor who defines the problem, the nature of the research, and, to some extent the quality of the interaction between him and his subjects" (p.73). The distinct power-relations to be described in the findings section (Chapter 3) parallels the power-relation between researcher and the researched subject. Fine et al. (1994) further argues that the social sciences have sought to hide the researcher in a veil of neutrality or objectivity. The imperialism involved in colonial research seems easily echoed in other areas of research where the researcher is able to determine the status of her subject as the "other" (Fine et al., 1994, p.72) whose impudent attitudes and behaviours are to be studied. Distance from the topic and subject is preferred to "authentic engagement" and the researcher remains silent, and without class, race or gender (Fine et al., 1994, p.74). This process of "othering" subjects who are deemed to be unworthy, dangerous or immoral removes the subject from her humanity, and limits the context in which the subject and phenomenon exists. For this reason, I chose to reveal my stance as researcher, and to examine my relationship with the participants and the data in an attempt to move away from this process of "othering" (Fine et al., 1994). The marginalisation of the "guilty" allows the researcher to ignore the voice of the subject and to speak for them (Fine et al., 1994). My endeavour was (as proposed in my research question) to allow for the voice of both the researcher and the researched to be heard in order to avoid speaking from a position of removed authority on an issue in which I have personal investments.

Olesen (1994) argues that from a feminist viewpoint, researcher bias should be seen as a valuable tool guiding research questions, data gathering and interpretation. It becomes a useful tool only if the researcher is sufficiently reflexive. This involves a thorough exposition of the

researcher's views, thoughts and actions. Slembrouck (2005) describes reflexivity as a process that involves questions such as: "(i) where do we come from and why do we do this research? (ii) what is the relevance of data histories and the contact with the researched worlds for our interpretations of data? (iii) how are researchers through their involvement in researched worlds implicated in power economies?" (p. 626). Olesen quotes Nancy Scheper-Hughes (1992): "[w]e cannot rid ourselves of the cultural self we bring with us into the field …" (p. 165). Proponents of this methodology have not made clear exactly how an interest in reflexivity should be included in data analysis and interpretation (Slembrouck, 2005). Choosing to include elements of autoethnography has provided me with the opportunity to use my own issues and views as a tool toward a richer end result as opposed to attempting to hide my own interests in and responses to the phenomenon under study. As Mischenko (2005) argues, autoethnography is "… an application from which to explore theories relating to the self, identity and power" (p. 204). This may not be the first choice for every researcher, and some may find it unacademic and disconcerting, but I feel that the only way to overcome the threat of subjectivity and researcher bias in such a personal piece of research, is to embrace it and share it. Consequently I cannot find myself guilty of "othering" or marginalising those with whom I have a relationship filled with issues of power, identity; and therefore potentially – if unwittingly - bias the data which they have provided.

Autoethnography provides the researcher with the opportunity to write reflexively about his or her experiences. Ettorre (2005) argues that it is an autobiographical research genre through which we can explore several layers of awareness in order to link the personal to the cultural. Ellis and Bochner (2000) cited in Ettorre (2005) argue that autoethnography enables the researcher to focus on both the social aspects of personal experience and the inner aspect of experience. In addition to this, Bochner and Ellis (2002) cited in Mischenko (2005) maintain that this kind of approach enhances empathy on many levels, including on the interactional level between the researcher and participants. The autoethnographic data used in this research has been extracted from field notes, diary entries, responses to the process of transcribing and conversations with the significant other who has been hospitalised repeatedly – this being the reason for my pursuit of this topic.

Reed-Danahay (1997), and Ellis and Bochner (2000) cited in Mischenko (2005) argue that autoethnography takes research to a point where personal experience is used to focus on the vulnerable self, and this is placed within wider cultural and social elements of that experience. It also acknowledges the researcher's role in determining the research topic, framework and interpretation. This method demands high reflexivity and an openness regarding my values and assumptions, instead of a detached, third-person approach where I am a neutral, objective instrument of research (Mischenko, 2005). I have chosen to move between these two realms of being, juxtaposing my personal self with my self as researcher; paralleling the movement of my

participants between their professional and personal identities. This has been done, since I have both a personal and a professional relationship with this research and I believe the one can complement the other.

The inclusion of my own narrative is also, in part, a response to the idea of writing as a method of inquiry as proposed by Richardson (1994). In trying to understand and develop my ideas regarding my data and my personal experiences that lead to the inception of this research, I took to writing my own narrative as a method of inquiry. Richardson (1994) argues that qualitative research should reach wide and diverse audiences, yet it fails to do so. He further argues that scientific models of appropriate academic writing undermines the creative aspect of writing, results in uninteresting work and expect writers to "silence their own voices and view themselves as contaminants" (p. 517). Writing is essential to qualitative research, since it is the result of the researcher's observation, interpretation, questioning and participation in the process. The question of how to position yourself in your research is difficult, yet I believe it to be fitting to this particular exercise. Every aspect of this inquiry has been part of a personal journey taken to find an answer to a personal question. Why do nurses abuse or neglect patients? How do nurses understand and explain this phenomenon? This question originates in personal experience, and despite valiant efforts to silence my own responses and to embrace objectivity, this was not possible and I strongly believe it would have been detrimental to the results of this study if I had not included a segment of my own narrative. Violence towards patients is an issue that could easily evoke emotional and personal responses from all involved – nurses, patients, family members and researchers.

Postmodernism proposes the belief that there is no ultimate 'right' way to gain knowledge and that all claims of truth are underwritten by political or cultural interests (Richardson, 1994). Therefore, from this perspective the researcher is allowed to know something, without claiming to know everything (Richardson, 1994). Richardson (1994) argues that poststructuralism links language, subjectivity, social organisation, and power. Meaning, social reality, power and subjectivity are constructed through the use of language, which is not individual, but historically and contextually bound (Richardson, 1994). Therefore, the meaning an individual would attach to an experience is determined by the discourse available to them. Subsequently, the issue of violence in nursing was viewed from this perspective in this research. The language used to tell nursing stories created an opportunity to look at personal narratives, greater discourses involved in nursing, institutional thinking that results from these nursing discourses, and the context of these stories and discourses as they all relate to the data provided. Richardson (1994) argues that "the individual is both the sight and subject of discursive struggles for identity …one's subjectivity is shifting and contradictory, not stable, fixed, rigid" (p. 518). Therefore knowledge is linked to "knowing the Self and knowing 'about' the subject" (Richardson, 1994, p. 518). We, as researchers and writers should

therefore "understand ourselves reflexively as persons writing from particular positions at specific times" (Richardson, 1994, p. 518). Some of the major concerns for postmodernist writers are the issues of subjectivity, authority, authorship and reflexivity. I found writing a narrative of my 'self' to be revealing of where I place myself in this research. It helped diminish forms of 'othering' discussed earlier, since I become the 'other' – as Richardson (1994) explains. This allowed me to see the data from another point of view – my own. This view is present in all research – the researcher is never completely neutral, and I was able to harness this point of view as a method of inquiry towards a multi-dimensional take on the phenomenon in question. It allows a way of validating findings by reviewing how they were developed and deduced from the data by me, the critical tool of analyses.

Silverman (1993) explains that according to interactionist views of interview data, data is generated in a combined construction of reality. Both the interviewer and interviewee are participants who observe during the interview process. Therefore data should be "interpreted against the background in which they were produced" (Hammersley & Atkinson, 1983 cited in Silverman, 1993, p. 94). My role as a middle class, educated, white, female researcher was examined. Firstly I have a certain position of power in my social role as researcher. As discussed by Macleod (2002), my whiteness could be linked to past connotations of competence, culture, education and legitimacy of enquiry; or to imperialism and oppression. My position as an educated outsider further attached certain class-based interpretations of my power relative to that of the participant. I was not a neutral object gathering data, I was an active participant in the construction of text. These positionings of power were augmented when my experiences with different participants were compared. The interaction ranged from refusal to answer and consistent questioning of the legitimacy and necessity of what I was doing to absolute acceptance of my unspoken 'right' to do what I was doing. Macleod (2002) argues that a researcher's reflection on self should be clearly connected to political practice and should deal with the particular power and relational dynamics of their research.

2.5 Ethical Considerations

Ethical clearance for research of this nature was obtained by Professor Khalil from the ethics committee of Groote Schuur and the University of Cape Town (ethical clearance number: 410/2004). In order to guarantee an ethical approach to such a sensitive issue, I considered issues of harm, consent, privacy, and confidentiality of data (Punch, 1994, cited in Berg, 1998). Research awareness was initiated amongst nurses by Professor Khalil and measures were taken to ensure confidentiality and privacy, which was maintained throughout this study as well. Participants were

approached and informed about the purpose of the study, possible negative and possible positive outcomes to be expected from participation. Thereafter, the participant was free to choose whether or not she would be willing to participate. Each participant received a written informed consent form, which further stipulated each participant's rights and contained further assurances of privacy and confidentiality. Each participant was given a code through their involvement with the research project. The list with the names of participants and their codes will only be accessible by the main researcher. I obtained no codes or any means to identify participants. Each individual nurse was brought to me by the Sister in Charge and was immediately given a chronological number before any discussion took place. All participants were given the opportunity to choose a pseudonym, but all were comfortable with using their allocated numbers in stead. Therefore all lists and data for the purposes of this study can be kept with the assurance that the individual rights of confidentiality will not be violated. Confidentiality was further ensured by excluding certain demographic details from the table provided in APPENDIX E. Informed verbal and written consent also ensured that participants were able to make informed decisions without undue influence from the researcher.

2.6 Validity and trustworthiness

Validity is an issue important to all research. The data collection process of this study has not allowed me to ensure trustworthiness through this means. The data may have been affected by the fact that collection was possible only from candidates chosen by the ward manager; and that no information was made available about those who were not approached or those who refused to participate. Yet, we have to work within the constraints of the setting and availability of participants. Trustworthiness and a degree of validity was ensured by the reflexive nature of the analysis process, where my role as researcher was taken into account, paying attention to setting, and engaging with the data, "being authentic" in data collection and anticipating the unexpected in the field. Since it was not the intention of this study to measure reality, but rather to explore how reality is experienced by a certain group of nurses, this aspect of validity has not been a focus. Validity can be enhanced by means of interviews and observation, both of which were utilised during this research.

CHAPTER 3
Data Analysis

3.1 Positioning of Self

As discussed in the methodology section, I have included some of my own narratives in this thesis, since they have played a vital role throughout the study and I believe that including these will illustrate my awareness of my own subjectivity and potential bias. The following narrative will be the first of two such pieces that have been included.

Reflections on the interviews.

I walk into the ward, heart beating rapidly. I expect to be 'put in my place' in a controlled, but harsh manner. I fear asking the questions I have come to ask today, well aware of my position as far below the nurse. I expect conflict - a subtle, yet decisive response which will leave me feeling insolent and daft. I firmly believe that I will have to be submissive, apologetic and very delicate when approaching these women for their time. I was warned beforehand by one of my supervisors not to ask directly about violence, but to ease into it. The other supervisor instructed me to be open and direct; and from the reading I had done on the subject it seemed to be the best approach, theoretically speaking. But, unlike my supervisor, I have had particular intimate interactions with nurses, playing the part of the difficult family member they will speak of, being a relative of the very sick and sometimes 'uncooperative' patient they describe as not wanting to nurse.

The long ward stretches ahead of me. Everything is quiet. I have never been in a labour ward before and I have anticipated more noise. Everything seems under control, cool and strangely pleasant. Some nurses are busy in the rooms with their patients, writing on charts. No one is rushing around in the hallway and I hear muted whispers as I stroll along. I walk to the nurses' station - instinct and experience tells me not to interrupt what is happening in the rooms. This will not be greeted with enthusiasm – I may not disrupt their nursing to ask my question. I remember suddenly how afraid I am of nurses. They are always in control of your situation, inaccessible unless they choose otherwise, and I have to admit - in my mind - completely untrustworthy. Their neutral attitudes, unwillingness to expose themselves to the pain of their patients, their neglect and violence have almost caused my mother her death on more than one occasion and has added more anxiety and distress to my experience in the hospital than I had ever needed to bear. I have come here to find out why. Why I have had to endure such treatment from people who are in the so-called caring profession. I fear the worst – that there is not a humane explanation for it involving more than

intricate power plays, and hope above everything else that I can leave here with a more positive, insightful view of this enigma, this mysterious group of women whom I have the intense desire to understand. I hope for a dual cathartic experience of insight that will go beyond the mere description and deductive links to explanations of violence that I find in journals. I want the essence of the individual nurse, the human being behind the uniform, behind the acts of violence. I seek the voice left unheard in a desperate attempt to find the person behind the evasive uniformed woman.

The nurses' station is quiet. Everyone is writing reports and whispering or murmuring to one another. They ignore me. A formidable, but familiar voice speaks into the only telephone. She is professional, 'manly' with short grey hair, slim body and possesses a self-assuredness that makes me tremble. She nods in my direction. I smile feebly. 'Yes' she says, 'can I help you?'. When I inform her that we have spoken and who I am, she - with a friendly smile - takes me to her office, which she has made available to me. There is no phone and people generally would not interrupt unless it is very important. This has been well-planned and organised. I was expected and the necessary things have been arranged to make this a smooth operation with as little intrusion on the running of the ward as possible.

She brings me my first interviewee. Against a deep-seated fear telling me otherwise, my sense of ethics and the voice of my supervisor help me to do the right thing – I must be honest. I inform her about the study. I pose my first question directly about violence and what follows is a difficult interview. She is defensive, I find it difficult to get her to answer my questions and am exhausted afterwards. I describe her as suspicious, not openly answering my questions and expect the rest to do the same. Interestingly, when I transcribe the interview, I have a completely different experience. She is friendly, a bit nervous, sometimes unsure, but sincerely trying to be as helpful as she can. She *was* cooperative. I had initially attributed the difficulty of the interview to her subconsciously not wanting to answer my questions, and therefore not understanding my questions. Shockingly, this interpretation of the interview is retrospectively flipped. It was not the case of the defended subject, but rather of the defended researcher (Hollway & Jefferson, 2002). I, not wanting to ask the questions, had put them in such a way that she could not understand them – therefore absolving me from suffering the consequences of confronting an issue that I have not been able to ignore.

What follows are three more interviews, brought to me the moment the previous is done - with no break in between. I think back to the analogy of the factory line worker and fatigue sets in (Van der Walt & Swartz, 2002). I am not used to such a non-stop onslaught of uninterrupted interactions. I realise after the fourth that I need to take a break. I had started at 07:15 and have conducted four interviews by 10:30. I ask for a break and am informed that seeing that it is tea-time, there will be no-one to interview for the next hour anyway.

The interviewing process is an experience of the hospital and nursing that I never expected to have. I realise early on that even though I am probably younger than most of the participants and have no nursing experience, my status as a Masters student and as a researcher who is respected and accommodated by the Sister in Charge, places me higher in the hierarchy. With this placement, I am given the right to ask questions and to expect answers. For the first time I am not at the bottom, even lower than the patient – being a relative, but I am the one looked to for instruction and who is 'in control' so to speak. I did manage in most interviews to create a relaxed and trusting environment within this context. Some even experienced it as therapeutic and rewarding, which means the world to me and is more satisfying than any results that may come forth from those interactions. The point here is that nowhere in my experience was the hierarchy more clear to me than now. Had I been in labour - or one of my relatives, I would have been placed somewhere else on the hierarchy. I would not have had the right to ask these questions. My questions were answered, contrary to my former experience and expectations.

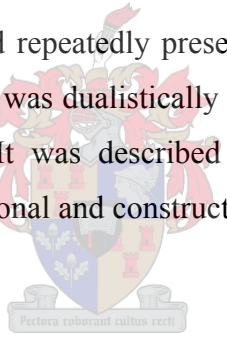
My power relative to that of the nurse's was even more clear when the Sister in Charge indicated that she felt intimidated by the presence of *two* recorders and I was in the curious position of reassuring the person normally at the very top of the hierarchy - who would usually be reassuring me. I was in the position to choose whether I wanted to reassure or not and she could not expect it of me. With the roles reversed, I have gotten to know a part of the women I sought to meet and developed an understanding of how relationships are negotiated and understood.

3.2 Findings

The data revealed an interrelated and complex view of violence towards patients. The participants provided a rich description of their own thoughts, feelings, observations and actions with regards to their experiences of nursing and violence perpetrated by nurses. This section will offer details of data provided by the nursing staff in order to portray the phenomenon in question as it was depicted. This thematic analysis has provided categories along which the phenomenon can be viewed and examined as it is experienced and understood from both my own understanding and the understanding of the participants involved. It was my aim to provide a rich, descriptive representation of the views of the participants in this section, categorising them only according to my understanding of the essence of these views.

3.2.1 Control

Control was an ever-present theme in the data collected. The phenomena of violence and the nurse-patient relationship were consistently and repeatedly presented as associated with the dynamic of control in the nursing profession. Control was dualistically portrayed as both a cause of violence as well as a means to prevent violence. It was described as an inherent aspect of the nursing profession, and a vital element of professional and constructive practices in the labour ward.



3.2.1.1 Control of the self.

The data suggested that nurses are expected to maintain control over themselves and their patients. Consequently, control over the self would imply control over violent behaviour. Participant 3, one of the two Sisters in Charge, explained why violence is unacceptable behaviour from a nurse:"it doesn't matter who you are, where you are, it's unprofessional and professional people … should be able to control themselves …"

Violence was therefore unacceptable behaviour, since control over the self and potential violent reactions, is an ability that all professional nurses are expected to maintain. Participant 6 (Sister in Charge and Ward Manager) revealed that nurses may want to become violent, but explained how *she is able to control her own impulses: "I just stop myself, mentally I just .... say: 'no, it's not how

* I have chosen to use the feminine personal pronoun in this research, since all the participants and patients in this research were female. The use of this pronoun is not intended to comment on the gendered nature of the nursing profession, and is merely used to simplify reading of the findings.

you think' and then it goes. It's a *very fleeting* sort of thought, if it occurs" (participant's emphasis). Her behaviour towards the patient is regulated by challenging her inner impulse with an ingrained thought pattern which rejects the notion of violent behaviour. Years of experience and maturity were the reasons she provided for being able to stop herself from becoming violent. This control over one's violent impulses is a learned behaviour and is reinforced within nursing practice. Participant 3 stated that guidance from older nurses or sisters help younger nurses, who are more vulnerable to violent responses, learn how to control themselves and find better ways of dealing with the provoking situation. Taking over helps those who are at risk of losing control and simultaneously provides the opportunity to get the patient under control.

> Participant 3: "… experience, maturity and also available help form colleagues … more support, if you can't handle a patient, come and ask for help or you can just hear an uncontrollable patient or you can HEAR somebody raising their voice … sometimes a new face and a little bit of a stern talking to by somebody else and the patient will … then calm down" (participant's emphasis)
>
> Participant 3: "With an uncontrollable patient, a more experienced person might go in and help a junior person so that they don't get out of their depth …"

Therefore, if control over her own impulses to become violent fails, the nurse is expected to remove herself from the situation and seek help from the more experienced. Note that Participant 3 indicated that it is the patient who is given the "stern talking to" and that the main focus remains on controlling the patient. Therefore, it seems that control over the self is closely linked to control over one's patient.

Participant 6 reported that consistency is of the utmost importance when nursing and this is achieved by replacing her normal, personal identity with the identity of an in control professional nurse. Participant 6 stated that she cannot afford not to have this strict control over her own responses: "I have to try and remain the same person each and every day, whether it be to a patient, to the smallest nurse, to the top management, I … I can't afford not to …"

Participants revealed that control over the self enables the nurse to control her patient, since the patient may be more obedient when she feels that the nurse is in control and knows what to do. An authoritarian mother-child relationship may be maintained with the patient. For example: the patient should be allowed freedom only when she has been assessed as responsible enough to be able to

control and behave herself if she is awarded this freedom (discussed below under *Appraisal of Patient*). Participant 2 indicated that patients regress and act like children when they feel that the nurse is not in control. A perception of the patient being irresponsible and immature, and therefore in need of being controlled is revealed in the data. The nurse, in her position of authority, has to maintain control over herself and her patient, since the patient is unable to do this:

> Participant 2: I want to *shout* at them! But *that* is the *worst* thing you can do … you must let the patient know that *you're* in control … they sometimes revert back to being a *child*" (participant's emphasis).

> Participant 2: "You must let the patient know that *you're* in contr*o*l. *Do not* (.) *shout*. … sometimes I think they revert back to being a *child*, they become more *stubborn*" (participant's emphasis).

The quotes above may illustrate a process that Van der Walt and Swartz (2002) explained to be the projection of one's irresponsible self onto the patient where it may be attacked and overcome by means of control and punishment (Frenkel, 2002). Therefore, as participant 2 reveals, the nurse must control herself, since the patient is irresponsible and should be controlled at all time. Control of the self is therefore illustrated in the data to be integral to the practice of nursing where it is assumed that the patient is irresponsible and in need of controlling care. A patient who is under control implies an in control nurse and vice versa. Control of the self is also seen to be integral to the prevention of violent treatment of patients, since nurses are expected to control violent impulses internally and externally (with the help of other nurses).

3.2.1.2 Emotional detachment.

Participants revealed that the control of the self is more deeply entrenched than the mere control over one's behavioural impulses. The nurses in this study conveyed that they should control their emotional responses at all times. Participant 1 described how an interaction with a patient affected her emotionally, but immediately (once I had paraphrased what she had said) revoked her statement:

> "suppose you come with a good heart from home and … you get this patient early in the morning that's difficult – spoils your whole day. It really does … (changes her mind) …I'M *FINE* AFTERWARDS (participant's emphasis)"

The quote above highlights Participant 1's experience of the expectation to be "fine". This control over the self involves an emotional detachment from the nurse's emotional responses and from those of the patient. It is deemed to be a vital aspect of nursing by some participants:

Participant 2:

"after a while you just go on like a robot …"

"you just got to switch off at the end of the day and (.) if you don't, you're going to be drained (.) and it's going to be to your disadvantage."

"you're going to crack if you don't. So you got to force yourself to do that – if you are a caring, feeling person that is."

"CARES for the patient, but knows at the end of the day where to draw the line, where to cut herself OFF."

"you've gotta de-stress, you can't take that *with* you … you've got to learn to insulate yourself and cut off (.1) umm (.1) you can go one of *two* ways: you can either feel NOTHING or you can just (.2) want to break free."

The statements quoted above demonstrate the extent to which Participant 2 must detach herself emotionally from her day-to-day activities when they become overwhelming. In order to be able to provide care for her patients, she has to cut herself off from them and their emotional needs. The strength of her belief in this way of dealing with her emotions is augmented by the statement that she could either 'feel nothing' or 'want to break free'. In this context, control of the self is believed to be a vital aspect of not only nursing, but of coping with nursing.

This control and associated emotional detachment is not Participant 4's first choice, but it is the only way that she knows of to deal with the emotional demands of her job. She has no other option, but to switch off. Interestingly, the data reveals that many participants cannot tolerate patients who lose control over themselves and cannot 'switch off' their own emotions. Perhaps, patients mirror what nurses repress, and this threatens their sense of control. Participant 4 continued her discussion of how she copes with difficult patients by stating that avoidance is the only option left.

> Participant 4: what *helps* in most cases is if you just switch off towards the patient … uh, it's not always adequate, eh, (.) but switch off your own emotions, what you go through … But like I said before, the *best* way to deal with anything *nowadays* it seems like, is to avoid it … Sometimes you *don't* have any other choice" (participant's emphasis).

Participant 6 explained that even though she experiences certain feelings, she has to keep them under control while she is at work.

> Participant 6: "I *do* get frustrated, *but* in the position that I am, of course, I can't let it show, so I have to sort of keep it locked away inside and vent my spleen when I ge home (participant's emphasis).

The participants, therefore, suggest an aspect of nursing wherein the control over the self is extended to their inner, emotional responses. Foucault (cited in Gilbert, 1995) refers to this as the process of subjectification where a part of the self is removed and becomes an object of moral practice. Loss of control is moralised as an unacceptable part of the self. Participant 6 describes this as her "spleen" – containing two meanings. Firstly it is an abdominal organ in the body, secondly it refers to the belief that the spleen is the seat of bad temper. This imagery illustrates that this aspect of her identity is split from her professional identity and "locked away" within the body where it may only be "vented" once she is not functioning in the capacity of a professional. This process of detachment determines the nurse identity in terms of discursive formation as the "in control nurse" and serves as a defence against the emotionally demanding aspects of the profession, and it is a function of the self control which should be maintained at all times. Participants become what Foucault (cited in Gilbert, 1995) terms "docile bodies" that practice self-regulation and accept this control. When this control is threatened by a situation which is out of control, participants reveal that violent measures may be employed – if inadvertently - to re-establish 'normality'.

> Participant 4: "… try your best to be calm and (.) you're not sure about things happening around you and then the patient, you *try* to explain something to the patient and … some of us, or I don't, we don't mean to be abusive or something, but sometimes it's just the way you talk in general" (participant's emphasis)

Colleagues play an important role in reinforcing the expectation of control. The stiff upper lip behaviour expected of Participant 4 becomes a stressor, since personally she is not always able to maintain the control expected of her. Yet, nursing discourse of the in control nurse expects it and

her relationship with her colleagues is changed when she cannot keep up the appearance of control. She recounts her feelings of loneliness and lack of support. She feels judged by her colleagues, since she cannot uphold the expected way of doing things.

> Participant 4: "sometimes it's also not a very good thing to talk with your colleagues or to somebody else, or somebody senior about it, because at the end of the day, it just seems like you're not coping (.2) or you're not assertive enough, or whatever. But then they don't see you as that strong person anymore. (.2) I don't think being a strong person has anything to do with it, (.) it's just people have (.) different ways and mechanisms of dealing with certain things."

This experience may be linked to the "normalising gaze" discussed by Foucault (cited in Deveaux, 1994). Individuals become aware of the watchfulness of those in the position of power, and of the regulation of their behaviour. They feel compelled to comply with the self-regulation of behaviour which is instilled by this "gaze". Participant 4 is acutely aware of this and tries to adhere to it professionally even though she cannot do so personally.

Participant 10 explained that she does not experience support from her colleagues when she is faced with a difficult patient. She is not able to detach emotionally as is expected and feels powerless, but she does not receive any support from colleagues. This leads to feelings of anger and helplessness:

> Participant 10: "You feel *angry*, yes you feel *angry* but there's nothing you can do about it. There's nothing you can do about your anger."
>
> Interviewer: "And what kind of thing happens when it's difficult, can you describe a specific incident? That made a day difficult for you? Something particular that happened?"
>
> Participant 10. "It's when the patients are fighting with us, and you can't protect yourself"
>
> Interviewer: "And when you can't protect yourself, what can you do?"
>
> Participant 10: "There's *nothing* you can *do*. You just sit with the problem. Because there's nobody you can talk to, you sit with the problem and it will *work* you."

Later:

> Participant 10: "Ja, you tell the person in charge. Ja, you go to the person in charge, you tell the person in charge, BUT NOBODY WILL GO AND SOLVE THIS PROBLEM, so that you can also be, be happy."

The participant experiences total isolation and lack of support in dealing with problems with patients. In addition to the experience of the "gaze" described by Participant 4 in which colleagues continually judge your ability to cope, Participant 10 describes the inability to obtain support from colleagues.

Interestingly, when the data is explored according to rank, one can see that the expectation to be in control and to be able to provide emotionally detached care is consistently presented by the sisters in charge and sisters. They create a picture of an ever in control nurse who must turn to colleagues when she cannot cope. Yet nurses report difficulty with this expectation of control and a lack of support. This implies that the issue of control may be experienced differently by nurses on different levels of the nursing hierarchy.

3.2.2 Control of the Patient

Paradoxically, the participants revealed that even though violent behaviour towards patients is never acceptable, there are some [†]violent nursing practices which allow nurses to gain control. These practices are defined as perfectly normal non-violent interactions when executed within a nursing context. Therefore, the definition of violence may be altered when certain acts are used to gain and maintain control. As outsiders looking in, the patient and even the nurse may experience certain acts as violent, but within the context of nursing, these practices are acceptable when they are utilised to gain control over the situation or the patient:

> Participant 1: "WE HAVE PATIENTS IN LABOUR HERE (.1) PATIENT doesn't want to cooperate (.) mm? Now YOU get (.1) you get (.1) frus*tra*ted(.) baby must come OUT and (.) the mother doesn't want to push (irritated) …you (.) pull the patient's legs and (.) BUT, that's the way we NEED to do it, but some people see it as abuse, but it's not abusive (.) WE need to get the baby out…" (participant's emphasis).

[†] Violence is defined as an act that causes physical, emotional or psychological harm. The motivation for violence – emotion, fear, frustration – will not be included in the definition of violence, since violence remains an act of harm regardless of the reason for its occurrence. The motivation for violence will be discussed throughout this thesis, as I explore how it is understood and explained by nurses themselves.

Participant 1 revealed that she experiences anxiety about the safety of the child and the mother's uncooperative behaviour. Control of the patient by means of violence is motivated by fear and anxiety regarding the labour. Participant 6 explained that violent measures for the protection of the patient are not defined as violence:

> Participant 6: "you get patients who is coming in, who is fitting persistently, yes you can probably call it abuse, physical abuse, when you're restraining that woman, holding her down, but you're actually doing it for *her* benefit, so she's not going to fall off the bed, until you can actually control the fits, so as I say, you could *look* at that as *being* abuse, but I don't see it as abuse at all" (participant's emphasis)

The data revealed that patients are expected to be in control of themselves when they enter the hospital. They are expected to behave themselves, cooperate with the nursing staff and the doctors, and nurses have the authority to obtain such control over the patient if it is lacking. When a patient's behaviour is deemed to be out of control and dangerous, violent measures may be taken to re-establish control. In addition to this, patients may be encouraged to control themselves:

> Participant 3: "you talk to them about breathing and coping and taking control of themselves"

> Participant 3: "She was totally out of control and I said to her 'take control of yourself … try and relax, I know it's difficult"

Patients are also expected to understand that the nurse is in control of things in the hospital:

> Participant 2: "you must let the patient know that you're in control."

The loss of control over the situation or the patient leads to feelings of anxiety and anger. The participants report fear of being blamed when things go wrong or that the baby will be endangered. Participant 7 explains:

> … if you're not going to do it (.) I'm going to be in trouble (.) you're not going to get the blame, because I'm supposed to tell you, you know. Difficult patients are those that don't want to listen when you speak to them, because they're not going to be told.

Patients are expected to follow orders, since the nurse is in a more powerful position and she is responsible for the mother and baby's life. She may also have to suffer the consequences if something goes wrong. When a patient is uncooperative, Participant 4 reports feeling anger: "you get angry with them, you still try to be nice … they *don't listen*, they do their own thing" (participant's emphasis). Her statement that she tries to be nice indicates that it is difficult to remain calm and controlled when the patient is unwilling to cooperate.

The experience of anxiety and anger is seen to be caused by the patient who is uncontrollable and does not listen, and consequently places the nurse in a compromised position. When the patient is identified as being difficult and control needs to be regained or exerted, the patient is the focus of all efforts. Violence becomes an accepted practice in this instance. The following quote has been used again in order to look more closely at what is being said:

> Participant 1: "WE HAVE PATIENTS IN LABOUR *HERE* (.1) PATIENT doesn't want to cooperative (.) mm? Now YOU get (.1) you get (.1) *frustrated* (.) baby must come OUT and (.) the mother doesn't want to push (irritated) … you (.) pull the patient's legs and (.) BUT, that's the way we NEED to do it, but some people see it as abuse, but it's not abusive (.) WE need to get the baby out…" (bold - my emphasis).

The emphasis on the words: "NEED" and "WE" underlines that the participant feels responsible for the life of the baby, and therefore employs violent measures to ensure this. "NEED" demonstrates that violent practices are a necessary part of nursing care, since they are linked to the nurse's professional responsibility and fear of not meeting this responsibility. Violent behaviour is redefined as non-violent in the context of a birthing process that may go wrong. The feelings of the patient become unimportant during the birth, since the focus is on preventing a negative outcome.

Participant 7 explained that she feels powerlessness over her patients. Fear of the possibility of something happening to the patient or her child evokes sadness and anger:

> Participant 7: "kind of just makes me sad, I mean, then I get *angry because* then I *think they're stupid*, they - I'm, or stupid(..) because we're not doing it for *us* , we're doing it for *them* , so then we, I also feel powerless, because I can't *force* you to stay here, there's nothing I can *do* or *say* that's going to make you change your mind … *I can't go and tell her: "*Yes, you're going to die or your baby's going to die, because you don't know that's going to happen, but you don't WANT that to happen, because it CAN happen*."* (participant's emphasis)

Participant 4 described an incident where there was a threat to the life of the baby. She described how the mother did not cooperate, even after she had explained that the baby's life is in danger. She explained that she becomes abusive towards patients that she believes know about labour, but who refuse to cooperate. She loses control over the birthing process, and is stressed by the anxiety of being blamed if the baby dies. Her violence towards the patient is reactive in nature and is driven by anxiety and the need to regain control.

> Participant 4: "I'd say. it's usually those patients who know …what's going to happen, especially in labour, you get those patients that you, before labour explain the whole procedure to them … and now you get to the part where they're busy delivering … you get those who *don't* work with us and in our case it's a fact of you're not just working with one, you work with *two*(.) and most of the time people don't think of what the *mom* did wrong it all comes back to the nurse. Now you explain there's trouble to get that baby out because you want the baby alive, you can see that the baby's life is in danger, but now you explain it … then the Mom becomes abusive and (.) that's the time that the nurse becomes abusive as well (.) because the more you explain – *you're worried about that child* , the more you explain, the more difficult they become, they don't listen to you , they swear at you and some just want to jump off that bed [ ] when the baby's head is halfway out already" (participant's emphasis)

Some participants described a kind of anti-climax after the 'crisis' of birth where they are able to let go of some of their control and if time allows it, they are able to speak to the mother. This enables the nurse to see the patient as an individual person who has also experienced a variety of feelings during the birth. Participant 2 describes an instance where a patient was uncontrollable and misbehaved as a result of pain experienced, but explains that once the birth was over and she spent some time with the patient, her view of the patient changed:

> Participant 2: "she was *screaming* and *shouting* – she actually told her companion to uh … said she was going to F him up… And I said to her, I was standing [ ] and I said 'haai, dis nie baie *mooi* nie you mustn't *talk* like *that*. And you know (.1) she just *looked* at us and umm (.) I just explained to her how to *breathe* … AFTER that I spent some *time* with her … we had a good laugh …she looked totally different and she said 'I'm so sorry' and then I said 'don't worry it *happens* … and it turned out that she is such a nice *lady*"

Participant 8 described her control over her patients. She described herself as 'assertive' and would not tolerate any abuse. She does not mind, however, if the patient is out of control up to a certain

point. It is acceptable, unless she becomes abusive towards the nurse. She stated that her control is rooted in the sharing of her medical knowledge with the patient and explaining what is happening:

> Participant 8: "I *don't*, I'll be honest to say I don't take much abuse from patients myself. I *am assertive* with the patient, umm, obviously if (.) I'm delivering a patient and the patient is really screaming, shouting and SWEARING (.) umm, that's not a problem, but somebody who's (.) [ ], who's drunk (.1) you know – starts getting (.1) quite physical, quire verbally abusive – I *don't* (.) accept that. And likewise with a patient (.) I find that if you explain everything to the patient (.1) they're *more* willing to be *patient* with you and to willing to tolerate [ ] from a sister. [ ]. That that's ME, *having* had the insight from working overseas, umm …"

Control over the patient is an inherent expectation of an effective nurse. Even though a nurse should never become violent towards a patient since she must control herself, violence may be employed as a method to control patients who pose a threat.

3.2.3 Power

It is necessary to mention that I am aware of the fact that there are other ways of defining the concepts of power and control, and that I have chosen one of these. I have chosen to organise data according to concepts highlighted in the interviews; and have found that there is a different understanding in the data of the need for control and the power to exert control. Some participants revealed that along with the authorised control over patients, they also have a sense of power over their patients. I have made a distinction between these closely related concepts, since the data has indicated a difference in the understanding of legitimate control and power. Therefore, the understanding of the violent behaviour associated with each may also differ. Power is associated with the sense that the participants are not only expected to be in control during labour, but are in the position to determine what the patient is allowed or not allowed. It is something that the nurse can choose to exert over the patient, and is not motivated by a perceived necessity to protect both the nurse and the baby during labour.

Participant 4 stated that a patient will be assessed as either cooperative or non-cooperative (good or bad) before she will allow them certain things: "sometimes it's much better if you assess the patient first: what kind of *person* the patient is before you *allow* them certain things." (allow - my emphasis)

Participant 3 also revealed the level of power that a nurse would have over her patient. When discussing an aspect of birth called, 'relief screaming' in which a woman would scream during contractions to relieve the intensity of the pain, she indicated that this is something that a nurse could choose to allow or not allow:

> Participant 3: "I know there's a lot of feeling that pregnant women, labouring women *should be allowed* to scream … but there is screaming and there is sort of relief screaming … that's an uncooperative patient" (my emphasis)

The patient may be seen to be uncooperative, whether or not she can control how she reacts to the pain of labour. If the patient is defined as uncooperative and the screaming is not defined as authentic relief screaming, the nurse may decide not to allow her to scream, even though it is not endangering anyone. With this power to control the patient, there may also be the expectation that the patient should be obedient. Participant 4: "so you expect that person to listen to you, to work with you"

Participant 4 discussed why she feels the need to exert power over her patients. She argued that patients take advantage of nurses when nurses do not maintain their position of power and authority over the patient:

> "You do get those [nurses] who are soft of heart, generally who (.) will excuse anything you do and will do anything you say to them (laughter), but I don't think that always works, because then the patients tend to take advantage of them, and the situation."

The power-differential must be maintained since the patient cannot be trusted. The patient is reduced to an object over which power may be exerted. When the patient does not embody the picture of cooperation and discipline, the need arises to impose this way of being onto the patient. Nurses who are seen to have an inability to do so may be labelled as weak.

The patient is not powerless in this relationship and has ways of resisting the power of the nurse. Patients may question the nurse's authority, may choose to remain silent, be uncooperative or may become violent towards staff

> Participant 7: "Yes, they don't want to be told**,** even with the policies or something nobody's going to tell *them or they'll just leave* ,(.) you know…"

> Participant 10: "…you find people from outside who come, the patient, the, they are partners in labour, and they won't understand when, when we tell them: 'Wait on the chair', because there is no bed available, and they become *so* violent."

Power, therefore, plays a role in how care-giving is provided. The nurse is in a position to exert power over the patient, and the patient is expected to be submissive to this power. When the patient challenges this power, she is labelled as uncooperative. Similarly, nurses who cannot maintain the power relationship are labelled as weak. Patients, consistent with the Foucauldian view of power, exert their own power. The act of care-giving is affected by this element of power in more interesting ways, as will be explored in the next section.

3.2.4 Withholding Care

Care-giving is defined by the participants as an integral part of their nursing duties. It is unacceptable not to provide care to patients in any way. Yet, care-giving involves the above-mentioned issues of control and power. Even though it is the nurse's responsibility to care for her patient, some participants revealed that withholding this care from patients is an acceptable method of gaining cooperation or disciplining the patient if she misbehaves. It differs from violence linked to control, since it is not motivated by fear of harm to the mother or child during birth, and it is not excused or justified. It is a means of maintaining the power differential between the nurse and her patient and it is not crisis-related. Care is withheld in two ways: ignoring the patient; or threatening to leave the patient alone. .These were described as a trick of the trade that enables them to gain control over the patient when she misbehaves. Participant 4 describes how she threatens her patients in order to obtain cooperation from them:

> "I would say okay, I'm leaving you now … just to scare them, you know, so that they know (.2) if you don't work with us we're going to leave you for a while, but then they think you're going to *totally* leave them … Sometimes that has a good effect (laughter) , just saying to them: 'I'm going to leave you now - somebody else can come' you know, because at that point you do get those patients that have become so comfortable with you that they don't *want anybody else* around them, so they *will* work with you if you say that (.) And then you get those that become so aggressive that they swear at you, and all the other patients can hear them can swearing at you (participant's emphasis)."

Participant 4 does not disclose to her patient that she will not abandon her completely, since this increases her power. This is done to gain cooperation and obedience from the patient. Noticeably, participant 4 reveals that she may use the relationship that she has developed with the patient as a means to exert her power in this way, since some patients may not want to lose her, therefore they may conform or cooperate. It does not always have the desired effect, but is seen as effective enough that she chooses this method to exert power over her patients. The participant shows how her power relative to the patient allows her to control the patient's behaviour. The patient also has a degree of power to decide whether to accept the power differential and cooperate, or to retaliate.

> Participant 4: "I've had a few situations where things have (.2) gotten worse, but *most* of the time it will, *most people* don't like being ignored, (.) start ignoring them, and they start changing their attitude (laughter) so most of the time, I'll say it works (laughter). Well *nobody* wants to be *ignored*, *nobody likes that feeling* of being ignored, so if you can't handle it, you must change your ways" (participant's emphasis).

Participant 4 describes ignoring and threatening to leave her patients as a disciplinary measure to change the behaviour of her patients. It is clear from the quote above that this kind of behaviour is not used to take control over a perceived crisis. It is used to control the attitude and behaviour of the patient in such a way that she will behave according to what the nurse would want. Participant 4 does this, since she has the power to do so. This sense of power may be linked to the expectations and experiences of patients, which will be discussed in the section on the appraisal of the patient. Participant 4 described the kind of patient who will be allowed certain things:

> "… the kind of patient who is very helpful, who listens to you (.2) and those who (.) although they've been through such a lot during the nine months of pregnancy, will still try to accommodate you as the nurse."

She demonstrates the belief that she is higher in the hierarchy and therefore can expect obedience and is more important than the patient. In this extract, it seems that the patient is stripped of her feelings and responses; and may be expected to place the nurse's needs above her own.

These acts of withholding care may be punitive and some participants revealed that they are accompanied by feelings of guilt and remorse. Participant 7 described how she felt about ignoring a patient or withholding care from a patient. She mentioned that 'respect' is something to be maintained 'generally' and demonstrated that she did not feel that ignoring a patient was showing respect for her:

> "… but [I] wouldn't even like to be treated like (.) um, the nurse just comes in to do what she's supposed to do, but she doesn't even pop in to ask if I'm okay. You know, *I* won't want to be treated like that, but *sometimes I* do it (.) to the patients, *because* of how they were now. *Maybe* it's not right, but that's just how I just feel. (.2) But generally the patient must be treated with *respect* (participant's emphasis)."

Participant 7 indicated that her actions are reactive to how the patient has been behaving. The nurse has the right to choose to do certain things for her patient. When the patients behave in a way which angers the nurse, it seems that certain forms of care may be withheld. When this happens, all forms of emotional care may be ceased, since the patient does not deserve it any longer.

> Participant 7: "*I don't* like it , and then *that* makes me angry, and then *that* ,I don't, I just want to do what I'm *supposed* to do, I'm not going to do anything extra for you, I'm not going to *speak* to you , I'm not going to speak to you much , I'm not (.) going to make you feel welcome here, because I take it - I *extended* my hand, but you (.) no. So I don't waste my time with you, I'm sure there's other patients who will appreciate it , then I just do what "I'm supposed to do, *that's* it No *extra* care and things. But you're *going to be looked* after, but not as I say - not special treatment" (participant's emphasis)… but if *you were offish* with me, you can just get everything available and nothing extra, because I don't *have* to, then I just do my work where you guys are concerned (participant's emphasis).

Withholding care, therefore, may be associated not only with the wielding of power over the patient, but is also closely related to the type of patient. It will be used when a patient is labelled negatively. Care, other than medical, is defined as something which the nurse can choose to provide. Therefore, if the patient is not seen to be worthy of 'special treatment', the nurse is allowed to refuse such care. The withholding of care is also used to elicit sought after behaviour from patients. It seems to be used as a means of negative reinforcement for wanted behaviour.

> Participant 4: "… do what is necessary and walk away from you, do what I have to do and leave you and come back later, (.) the only time I'll really stay with you is when there's problems or (.) you're busy delivering.

Participants reported that patients also have a degree of power to cooperate or to refuse cooperation. They can also refuse to accept what the nurse has to offer:

> Participant 7: "Then you get the cheeky kinds, like: "You're not going to tell me what to do, *No I don't want that*, but you know better. You say "Why don't you" "*No, no, no, I don't want that. With my last pregnancy I never had that"* (participant's emphasis)

The relationship with the patient may contain power struggles. Patients may be expected to be obedient, yet they may also rebel against the system in the hospital and try to assert their own power. The resulting conflict may involve an assertion of power by the nurse, retaliation and a counter assertion of power:

> Participant 7: "YES, THEY DON'T WANT TO BE TOLD - even with the policies or something nobody's going to tell THEM OR THEY'LL JUST LEAVE (.) you know, but WHY do they come to the hospital in the first place, they now came for help, but if it's not the way they want it, they always telling us [ ] they will leave or they will sign a red ticket" (participant's emphasis)

> Participant 4: "I'll just get up and walk away, I'll get them back by ignoring them" (.3) (cough and laughter).

Participant 6 has a different view. She feels that patients do not have the right to be demanding and therefore upholds the belief in the power differential between nurse and patient, but she disagrees with the use of ignoring a patient to achieve this:

> Participant 6: "I if the patient was *being ignored, then DAMN RIGHT, they have the right to demand"* (participant's emphasis)

The discussion of power and control, as well as violence and withholding of care contain a paradox. Violence towards patients may seem to the outsider – to me as researcher – as unacceptable. Yet it may, when looked at more closely, represent a form of engagement with the patient. When violent measures are used, the nurse does not detach herself from her patient, hence resolving the dimension of care-giving in her interaction with the patient, but remains actively engaged in the situation. Violence may therefore involve a form of care-giving, rendering it as better than withholding all forms of care. On the other hand violence is seen to be unacceptable, and threats or withholding of care are used to control the patient. This method of gaining control is an individual activity, involving withdrawal of care – the main function of a nurse as depicted in the data.

Therefore it is implicitly understood as unacceptable and involves feelings of guilt. In the midst of these opposing tensions regarding methods of gaining control and power over patients, the definition of violence itself is fluid, changing as contexts, texts and individuals change. This aspect of the definition of violence in care-giving will be discussed in the next section.

3.2.5 Accepted Violence VS Unacceptable Violence

Violence has been discussed in terms of its origin and the participants' understanding of the concept has been divulged in the section on control in nursing. On the surface, it may seem adequate to stop there – having explained that violence is linked to issues of control and power aimed at diminishing anxiety and asserting power over the patient, but the participants of this study allowed another understanding of violence as seen from their point of view.

Direct questions with regards to violence against patients induced a general response that it is unacceptable, unprofessional and not part of nursing ideology. When the issue was discussed in more detail, it became clear that violence towards patients is not a simple issue. It concerns both practical and ethical elements of nursing practice and therefore becomes complex. Control is a vital element of nursing practice. Controlling the patient can be difficult and violence is proposed as an acceptable tool to be used when other methods have failed. A thin and flexible line is drawn between acceptable and unacceptable violence. Therefore the definition of violence from a nursing perspective should be investigated and the definition of what is acceptable and what is not acceptable will be illustrated. In this section, I will be looking at some of the same texts from a different angle in order to expose the multiple meanings contained in the data.

> Participant 1: "you (.) pull the patient's legs and (.) BUT, that's the way we NEED to do it, but some people see it as abuse, but it's not abusive (.) WE need to get the baby out…" (participant's emphasis).

The participants of this study offered many understandings and definitions of violence toward patients. Broadly, there would be unacceptable violence which included all forms of violence: emotional, physical and verbal. Yet these unacceptable forms of violence were redefined as acceptable when they were employed in certain situations. Unacceptable violence was predominantly defined as physical in nature – slapping or hitting the patient. The participants identified 4 types of 'acceptable violence": verbal and emotional violence, and threatening and ignoring the patient.

Verbal and emotional abuse was described as reactions to patients who are deemed to be difficult, endangering the life of the infant and to be in a crisis situation. These types of violence are interpreted differently by different participants. Two participants offered descriptions of an incident where violence was perpetrated against a patient. What was evident in these descriptions was that their perception of violence seemed to be associated with their status as an insider or an outsider within the particular social event. Participant 4 was what I have termed an 'insider' who is part of the violence. Participant 7 was an 'outsider' watching such an incident. Both instances described involved a number of individuals who participated in a form of group violence:

Participant 4 described an incident with a mother who was in labour. She had come to the hospital as an emergency labour and participant 4 described how they had to deal with her in order to prevent the baby from dying:

> "the year before that (.2) she had um (.2) stillbirth, (.2) BECAUSE OF HER ATTITUDE TOWARDS STAFF, (.) um (.2) actually it *wasn't* a stillbirth, it was a neonatal death, (.) um (.) she wasn't really helpful, she didn't work with the staff, baby survived, but (.) there was some (.) brain damages or something (.) baby died a few hours after birth (my emphasis)."

She initially refers to the death of the infant as a stillbirth and the child is said to have died as a result of her attitude towards the staff. She had not cooperated the previous time she was there and was already labelled as 'difficult'. The baby had died as a result of complications and the patient was described to be wholly to blame. Participant 4 continued to describe the incident as follows:

> No, you're making me sore, (.) you're doing this, and you're hurting me, (.) and eventually two of my colleagues had to grab her legs - It was tied up in the poles already…but even so, one on each side of her, had to hold her legs, and one had to pin her down on the bed (.) and (.) that's the time she started screaming at us, that we're abusive to her, and we're being spiteful, and (.) you know what happened at the end of that? We sort of *had to push* that baby out ourselves, we're doing the delivery, two people pushing on her tummy. (.) which we normally don't do, but *that* day we *had* to and (.) *almost everybody* was screaming at her. Cause this baby's heart, and you know, luckily for us, this baby came out, baby was *flat* but baby survived (.) just with oxygen and resuscitating the baby - baby went down to the nursery for the night (participant's emphasis)

The use of the verb "had to" indicates that participant 4 believes that the way in which the birth was handled was necessary. The nurses had to do the delivery. There is no consideration for the

possibility of the birth being complicated due to medical reasons or the mother being distressed, afraid and in pain. The mother is the medical condition, the body to be dealt with and not a person. "Luckily for us" indicates that participant 4 is aware of the fact that they may not have been following procedure and that the baby may have died. It also indicates that, in this situation, the mother is not considered to have an emotional investment in the birth and would not be held responsible if something went wrong. Violence towards this patient is defined as acceptable, since it was believed that the mother was endangering the baby. She must be controlled and forced to give birth, since she cannot be trusted to do this.

Participant 4 described how she confronts the mother after the birth:

> "*if this child died*… before you could report us, I would be down (laughter) at Woodstock Police Station, *reporting you first*! Because if anything happened to this child now, you would have reported us and told everybody: " Nursing staff is doing this, and nursing staff is doing that," and *we killed* your baby , instead you won't go out there and tell everybody what *you* did wrong (.) not listening to us in the first place." (participant's emphasis)

Participant 4 revealed that this incidence of violence may have lead to consequences for her and her colleagues had the child died, but she feels justified in what had taken place, since she believes that this would be the only way to ensure a positive outcome and to avoid negative consequences. This reflects what Menzies-Lyth (1988) found in her research on nursing - that splitting may have been used to deal with this intensely anxiety provoking situation. The narrative reveals that all the negative and unacceptable aspects of Participant 4's behaviour has been split from her role in the incident and placed upon the birthing mother. This is done with the aim of being able to attack feelings of guilt, fear and anxiety. The mother is 'demonised' (Phipher, 1996) in the process and becomes the target of all feelings of loss of control, anger, distrust and anxiety. The mother becomes the irresponsible and dangerous self. This process is described as occurring in the group context wherein it has been found that such behaviour is strengthened. This is an instinctive response and Participant 4 reveals her discomfort with it in her conversation with the mother the next day. Time allows reflection and may necessitate justification.

Participant 7 described an incident where she witnessed violence towards a patient:

> "I *have* written a, a, a, *statement*, whatever, I witnessed it, and I *never liked* it, first of all because, ag, even if the woman was thin or so , *my mother* is fat and so this woman was *ridiculed* because she was fat. (..) and because she was a cae … she was an *emergency Caesar* (.2) So (.) it was a rush-rush business, It was a fine cheek, because she was still so

fat, so she was being shouted at, and then for a *fine cheek, the sister, *to add to their misery***,** the sister got *pricked* (.2) by trying to put in a, a, a drip, the doctor **[ ]** *getting a line***,** so *that* needle that she used, (.) with the *blood* on, she pricked the sister with, by accident, and *then* they checked; was the patient tested for HIV, (.) Then, on top of that she *wasn't,* so they don't know what the patient's status is, so she got *shouted* at, and pushed around and pulled around, because *you're just going to be tested*, and they just tested her without her *consent* , *she was totally violated, and I just don't think that was* nice and … Mm, it was even *going lekker,* they were *enjoying theirselves, going on and I was,* I just, didn't , I just never liked it, I don't think it was nice. "*Get this fat out of here*, and, no it's not nice, it just isn't nice and (.) I wasn't going to say anything, and I left it there, and I was off two days, (.) and (.) Wednesday when I came to work, [ ], make a statement, and I just said I'm not happy with this, because I just think it *can* be my family, and I'm not going to like my mother to be treated like that …but nothing came of it, nothing , I really think, they just got a *warning* but nobody came back to me , seeing that *I* was the one who launched the complaint, *nobody* came back to *me* and said they did this and they did that, maybe I'm not supposed to know, I don't know, nobody came back, just for future reference, *I kept my copy,* I still have it at home, and so [ ] forget, you forget what happened. That was the only *time*, that I know of." (participant's emphasis)

This description reveals that those participating in the violent treatment of the patient may have the sense that they have the power and authority to do so. It is legitimated in the group context and is part of the processes discussed in Participant 4's narrative. Participant 7 revealed that she was not part of this engagement with the patient, and from the outside, she defined the same incident as unacceptable. Participant 7 also revealed a moral judgement of the incident in saying: "it wasn't nice" repeatedly. In addition to this, she exposed the difficulty in being an observer of this kind of violence, being unable to do anything and falling on her only defence – staying at home.

The definition of what is acceptable and what is not acceptable is not always clear and is interpreted differently by different participants of this study. Some insist that violent behaviour of any kind is unacceptable, some do not believe in physical violence, others agree that there are times when it is acceptable and indeed, necessary. Verbal and emotional forms of violent behaviour seem to fall under the same inconsistency – it being acceptable in times of crisis, yet completely unacceptable when nurses are not involved in the crisis. This inconsistency in the understanding of what constitutes violence, and what is acceptable or unacceptable creates conflict, division and other social problems in nursing practice. It impacts negatively on relationships with colleagues,

* fine cheek. Colloquial use of language. Fine = of feelings: elevated. Cheek = impertinence, audacity. (Concise Oxford Dictionary, 2002). 'Fine cheek' is used to describe behaviour as impertinent and audacious in the extreme. Usually used in a sarcastic tone of irritation. Used in this quote to describe the feelings of the nurses whom participant observed.

since individuals who are violent cannot ask for help and those who witness it cannot report it. It creates confusion and individual' beliefs or feelings are not always congruent with their actions. Participating in the violent treatment of patients reportedly impacts greatly on Participant 1. She describes how she feels when she verbally abuses a patient:

> I don't feel right about that, *telling* (.) patients (.) you're not the only one here, because we need to help them – they're sick here, but what can you do, it's ONLY FOR THAT MOMENT, but I feel I'm a *different* kind of person … I don't feel *good* when I tell someone (.1) something like that (softly) (participant's emphasis).

Participant 4 explains the difficulty of the changing definition of violence:

> I don't think you can say it is the right thing to do, but you get times when you have to be harsh with patients …not hit them, or slap them … but just talk loud with them, talk hard with them just so that you can get through to them. But you do get nurses who do (.) take advantage of their position and hit patients.

The inconsistency in the understanding of what is acceptable or unacceptable and indeed what is necessary or unnecessary is problematic for the participants of this study. Where to draw the line with violence is unclear. The definition of what is violent fluctuates from participant to participant, and from context to context:

> Participant 2: "might be a bit [impatient] short, short-*tempered* and I suppose in first world countries … it might be construed as *violence*, but here (.) in Africa, it's certainly (.) normal, *normal* practice really."(participant's emphasis)

The Sister in Charge also reveals an ethical definition of violence in nursing practice:

> Participant 6: "I *completely* disapprove of it, I think it's not necessary, it's *not ethical.* It is *not* part of one's training, because you go to learn to care, *not violence"*

Violence is stated to be completely unacceptable under all conditions and is not associated with care. Yet later in the interview, she redefined abusive behaviour as care when it is done with acceptable intentions. Notice the emphasis of the personal pronoun, "her" in the following quote.

Participant 6 condones certain actions involving violence when they are for the benefit of the patient:

> "… you get patients who is coming in, who is fitting persistently, yes you can probably call it abuse, physical abuse, when you're restraining that woman, holding her down, but you're actually doing it for *her* benefit, so she's not going to fall off the bed, until you can actually control the fits, so as I say, you could *look* at that as *being* abuse , but I don't see it as abuse at all" (participant's emphasis).

This also indicates that this fluid definition of violence and its acceptability stretches throughout the nursing hierarchy – from the sister in charge to the nurse. Furthermore, the use of anger and violence in dealing with patients is reportedly condoned and perpetrated from the top - down. As Participant 4 put it: "even the doctor got angry". It is experienced differently by Participant 8 who has been nursing overseas. She does not experience the violence from doctors as a justification, but as a great problem in health care in South Africa:

> Participant 8: "When I returned, I was absolutely horrified to find (.1) coming back *here*, because this was my training hospital .hh that (.) ESPECIALLY the way that doctors speak to nurses and the patients. I've had various incidents where .h doctors have been, umm, rude in referring to various parts of the female anatomy (.) in *front* of patients, .h umm, they're rude to nurses, *incredibly* [ ] umm (.1) shouting, deman – umm *very* demanding and normally *so* in, in (.) in a fairly – this is a fairly stressed situation, but (.) umm, they, they go – *I* think, okay, *I* perceive them as going [overboard] here."

She experiences doctors as rude towards both patients and nurses. She finds it completely unacceptable. Interestingly, in spite of being completely against any form of violence or negative treatment of patients, she acknowledges that as she works in South African hospitals, her treatment of patients changes:

> Participant 8: "I *do* find *some* South African nurses rather (.) abrupt with patients, rather I'm going to say rude – I'm using that very broadly, umm, so much so that I'm *myself*, I'm becoming very (.) *similar* to that, which *bugs* me"

This adds to the earlier descriptions of group violence and highlights the question of medical discourse, culture, and practice in South Africa. It leads me to ask a new question: Is violent

behaviour towards patients a matter of the specific medical culture that has determined the way in which the health care practitioner-patient relationship is constructed? (Helman, 1994) The words of both Participants 2 and 8 bring to the fore an important issue with regards to violence, neglect and abuse of patients in South Africa. The fact that violence is described in the South African and African context as the norm and as behaviour that one adopts here, in spite of beliefs that contradict the this kind of treatment of patients. The earlier quoted statement that "… here (.) in Africa, it's certainly (.) normal, *normal* practice really" (Participant 2) raises an important issue in the problem of violence towards patients in South African health care facilities in need of further attention.

Participant 8 further describes how she was affected by doctors' abuse of patients when she was less experienced:

> Participant 8: " … probably when I was *younger* and still training [ ] I felt some animosity towards the patient, but (.1) *now* I just feel very guilty and *ashamed* that the doctor spoke to the patient like that and, you know (.) I'd try (.) to be more polite to that patient …"

Interestingly, the unacceptable violence of doctors towards patients caused her to feel animosity towards the patients in her earlier nursing experiences and not towards the doctors. It may be due to the subtle presence of the hierarchy, since the nurse cannot express her negative feelings towards those more powerful, thus expressing it towards those less powerful. Experience and working overseas where laws are strict and law suits more common are the reasons she provides for her current contradictory views.

Another important aspect that affects the treatment of a patient is how this patient is perceived by the nurse. Therefore a section on the appraisal of the patient follows:

3.2.6 Appraisal of the Patient

The patient plays an important role in the occurrence of violence. She is not a neutral canvas and contributes her own personality, belief system, culture, attitude and responses to the situation. The participants of this study indicated that patients are assessed before the relationship is developed. If the patient is seen to be potentially difficult or uncontrollable, they will act accordingly. Participant 7 explains how her experience has taught her to appraise her patients when they enter the ward:

> "You can normally see on the patients, the way they're dressed, the way they speak to you, you know, how they're going to *react* if they're going to hear something they don't *like, (.)*

> *especially where rules are concerned, especially* when visiting (..) are concerned, they're very aggressive where that's concerned" (participant's emphasis).

The patient is evaluated in terms of her potential to follow rules and to be obedient. Interestingly, the patient is seen to be the creator of her experience in the hospital. If she behaves according to the norm and shows obedience, she will have a better experience and relationship with the staff. Participant 7 acknowledges that some patients are not always treated well, but these are individuals who elicit negative reactions from staff.

> Participant 7: "I don't want to be *treated* like *some* people are treated here I don't even want … but then again, *I'm not going to go with the attitude to spark the next person off"(*participant's emphasis).

The participants reveal high expectations of their patients. They are expected to be friendly, helpful, cooperative, quiet, respectful and obedient. Difficult patients are generally described as uncontrollable: they do not listen, do not follow orders, shout, verbally abuse others, do not follow protocol or the rules. A difficult patient is described by Participant 2 as:

> "… one that doesn't (.) behave according to the norm – now that is : the patient is restless, aggressive and thrashes around (.1) sometimes verbally abuses somebody they are usually the people who are scared, they don't know what's going on … they are in a lot of pain, they could have a lot of psychological problems, or umm, social problems."

Even though she understands that the patient is in pain and scared, the patient is expected to control herself. The 'norm' according to which the patient should conduct herself is determined by the nurse and may not be understood by the patient. Irrespectively, demanding and difficult patients are in the wrong:

> Participant 6:"I don't believe any patient should be demanding but obviously *some are*, maybe it's (.) the individual themselves, it's the way they've grown up in life, and we as nursing staff aren't going to change it, we just sort of, get them better and get them out"

Difficulty in the relationship with patients is attributed by Participant 7 to a lack of communication and understanding, which influences how the patient is appraised. Cultural and linguistic

differences pose a problem, since the motivation for behaviour may be misinterpreted. Patients and nurses may both find it difficult to understand the behaviour of the other party.

> Participant 7: "black people, they can't actually speak English. Not all of them. *They can, but they don*'t - some of them, some of them, most of them don't understand when you're speaking to them, so it's just sometimes you just get this (.)" I don't care "attitude, or just do what you want to do, attitude." (participant's emphasis)

Participant 7 describes how she develops a better relationship with her Xhosa patients by learning a few words of the language, yet the relationship is strained by cultural differences.

> *You, you, you get a whole lot of characters,* it depends on the people, now not all black people are like that, now those who can speak English or those that can speak Afrikaans, now at least you can *communicate* with them sometimes. I picked up one or two lines, quite a few Xhosa words, then I can now *ask* them something, now then some of them respond like 'Hh, oh, you can now say something', and others will just; 'do what you will, couldn't care less' (participant's emphasis)

It is clear that some patients are non-communicative and withdrawn, because they don't understand the language or what is expected of them. They respond to Participant 7 when she speaks to them in Xhosa. Cultural and language barriers may affect the relationship negatively. Therefore, the difficulties of culture and language in multicultural care-giving are highlighted as problematic in the nurse-patient relationship and the provision of care, as it is defined by nurses in this study. Care can be given only when communication allows obedience and cooperation. Yet, what happens when patients are unable to understand not only the language, but also the culture of the ward? This lack of understanding may influence the appraisal of the patient, and therefore the care provided to the patient.

Importantly, participants report that nurses easily judge their patients and may misunderstand the intention of the patient. The patient is easily labelled as difficult:

> Participant 1: "I would like to understand them, because … we like to judge patients … JUDGE them on what they're doing now, but maybe …we don't know the background" (participant's emphasis)

> Participant 2:“ you must actually *learn* (.) to understand people (.1) to take into account that they (.1) act or behave un*reas*onably (.1) *totally* out of character (.) when they are in extreme pain (.1) and it is so easy to label somebody as (.) *difficult*, *demanding* …” (participant’s emphasis)

Participant 4 reports that nurses warn each other about these patients:

> “… if you know this is a difficult patient, prepare your colleagues offhand (laughter), beforehand, especially if you know that (.) this is a person with attitude. Rather tell the person: ‘you and this patient is not going to hit it off very well, rather stay away from this patient.’”

The patient is therefore sometimes categorised as difficult before a participant meets her, since other nurses may have informed her about the patient’s behaviour. This appraisal of the patient is not always conducive to nurse-patient relationships and is prone to mistakes.

> Participant 7: “*sometimes* you *can* be wrong, sometimes they are just like, say maar, poor people, but (.) no, most of the times I like them, I see why they’re maar so dressed so , it’s just the way they *speak* to you, the first time you speak to them and they answer you, you can *pick up* [ ] what *nature* this people” (participant’s emphasis)

It is consistently argued during the interviews that if nurses could spend more time with a patient, this appraisal would not be as necessary. The relationship between the nurse and the patient would be improved by understanding the patient better and being able to build a rapport with the patient. This may be of the utmost importance, particularly in transcultural nursing (Oosthuizen, 2002).

> Participant 4: “it will make YOU a *calm* person … the RELATIONSHIP BETWEEN *YOU* AND A PATIENT will be much better if we had more *TIME* with the patient, and under*stan*ding (.) between the two of you”

> Participant 3: “I try to get my staff to build a rapport with the patient and to keep the patent informed … find out a little bit *about* the patient”

The data brought to light that the appraisal of patients takes place along two broad categories: the good patient and the bad patient.

3.2.6.1 The good patient, the bad patient.

Participants reveal that difficult patients are noisy, agitated, won't sit still, move around, make a mess, are demanding, manipulative, are disobedient and don't follow orders

> Participant 7:"A difficult patient is somebody who refuses to do something for herself, who doesn't make an effort to *try*, doesn*'t want to take your advice* …"

The Sisters in Charge indicate that they believe patients are difficult because they are afraid and don't know what to do. They indicate that a nurse's duty is to help them take control over themselves, to give them something for pain and to explain exactly what is going to happen. As a last resort, the nurse is to remove herself from the situation when things get out of control.

> Participant 3: "if it's a difficult patient, normally try to talk to them, and if you can't get through to them, you should try to get somebody else"

Difficult patients may make it difficult for everyone to cope. If they scream and shout, it "puts everybody on tender hooks … the NOISE LEVEL eventually stresses people … everybody becomes a little bit more edgy." (Participant 3)

The patient who does scream and shout, however, is the exception and is deemed to be out of control. She becomes the point of irritation or banter, and therefore should be brought under control:

> Participant 3: "it does become a little bit of a joke. The other patients will say: 'Oo, is that labour?' and then we can joke and say: 'No, the poor lady is really taking a lot of strain … it's not normal, there are six other patients in there and one is actually like that' and you can normally find a little banter or have a bit of banter with some other patients … maybe it betters the relationship with the other patients, because you can actually encourage them and have a better rapport with them … and then you talk to them about breathing and coping and taking control of themselves."

Patients are not always to be trusted:

> Participant 4: "you still get those patients who say: 'yes Sister, no Sister' and all that – they're very friendly with you, but behind your back they go and tell the doctor: 'Oh, the sister is doing this and the sister is doing that and I don't feel the treatment the sister is giving *me* is proper treatment' "

A general distrust of patients is reported: they endanger their own lives and the lives of their babies; and they betray nurses by complaining about them to the doctors, who are seen to be highest in the hierarchy and in a position of authority over nurses. Nurses are aware of this surveillance (Foucault) from patients and therefore regulate their interaction with patients in order to protect themselves. This leads to a mistrusting relationship with patients and a fear of unexpected negative consequences to their actions. Nurses may feel powerless in the relationship, even though they are in a position of authority and may assert power.

Difficult patients are defined as demanding patients who expect nurses to help them with small things:

> Participant 1:"demanding patients – patients that just want …it's ONLY one that's asking for this and for that, she's really difficult, but you know … SHE can go and get *water* for herself, while you're busy doing *this* patient that's *bleeding* here, now *she* wants this, *she* wants that … THAT'S WHEN WE GET ANGRY …" (participant's emphasis)

The nursing staff report experiencing abuse from patients:

> Participant 3: "you go to examine them, and they close their legs and kick you … we obviously prepare them and say (.) look we are going to examine you to see how far the labour is (.) and we get kicked … those are the sort of things we get subjected to"

Patients are also experienced as being manipulative:

> Participant 1: "it's REALLY *frustrating* working on the orthopaedic wards …the patients lying in traction and they call you the WHOLE day … THEN THEY are looking at your *face*. If you bring it this morning and you don't have a problem doing it, then they going to call you the *whole* day and then they *manipulate* you … then you never get your work done" (participant's emphasis)

> Participant 4: "They try to manipulate them to do certain things for them, they'll use any excuse to go to the toilet"

> Participant 1: "THEY ARE VERY UNCOMFORTABLE … but we think of *ourselves* and *how* do you feel at the end of the day" (participant's emphasis)

Bad patients are demanding and have an attitude:

> Participant 7: "you've got bad and you've got bad, I mean BAD patient who (.) comes here unbooked (.) and wants (.) the *world* on a plate because the government is going to pay for it and they live down the road

Participants in this study revealed that difficult and abusive patients cause anxiety about the consequences the nurse will have to suffer if they are not controlled. Nurses feel that they have to take the responsibility and hence the blame for whatever goes wrong – even if it was the patient's fault. The nurse will "get the blame" and suffer the consequences, regardless of the context:

> Participant 4: "at the end of the day if a nurse says something wrong to you, (..) then it's the nurse who was abusive, they don't look at what was, what was said to the nurse or what was done to the nurses, (.) because I know I've gone home with my arms *purple* and *blue* (.) *patients* hitting me or *patients* just grabbing me" (participant's emphasis)

Participant 7 reveals that if a patient refuses to cooperate, she will be blamed if something goes wrong:

> Participant 7: "*and if you're not going to do it, (.) I'm going to be in trouble (.) you're not going to get the blame, because I'm supposed to tell you, you know, difficult patients are those that don't want to(.) listen when you speak to them,* because they're not going to be told" (participant's emphasis)

Good patients, on the other, hand are friendly, obedient and take the nurse into account:

> Participant 3: "*Some of them are very nice*, they're bubbly, friendly, and *certainly* with the help of birth companions it makes *our life* a lot easier" (participant's emphasis)

> Participant 1: "cooperative patient … they UNDERSTAND (.) *your* way of doing things, they understand the circumstances, they understand .. that we don't have *enough* staff now …and what they must do …" (participant's emphasis)

Interactions between nurses and patients are regulated by specific expectations of how each party should behave. There are certain expectations of nurses – from their colleagues and within the nursing profession, and certain expectations of patients. Nurses are expected to be calm and authoritative; patients should be cooperative, obedient and friendly, and they are not allowed any level of freedom that may endanger the child. The relationship degenerates when the patient does not follow the script. The nurse feels powerless and anxious and exerts her power to normalise the situation. The anxiety felt by the nurse is caused by the knowledge or expectation that she will be held responsible for what happens as well as the emotional strain involved in births that end in death.

Patients are therefore categorised and appraised when they come into the hospital. Nurses have a tendency to construct stereotypes of patients that suggest their potential for legitimating or disrupting nursing work (May, 1992). This leads to the emergence of judgements of the 'good' or 'bad' patient. Those who fall into the 'bad' category will be treated accordingly. They need to be controlled and need to be made aware of their position in the hierarchy. This could be pursued toward ensuring a positive birthing outcome or a general exertion of power. The particular interaction between each patient and participant determines the role that each assumes.

3.2.7 Reasons for Violence

An interesting finding in this research was that direct questions regarding violence elicited different responses to the themes discussed above. When violence was questioned directly, consistent and clear answers were provided, yet these answers differed from the stories that were told about violence. What follows is a summary of nurses' explanations for the occurrence of violence towards patients. Violence is attributed to other factors not relating directly to the patient:

> Participant 1: "I don't think it's a (.) PERSONAL problem between the nurses and the patients … I THINK ABUSE COMES because of (.1) frustration, anger and tiredness – overworked" (participant' emphasis)

Participant 3 states that violence is due to workload and a lack of support:

> "I think most of it boils down to stress levels … I think (.) NINE out of ten times (.3) it is (.) overwork, stress (.) and not a great deal of understanding from management" (participant's emphasis)

Participant 4 adds that nurses are under stress and have personal problems at home:

> "… stress of the workplace … those who generally don't deal well with stress … those who also goes home and have to deal with other problems"

The working conditions are also rendered as stressors increasing the potential for violence:

> Participant 6: " I think it could be also as a result of frustration … if there isn't enough nursing staff, they will tend to get very pressured, and pushed and rattled in their work environment, and get short-tempered and snappy and (.) not (.) think before they (.) would commit an act of violence. Also I think it could be (.) possibly (.) as a result of (.) increased patient numbers"

Participant 6 believes that violence is not the result of an uncontrollable patient, but that it is a consequence of personal problems:

> "… their personal underlying thing which is actually the reason, *not* frustration with the uncontrollable patient" (participant's emphasis).

Participant 7 offers a detailed description of what a nurse who is under stress and overworked might be feeling when she becomes violent with a patient:

> "they're frustrated, I would think because they're overworked, I would think, *maybe they've been so busy here* **…** and now eventually when they have a time to rest, and now they have this emergency, *and now***,** you're *already tired yourself* and you think okay, this is going to take *approximately* one hour just like from start to finish, so now after that hour you're going to sit, *but now you run into problems*, now you start getting frustrated because this is now going to go wrong or whatever (.) *I don't know man, I don't know* that's all I can think is because you're *vies now* because you don't want to work now, you want to rest now … SO IT'S YOUR issues that you want to take out on the patient , and the patient is not to blame for [ ] any of this" (participant's emphasis).

This section has provided details about the issue of violence perpetrated against patients as it was discussed by the participants of this study. The simple thematic analysis has identified contradictions within the data that may benefit from further discussion. The following section will address the role of talk and identity in the phenomenon of violence and nursing in order to give voice to the different narratives of nursing provided by the participants of this study.

3.3 Secondary Analysis

Further analysis of the data involves a critical look at the elements of institutional talk, social roles, and nursing discourse and ideology as they relate to the phenomenon of violence. I believe these to be meta-themes that direct the initial findings.

3.3.1 The Voice of Violence

A closer look at the data combined with consistent and repeated listening and reviewing of audio interviews have led to the discovery of what I believe to be a split in the discourse of nursing. The woman practising in the nursing profession experiences a separation between the institutional voice and her own. Here follows a description of the two voices in order to illustrate how each is related to the experience of the self and the ideology of the nurse. Both contribute to the subjective creation of reality through the use of language and the consequential understanding of violence as it occurs in the workplace.

3.3.1.1 The institutional voice.

Nursing ideology seems to create a filter for experience. It becomes a lens through which the experience and actions of the nurse or others within her sphere are understood and evaluated; and it determines the meaning she attaches to her experience. This ideology is historically and culturally bound and it determines the social identity of the nurse. It determines what a nurse would expect of herself, her colleagues and her patients. I see a commonality between the participants when nursing issues are directly addressed. When I speak to the nurse, I speak to an individual who is professional, helpful, pleasant and in control. Her voice is level, clear, sometimes monotonous with few intonations, unless she vividly describes an emotionally-charged moment. She speaks with authority and power; and I feel at times that I am attending a lecture, rather than conducting

interviews. When the nurse replays an interaction with a patient during the interview, her facial expression, tone of voice and enunciation changes into a more formal communication. The Sisters in Charge who have years of experience are direct, keep eye-contact and emanate a subtle, but constant essence of confidence and being in control. This is expected of all nurses:

> Participant 3:"professional people should be able to control themselves"

> Participant 6:"I have to try and remain the same person each and every single day, whether it be to a patient, to the smallest of nurses, to the top hospital management, I, I can't afford not to"

Participant 6 reveals that the identity she assumes at work is a necessity, not a choice. This way of being is instilled and developed through training, which focuses not only on what one practises as a nurse, but how it is practised - the values attached to being a nurse. A nurse is expected to be in control of herself, caring, patient and ever professional. This is illustrated by an account by the Sister in Charge as she describes her own training and what she expects of a good nurse:

> Participant 6: "I was taught is your *basic nursing care*, being *pleasant* to the patient, *seeing* if they're in pain, *doing* something about it if they are … washing their hair, brushing their hair, *anything*, just to make the patient feel special, because I think each patient should be dealt with as an individual, not just a bed with something in it um, empathy is, is showing that you care, you know whether it be that I sit for two *hours* with a lady who's, who's has a miscarriage (.) because she needs somebody to talk to, that, that to me , is also empathy." (participant's emphasis)

Self-sacrifice and care are synonymous with being a nurse. The patient's needs supersede the needs of the nurse. Student nurses are schooled in this way of being and are expected to live by the professional codes of conduct. Whatever their personal ethical beliefs are, they are expected to behave as a nurse would. The use of the words 'nurture' and 'channelled' in the quote below reflects a view of the student nurse as a child to be moulded into a proper nurse. Note the use of the words 'how' and 'what'. It is the participant's duty to teach them not only *what* a nurse does, but *how* a nurse should behave. The extended metaphor of the nurse-equals-child is reflected in the participant referring to other nurses as 'girls' throughout the interview. 'From day one' reveals an expectation that the correct nursing behaviour should be adopted and developed from the beginning.

> Participant 6: "*from day one* when they come out as a registered nurse, they have to be nurtured in the environment where they are, they have to be channelled in the direction of this is how; this is what you're trained to do" (participant's emphasis)

The subtle presence of the hierarchy is revealed in the following quote. The Sister in Charge, from her position, has the authority to reprimand and moralise student nurses:

> Participant 6: "I've actually called several in and I've said;" Listen you are training to be a professional nurse, there are a couple of *basics, ethical things, professional things,* that *you've* got to start practising now," and I've said: "that is like punctuality attendance, *all those* things (.5) and *religiously"*. After I've spoken to any of them, they never *came back* … I think they were ac … so *gob-smacked* that I actually pulled them *down* and said;" You know, you're not actually behaving like a nurse at all" (participant's emphasis)

Participant 6 exposes the process of developing what Douglas (1986) calls "institutional thinking". Douglas (1986) cited in Holstein and Gubrium (1994) argues that institutions are socially organised gatherings wherein social reality is represented in typical and routine ways. In nursing it is expected that student nurses adopt certain ways of assigning meaning and responding to things. As Sacks (1974) states, a culture does not instil precisely the same beliefs and behaviour, but ensures a similarity in the finer detail. The "basics, ethical things" that student nurses should start practising replace the individual's own ways of understanding and responding with those of a professional nurse. Foucault refers to this as subjectification. The woman entering the nursing profession is expected to separate an aspect of herself, which will perform a moral function. This removed aspect becomes the role of the caregiver who places the patient first, is punctual, obedient and in control. It is instilled by means of the normalising gaze wherein Participant 6, as the trainer will evaluate the student's behaviour according to accepted nursing discourse. Students resist this kind of surveillance by avoiding the environment in which the origin or the individual executing this regulation exists.

The expectation of *how* a nurse should behave is instilled not only within the hospital, but is evident in the broader community:

> Participant 4: "you also have a *social life* just like *everybody else* (.) but now you do get these people that (.) *Oh you're* a *nurse*, *you're not supposed to do this*! (.) You're a nurse, you're supposed to act *this way* … Sometimes it makes you feel like (.); What am I *doing* here ? Isn't there something else I can do?" (participant's emphasis)

The extract above reveals the expectations felt by the women practising in the profession of nursing. The individual behind the uniform carries her own personal and interpersonal history and reality, yet these are perceived to be secondary to her nursing identity. She feels constrained by the high expectations created by nursing discourse which extends into her personal social experience. The individual self questions these constraints and is affected personally by them. The professional self accepts them and suppresses her inner feelings.

This Institutional Voice determines what is acceptable or not acceptable in the nurse's behaviour. The concept of violence is constructed by the "institutional talk" present in the data. The interpretation of violence in nursing is directed by organisationally promoted ways of making sense of experience. Therefore, the institutional context of nurse-patient interactions conditions violent nursing practice (Holstein & Gubrium, 1994). Acts of physical violence, such as slapping or hitting is completely unacceptable and frowned upon, since it is incongruent with the moral expectations of a nurse. The following quotes are initial responses to direct questioning about violence towards patients. They are structured in such a way as to sustain the institutional voice, which at times seems to produce automatic responses.

> Participant 3: "I DON'T AGREE WITH IT." (participant's emphasis)
>
> Participant 4: "I don't like I, I don't approve of it" (participant's emphasis)
>
> §Participant 6: "I *completely* disapprove of it, I think it's not necessary, it's *not ethical.* It is *not* part of one's training, because you go to learn to care, *not violence…*" (participant's emphasis)

The word 'violence' elicits an automatic response. Discourse determines the answer to this question: that it is frowned upon or not acknowledged. The participants do not provide any other answer until conversation and reasoning has taken place during the course of the interview. The attachment to the institutional voice and its perception of violence in the nursing profession generates a form of professional denial of the occurrence of violence towards patients. The following quote is Participant 6's initial response to a direct question about violence:

> Participant 6: "Nothing that particularly stands out to me, I mean I did my training in Rhodesia, Zimbabwe, I don't recall it ever happening there, even in the psychiatric unit that I worked in there"

§ Some phrases have been repeated throughout the *Findings* section, since I have used multiple methods to view the same data. Therefore, the same data may be presented at different levels of analysis or intepretation.

Participant 6 is later able to recall one incident, but is unable to describe it. This occurred in a few interviews where participants were unable to describe what happened and were able to state only that it may have happened:

> Participant 6 "There's *one* incident that sticks out very much in my mind and that was verbal abuse towards a patient and (.) I think that was u um pers … personal problems, I think and work and *exams* that just got on top of the person, completely" (participant's emphasis)
>
> Interviewer: "Could you describe the incident?"
>
> Participant 6: "Too long ago, I just know it was totally verbally, and the patient actually complained, it was a fiasco."

Participant 1 stated that she could not comment on violence towards patients and proceeded to describe an incident where she was the victim of violence:

> Participant 1: "I can't really comment on THAT …I NEVER experienced *violence*, umm (.) ex-CEPT the time when (.1) umm, there was confused patient who slapped me in the face, but I understand, … she didn't know what she did or what she was doing." (participant's emphasis)

Participants 1 and 2 were unable to recall specific incidents of violence towards patients:

> Participant 1: (asked for an example of a difficult patient and what she did) "THERE IS SOME, BUT I CAN'T I CAN'T RECALL ANY …" (participant's emphasis)
>
> Participant 2: "never *seen* any particular violence towards patients per se" (participant's emphasis)

Coffey & Atkinson (1996) argue that informants may be performing certain kinds of speech acts in order to justify, legitimate or excuse social actions. Certain ways of accounting for experience may produce acceptable and plausible constructions of participants' world of experience. Lyman & Scott 1970; Potter & Wetherell, 1987, cited in Coffey & Atkinson (1996) maintain that accounts about questionable behaviour are organised as excuses and justifications. Excuses involve socially approved vocabularies designed to mitigate questionable actions. Justifications neutralise or attach positive values to behaviour rather than denying responsibility.

Nursing discourse draws on certain vocabularies and metaphors to justify acts of violence as acceptable nursing practice. The justification vocabulary involves: the uncooperative patient, the need for violence, the endangered life of the baby, the good nurse, responsibility and the avoidance of blame. The value attached to these acts of violence is the goal of a positive outcome for the birth. Violence is redefined by attaching positive values to it. Therefore, behaviour which may be seen as violent by an outsider looking in is not defined as violence by the insiders who have acquired this organisational reality and ways of justifying consequent actions. Certain acts are believed to be violent in nature, but are not violent when practiced within nursing in order to achieve the desired goal.

> Participant 2: "might be a bit [impatient] short, short-*tem*pered and I suppose in first world countries … it might be construed as *violence*, but here (.) in Africa, it's certainly (.) normal, *normal* practice really."

Normalising judgements are attached to violent actions, since the context in which these actions occur are defined as legitimate. As stated by Coffey & Atkinson (1996):

> Justifications … are socially approved vocabularies that may situate the act in a justificatory context, trivialise the consequences or the victim of the act, and in other ways justify the act as acceptable (if not desirable) … they must draw on shared knowledge and understanding … [and will] conform to the norms of a culture or situation. (p.101)

> Participant 1: "WE HAVE PATIENTS IN LABOUR HERE (.1) PATIENT doesn't want to cooperative (.) mm? Now YOU get (.1) you get (.1) frus*tra*ted (.) baby must come OUT and (.) the mother doesn't want to push (irritated) … you (.) pull the patient's legs and (.) BUT, that's the way we NEED to do it, but some people see it as abuse, but it's not abusive (.) WE need to get the baby out" (participant's emphasis)

The participants of this study never offered excuses as defined by Lyman & Scott (1970) for violent behaviour towards patients. Descriptions of violence towards patients were never mitigated by reducing the impact of the action on the patient, since it would be either unacceptable or necessary:

> Participant 7: "so to me there is no excuse as such … but I've heard some people, like, they will *justify* it and say *even* some people that are nurses, *people in* the *nursing profession*, they'll say;" *Yes*, *but the patients are rude*" and whatever." (participant's emphasis)

When the above quote is closely examined, it becomes clear that ways in which the role of the nurse and the concept of violence are constructed create a point of contradiction. This is illustrated by the following quote:

> Participant 4: "I don't think you can say it's the right thing to do, but you get times when you have to be harsh with patients … not hit them, or slap them … but just *talk* loud with them, talk hard with them just so that you can get through to them. But you *do* get nurses who do (.) take advantage of their position and hit patients." (participant's emphasis)

Violence towards patients is not acceptable according to the discourse of the nurse as the carer, yet nursing practice calls for and justifies such behaviour towards patients. The individual nurse is in the middle of two contradictory discourses and therefore in the precarious position of deciding which is the best to follow in a particular situation. The meaning of violence is created internally by Participant 4's own interpretive procedures. Being harsh with the patients is not being abusive, yet Participant 4 feels that some nurses take advantage of the right to be harsh. This indicates that nurses may rely on their own interpretations of violence to determine what is acceptable.

3.3.1.2 The professional identity.

The nurse assumes a professional identity, which incorporates the institutional voice and associated nursing practice. This identity is something that Participant 6 takes pride in, even if it took her a while to do so:

> Participant 6: "I can remember that when I was *nearly* finished (.) my general training, I didn't want to go anywhere in my uniform, because people would go ; "Oh God, she's a nurse you know [ ] but I, I'm proud of the *profession that I'm in now,* and I do my best." (participant's emphasis)

The professional identity, however, is insecure and linked to how the nurse is treated by the doctors, superiors and her patients. The professional identity determines the relationship with the patient and is linked to violence towards patients. Participant 8 described the emotional attachment to the professional identity. She discusses how disrespect and verbal abuse from doctors caused her to feel animosity towards her patients. Her professional identity involves being knowledgeable,

trustworthy and in control. When this identity is threatened, it reflects on the relationship with the patient:

> Participant 8: "…I *do* think that it has an effect on the patients as well from the point of view that (.) the people are (.) [ ] They will say (.) you know with my last baby I had here at [the] [ ] [ward], the doctor shouted at me, the sister (.) hit me (.) and stuff like that …"
>
> Interviewer: "The treatment of nurses by doctors – does that affect the relationship between the nurse and her patient?"
>
> Participant 8: "Umm (.3) [I'd find … a solution to it] umm, probably when I was *younger* and still training [ ] I felt some animosity towards the patient, but (.1) *now* I just feel very guilty and *ashamed* that the doctor spoke to the patient like that and, you know (.) I'd try (.) to be more polite to that patient, umm, (.1) ja ghh. I probably, I probably (.) the student would a better person to ask that question, know, I'm, LOOK I'VE LEARNT OVER THE YEARS to be a lot more assertive and I don't take much (.) much (.1) nonsense from (.2) either (.1) *mostly* the doctors, you know (.1) I probably take a lot more from the patients, [ ] their perspective."
>
> Interviewer: "So, you did mention that you would have (.1) animo[sity"
>
> Participant 8: O] yeah
>
> Interviewer: *Why* would that be?
>
> Participant 8: "Umm (.1) because I think most people want to be liked, umm, I think you know, being a student you try to impress (.1) you are newly out of the midwife [ ] you want to, you know (.) *have* that feeling that they can trust you" (participant's emphasis)

Participant 4 describes how her relationship with her patients is affected when her professional identity is undermined by her colleagues:

> "Or they talk in front of the patients about you (.2) another person: "Oh this sister is so and so" and so that patient has attitude already even before they know you or get to know you, you're already bad"

This identity is linked to feelings of being liked or disliked as the professional care-giver and influences relationships with colleagues and patients. Furthermore, this identity and its associated discourse may create the presence of insiders who adopt it and outsiders who reject it.

3.3.1.3 The outsider, the insider

Institutional talk informs certain acts of violence in nursing practice. It is concluded from the descriptions provided by participants that these acts are perpetrated in groups and sanctioned by organisational values of acceptable behaviour. Insiders are participants in these interactions with patients and behaviour is justified by the context. Participant 7 describes an outsider's view of an incident where violence was perpetrated against a patient:

> Participant 7: "I STOOD THERE**,** I am maar a nurse, I am so low down in the **[ ]** CONSULTANT, the sister, she's a matron already actually, ja I am the lowest so I just felt so powerless. I WANTED to tell them: "This is not necessary", but just because I *didn't* want to be shouted at as well (.) I just left, but I took, *I didn't know what I was going to do, but that's why I took notice of what's going on*, just in case it became anything."(participant's emphasis)

The nursing hierarchy is present in her words in the quote above. She is the lowest in the hierarchy and therefore feels that she cannot intervene, since she fears retaliation. Note that, as the outsider, she does not feel that violence towards the patient is necessary, yet she cannot intervene in the organisationally justified behaviour of the insiders. It is evident that she feels disappointed in her own self-preservation and reluctance to take action.

Helplessness in the situation causes her to stand aside and watch. She feels guilty for not protecting her patient, since she feels that she is not acting as a nurse. This reveals the conflict between the individual who is afraid of the group perpetrating the violence and consequently feels guilty and powerless (the group ethos as described by Whitaker, 2000); and the nurse who is duty-bound to protect her patient (professional care-giver). She describes that she is only a nurse – therefore powerless as a result of her position in the hierarchy. This is in conflict with her position as protector of her patient.

> Participant 7: "At that moment I felt that; if I - a*re* they going to listen to me? I'm going to say: "*Look here, don't treat a patient like this or whatever, whatever would have come out*

> *that time. Were they, they weren't going to listen to me, they were just going to (.) do whatever (.) they were busy doing* and besides, I was just there to catch the baby in any case. I wasn't even supposed to be there, I'm a labour ward nurse, I just went to go and relieve - catch the baby. *So why are they going to listen to me*? Or maybe they're going to verbally abuse *me* tell me like, "oh, *shut up"* or whatever. So I just left it, but I wasn't happy about it, and I didn't like the way it made me feel, and the other thing is this, I'm supposed to be the patient's advocate, and I *did do nothing* to protect her, so it wasn't nice, so, *but I did tell myself,* the next time this is going to happen, I'm not going to let myself (.) feel so *powerless, no I'm going to say something* and if you like me or don't like me or, I couldn't care less, at the end of the day, I'm here for the patient" (participant's emphasis)

Even though her own fears guided her behaviour in this situation, she vows to hold to her ethical duties as a nurse if it happens again. Participant 4, who has adopted the role of an insider before describes her experience as an outsider:

> Participant 4: "you don't say much, you don't do much, you just look at it and keep your mouth shut otherwise it is almost as if it will come back to you, afterwards (.) the sisters have a certain *attitude* towards you" (when witnessing abuse, participant's emphasis)

The power of the hierarchy and the group keeps the outsider from taking action, reporting or intervening. This may be explained in terms of a form of conformity to a group ethos (Whitaker, 2000). This causes individuals to relinquish their personal values for those of the institution. Interestingly, the institution promotes values that oppose violence, whilst simultaneously normalising violence as part of care-giving. Therefore the nurse experiences conflict between her personal values and her nursing values, and legitimated nursing practices that contradict them. Insiders will therefore adopt the institutionally sanctioned behaviour; outsiders will find it difficult to oppose it even if they do not follow it. Here the "normalising gaze" that would inhibit this kind of behaviour is not allowed. Those who do participate may harbour feelings of guilt and may displace their resentment towards themselves and the other insiders onto the patient and outsiders. Therefore the outsider finds it difficult to react to these instances of violence for fear of retaliation, and the patient may become the focus of feelings of anger and frustration.

3.3.1.4 The role of the patient.

The prescriptive institutional thinking also creates a social role for the patient as an actor who is expected to follow the script of the interaction between a nurse and a patient. Patients are expected to behave according to certain norms. These norms include: being obedient, cooperative, friendly, independent, yet following the nurse's orders. Patients are expected to become "docile bodies" that can be manipulated and controlled (Foucault, cited in Deveaux, 1994).

> Participant1: "cooperative patient … they UNDERSTAND (.) *your* way of doing things, they understand the circumstances, they understand … that we don't have *enough* staff now …and what they must do …" (participant's emphasis)

The patient needs to be understanding and should fall in line with the way things are done in the ward. When the patient does not follow the prescribed behaviour, the nurse may retaliate. Violence towards patients is discussed earlier to be a practice which may be justified and therefore redefined as non-violent or acceptable when conducted within a particular context. This aspect of violence is related to typical acts of violence involving physical, verbal and emotional abuse that result in institutional control over patients - especially during labour. There is, in addition to this, also a form of aggression relating to the power relations between nurses and patients. These include: ignoring a patient, withholding care and threatening to leave a patient. Importantly, this treatment of patients occurs when they do not adhere to their prescribed roles and may be used to coerce them into displaying desired behaviour.

> Participant 4*: most people* don't like being ignored, (.) start ignoring them, and they start changing their attitude (laughter) so most of the time , I'll say it works. (laughter) Well *nobody* wants to be *ignored*, *nobody likes that feeling* of being ignored, so if you can't handle it, you must change your ways" (participant's emphasis)

Participant 7 explains that unwanted behaviour that does not adhere to the patient's role as the docile body (Foucault) results in her limiting her provision of care to medical attention..

> Participant 7: "but if *you were offish* with me, you can just get everything available and nothing extra, because I don't *have* to, then I just do my work where you guys are concerned." (participant's emphasis)

The nurse, from her position of authority and power, has the right to judge her patients, decide how to behave towards them and may become violent towards the patient if expectations are not met.

> Participant 7: "*I don't* like it , and then *that* makes me angry, and then *that* ,I don't, I just want to do what I'm *supposed* to do , I'm not going to do anything extra for you, I'm not going to *speak* to you , I'm not going to speak to you much , I'm not (.) going to make you feel welcome here, because I take it I *extended* my hand , but you (.) no so I don't waste my time with you, I'm sure there's other patients who will appreciate it , then I just do what "I'm supposed to do, *that's* it No *extra* care and things. But you're *going to be looked* after, but not as I say - not special treatment" (participant's emphasis).

Even though a patient may have medical reasons for being difficult, Participant 8 describes refusing to care for her, since the patient overstepped her boundaries and behaved inappropriately. :

> Participant 8: "There, umm, there's been various (.) [ ] where I've actually walked out and *refused* to care for a patient, because I feel (.1) that the patient has pushed me too far (.) and I don't want to get to that stage where I (.1) I have walked out on occasion (.2) ja, I would rather walk out and (.) give the care to someone else than take responsibility for the patient. Umm, one instance, I had a (.) *17* [old girl] [ ] she *really* was (.1) you know (.) *irritating*, umm (.) she, she threw her things on the floor in (.) post-anaesthetic shock (.) that she didn't handle very well, I, I *understood* that, umm (.1) I just wasn't prepared at that time (.) to handle it." (participant's emphasis)

The patient plays a pivotal role in the nurse's sense of security. When the patient is out of control and is seen as threatening, the nurse's sense of security is threatened Patients may be evaluated on a variety of things: the way they look, their facial expression and how they respond to the nurse. These evaluations precipitate judgements of the patient and may determine the way in which the nurse will interact with the patient.

The need for and practice of violence in order to exert power is present when the patient is experienced as: wielding power of her own, uncooperative, a danger to the baby or out of control and hence is judged to be threatening. When the patient is not obedient, nurses may attach negative attributes to the patient. The patient becomes objectified as a threat to both the nurse and the baby and violence becomes justified. The lack of time was indicated by some participants to be the main obstacle to developing a more balanced view of the patient as an individual. Perhaps the availability

of more time will allow more flexibility in the role the woman has to assume when she becomes a patient.

> Participant 2: " you must actually *learn* (.) to understand people (.1) to take into account that they (.1) act or behave un*reas*onably (.1) *totally* out of character (.) when they are in extreme pain (.1) and it is so easy to label somebody as (.) *difficult*, *demanding* …" (participant's emphasis)

Participant 1 had longer interactions with patients on the orthopaedic ward and appraised her patients negatively, since they were seen to be manipulative, needy and interfered with her job. This raises the question of how nurses define their work, since the following quote illustrates that basic caring may not be included in this definition. The following quote illustrates her irritation with helping patients with their toileting needs.

> Participant 1: "it's REALLY *frustrating* working on the orthopaedic wards …the patients' lying in traction and they call you the WHOLE day … THEN THEY are looking at your *face*. If you bring it this morning and you don't have a problem doing it, then they going to call you the *whole* day and then they *manipulate* you … then you never get your work done" (participant's emphasis)

The patient plays an integral role in her relationship with her care-giver; as well as in the care she receives. It seems that patients who adhere to their prescribed roles receive better care than those who do not.

3.3.2 The Voice of the Individual

When I suddenly hear the voice of the individual person speaking to me about her own experiences, not as nurse, but as an individual, I am stunned. This aspect of the interview reveals a woman who is different from the nurse. Participants who were lower in the hierarchy (nurses) more often revealed this personal side. The expression of their language and their tone of voice are more variable. Rich personal accounts of nursing are more readily provided when the participant does not function from the role of the nurse. She is not as reserved and chats away easily. I do not experience her accounts as detached. She reveals that she is not always in control, and that she has feelings of loneliness, fear and being unsure. She is affected by her environment, even though she may not always express it. The individual reveals the impact that violence has on her. Participant 1 explains

how verbal violence is a necessary part of the birthing process when the patient does not want to cooperate and this may lead to problems, yet this professional practice has an effect on her:

> … it's ONLY FOR THAT MOMENT, but I feel I'm a *different* kind of person … I don't feel *good* when I tell someone (.1) something like that (softly)" (participant's emphasis)

Her behaviour is justified by the institutional talk surrounding violent behaviour towards patients, yet she experiences a personal dilemma. Her socially sanctioned behaviour changes the essence of who she is and results in guilt. Conflict arises between her own beliefs regarding nursing and those that are institutionally developed and justified.

She communicates a more personal reason for violence towards patients, which involves a personal interaction with the patient:

> *We* DON'T KNOW WHAT THE PEOPLE, WHAT THE PATIENT THINK WHILE THEY LAY, THEY ARE *LYING* THERE, THEY WAIT FOR PEOPLE TO HELP (.) .h SO THEY (laughs) … THEY MAKE THEIR, THEIR UMM *SUMMARY* ALREADY OF THE, OF THE *PERSON* ***(.)*** WHO HELPS THEM …WHILE *LYING* THERE, because they are *watching* the, the person the, they're *observing* the place inside .hh so that can also be and a (.) reason. (participant's emphasis)

She reveals an aspect of the nurse-patient interaction which is not commonly shared – her own vulnerability to the patient's appraisal of her. This also relates to Foucault's description of surveillance (Foucault, cited in Deveaux, 1994)). The individual feels that she is being watched and that judgements are made of her behaviour. The feeling of being watched is offered as a reason for violent behaviour towards the patient. It may be a consequence of the hierarchy, in which the nurse is usually in the watchful position, but the individual now finds herself vulnerable to the judgements of her patient.

Participant 7 questions her social role as a result of a threat to her life from a family member of one of her patients. She examines the effect that her behaviour may have on a patient and therefore is too afraid to function from a position of authority as she usually would:

> That's why , from *that time* I ask for somebody rather, if I *see somebody* doing something wrong, I'm too scared to approach them, I go and fetch somebody, BECAUSE SOMETIMES I THINK THAT MAYBE I'M THE ONE THAT'S OFFENDING THE PERSON BY WHAT I AM SAYING OR HOW I'M SAYING IT - maybe I'm saying it in a *bossy way*, so they

> don't like it, I also don't like it sometimes, if they speak too me in that *tone* you know maybe, maybe hurt their feelings, so I rather go fetch somebody else. (participant's emphasis)

When she has to function from her professional role, she prefers to have another nurse take over. She is unable to suppress the impact of this negative experience and embraces once more the role of the authoritative professional. Participant 7 further reveals that when she ignores a patient, she feels guilt even though it may be a justified aspect of nursing. Even though it is acceptable behaviour, it contradicts both her belief about nursing as well as her personal discourse:

> Participant 7: "but wouldn't even like to be treated like (.) um, the nurse just comes in to do what she's supposed to do, but she doesn't even pop in to ask if I'm okay. You know, *I* won't want to be treated like that, but *sometimes I* do it (.) to the patients, *because* of how they were now. *Maybe* it's not right, but that's just how I just feel. (.2) But generally the patient must be treated with *respect*." (participant's emphasis)

Initially she describes, from her personal view why she does not feel that her behaviour is ethically sound. Later she refers back to nursing discourse that stipulates how the patient should be treated. This portrays the consistent interaction between the individual voice and the institutional voice, both directed by different discourse. The individual questions, feels, shows empathy and is affected by interactions. The professional must show respect, be in control and embrace the role of the 'perfect nurse'. Nursing discourse and nursing practice may be experienced as incongruent. Discourse stipulates respect, yet practice involves actions that the individual may interpret as disrespect. An internal conflict arises, which is reflected in contradictory narratives.

I find it easy to ignore the voice of the individual when I investigate violence towards patients. The participants are so well-practised in the art of hiding this voice that I find it difficult to separate it from the voice of the nurse when I look at the data. It is revealed through the way in which story-telling changes from the one to the other. This individual dialogue allows me to understand violence from a more humane perspective. I am able to understand both and this allows a fuller description of the reality I would like to explore. Participant 1, who describes moments of violence towards patients, reveals the personal stressors of nursing:

> Participant 1: "if I have a problem here at work, it's not easy for me to (.) just get rid of it here and go home. It stays with me … it does have an effect on my (.1) married life also"

Even though she is affected personally by her career, she states that she comes to work, because: "people needs me over here, they needs me over here." Even though her relationship with her patients is not always perfect and in spite of the stressors, she feels the sense that her work is a calling and attaches personal meaning to it.

Participant 4 reveals that even though nursing is perceived to be a calling, nurses are affected negatively by the work:

> Participant 4: "you get those days that you don't feel like coming to work, but of course you just simply have to and (.) you get to work and try your best to be calm and (.) you're not sure about things that are happening around you"

There is a delicate interplay between the major discourses regarding violence, the role of the patient and nursing practice. The nurse and the patient are involved in an interaction directed by competing and contradictory discourses. On the one hand, the nursing ideology presents an idealised prescription of nursing behaviour and a submissive role for the patient. This prescription of nursing behaviour includes high moral standards. Within this sphere, the nurse may not be violent towards the patient and the patient may not disobey rules and protocols. When this role of the nurse is threatened and her power relative to the patient is at risk, she may employ violent measures to reassert her position, consequently transgressing the moral discourse and entering discourse surrounding nursing practice. These actions are not always defined as violent, but rather acceptable ways of regaining control. Certain acts which may be deemed as violent are redefined as necessary and therefore become non-violent when they are perpetrated as normal nursing practice. Nursing ideology and nursing practice become incongruent forces impacting on both the nurse and the patient.

3.3.2.1 The objectification of the self.

This section describes, in detail, the process of that may be involved in becoming a professional nurse and assuming the discourse described above.

The woman walks into the working environment and becomes a nurse. This involves almost stripping herself of a part of her personal identity. Colleagues are not interested in her problems at home, she doesn't complain, she cannot be weak, vulnerable or fallible. She has the function of caregiver, provider of medical care and of controller of herself and her patient. The woman embodies the identity of the nurse who performs a certain function – helping with the birthing

process and ensuring that it runs smoothly. Mistakes and loss of control are frowned upon, unacceptable and cannot be made.

The nursing persona becomes a source of strength and safety. It is how she relates to her colleagues, it is her professional identity and it is what makes her a good nurse – one who can follow the rules, be in control, be ever-friendly, patient at the same time, must be able to follow orders, be intelligent, competent, independent and trustworthy. The good nurse has to be able to cut herself off from emotions that may lead to unacceptable behaviour. Some describe behaving like a robot, going into "robomode" (Participant 7).

Yet, the person behind the uniform is often ignored or suppressed. There is no time for feelings of insecurity, being overwhelmed and not knowing what to do. This is due to nursing discourse as well as certain environmental factors: staff shortages, lack of time, too many patients, lack of funds and equipment. The nurse, however, does have a personal side, a unique personality, problems of her own and these affect her way of functioning at work, but she has to leave these at the door when she comes to work. Lack of support, lack of time and high expectations place pressure on the nurse who goes home at the end of a hard day, taking with her what she has experienced at work.

Participants indicate that even though it is not acceptable to lose control over oneself (see *Institutional Voice*), the nurse's personal feelings do impact on her behaviour at work: "…and it also depends on your own day, I mean if you've come with a bit of extra baggage at home … I mean we're all just human". This expresses the need to be seen as a person who is human, not a function of her objectified persona.

3.3.2.2 Emotional detachment.

Nursing involves the closest of encounters with other individuals. The nurse is sometimes the sole provider of information, guidance, medical help and reassurance. Caring for the patient cannot be allowed to penetrate the outer armour and the nurse protects herself by means of cutting herself off from her emotional responses: "you can't take that *with* you … you've got to learn to insulate yourself and cut off (.1) umm (.1) you can go one of *two* ways: you can either feel NOTHING or you can just (.2) want to break free" (Participant 2).

This is a necessary part of being a good nurse. The nurse is expected to be able to detach herself emotionally from negative experiences: "you're going to crack if you don't. So you got to force yourself to do that – if you are a caring, feeling person that is" (Participant 2).

Participant 7 compares this kind of functioning as going into 'robomode'. The nurse follows her routine, keeps to protocols and does not allow anything interfere with performing her duties.

This description has the familiarity of the task-orientation described by Van der Walt & Swartz (2001) that serves to control the environment, create distance between the nurse and her patient and to protect the nurse from the emotional demands of the job. The nurse is wholly preoccupied with her duties – observation, her pattern that follows a time-table. There is no space for the patient to interrupt this pattern. Participant 7 indicates that when it is interrupted, she just wants to stop. This illustrates her inability to switch off at work, to deal with anything other than her routine and prescribed duties – the tasks set for her to complete.

> Participant 7: SOMETIMES YOU GET BUSY**,** now you work like a robot, because you have everything set to a time, *now this patient comes,* IT'S A FACTOR ALREADY, IT DOES HAPPEN**,** now you just want to do your observation, and you [ ] now this patient comes:, " *Nurse don't you want lift to my bed for me ?"* now that breaks your pattern … I just make ag joke and I say" It breaks my robomode, then I want to stop" (Participant 7, participant's emphasis)

A nurse cannot allow herself to respond in a way that shows her weaknesses and this leads to feelings of isolation and distrust by nurses are not coping and who need support:

> Participant 4: "… sometimes it's also not a very good thing to talk to your colleagues or to somebody else, or somebody more senior about it, because at the end of the day, it just seems like you're not coping (.2) Or you're not assertive enough, or whatever (.) But then they don't see you as that strong person anymore. (.2) I don't think being a strong person has anything to do with it, (.) it's just people have (.) different ways and mechanisms of dealing with certain things."

Therefore, it seems that the emotional detachment discussed earlier is a function of the professional nurse identity. The role of conflicting and contradictory discourses in care-giving and the occurrence of violence have been explored in this section. In addition to exploring nursing ideology and discourse, I investigated participants' narratives in order to find the voice of the individual behind the nurse. Consistent with my approach of transparency in my role as researcher, I have included my personal narrative about my experiences in conducting this research in the following section.

3.3.3 The Voice of the Researcher

Personal Reflection on Data

Ironically, I find myself in the same position as the one I set out to understand. Having started teaching when I started my thesis, I was exposed to similar discourses of sacrifice and control. I simultaneously tried to understand my own struggles at work and those of my participants. The parallels grew and I found myself changing. I felt the demands to act in a certain way, to take responsibility for certain things over which I did not always have control and to regulate my interaction with my students. I experienced the anxiety of being responsible for the outcome of my attempts at teaching, yet being unable to control how my students respond to my efforts. I could not force them to learn, to respect, to achieve, yet I was responsible for these things. I gradually started to assert my power and inflicted an educational "gaze" upon them in order to regulate their behaviour. Similarly I felt the internalisation of the pressures to conform to the ideal of the good teacher. When I failed this ideal – being in control of myself and my students; friendly, yet stern; empathetic, yet never allowing them to take advantage or manipulate me - I would turn to more overt punitive measures to exert my power.

I remember a particular incident. I was faced with a situation where a child was unhappy with the discipline I was imposing on him. He was very upset and became verbally abusive. He was out of control and disrespectful – resisting my power. Even though I knew that he needed to be heard and that on a personal level I would embrace and listen to his voice, I purposely silenced him, since my role as an educator did not allow me to "lose" the battle and back down; and his role stipulated that he should be allowed to question, but should be obedient and in control. I could not afford to lose face in front of the other students, since my control over them was directly linked to how I addressed this incident. This plagued me for days, since it contradicts every bone of my personal discourse. I do not believe in silencing people, rendering them powerless, but it was an implicit expectation, a part of teaching culture to which I was beginning to conform. Thus finding myself changed, I was uncertain about what to do. I felt resentment and anger towards the child for forcing me to act in this way; unhappiness with the profession for not allowing me to be seen as a person and not an object of education and an inner dislike for the person I was becoming. I felt embarrassed at my insecurity at handling the situation. Yet in the social setting, there was not really an alternative.

I go home and find myself interacting with data which become more and more familiar. I develop an understanding of what is being said, interpret not only the data, but my own experiences as well. The humanised view of this phenomenon I sought became easier to find in the midst of my

own experiences. Having seen the worst face of the care-giver, I have also found the worse face of the educator. Teachers and nurses are alike in many ways. Both are criticized for and guilty of incompetence, indifference, aggressiveness and in the more extreme - violence. I find both my individual voice, and that of my participants desperately seeking congruence between what is expected and what we can offer. Being responsible for others, without controlling them is difficult; and with control power enters the equation. In addition to this, the great emotional demands of the day-to-day practice wear one down. I find it difficult to focus on my thesis after a day of controlling, shouting, listening and comforting. I am exhausted, and find the same being said in the interviews. But tomorrow I must go back, be the same, never let it show. At least I have four holidays and a supporting team of colleagues. I cannot imagine what I would become without these and therefore understand, if not approve of, how violence occurs in the workplace, since I feel at times that I could slap a child silly for not understanding that the cooperation I expect is for his / her own good, not mine!

The path towards understanding the occurrence of violence has been long and winding. It has lead me into many directions - from discovering stories that I never imagined in my wildest dreams to hear, to becoming acquainted with the difficulties of research. In finding the voices of my participants, I have found my own voice as a researcher, challenged my role as the scientific knower and challenged my participant's roles as 'caregiver knower'. We both tend to speak with authority about our subjects, yet our 'talk' is imbued with power, contradictions, responsibilities and emotion.

The participants of this study allowed me to view two aspects of their identities that I hoped to find at the inception of this research. The first was the individual, the person with feelings that I never met when I spent months in hospitals at my mother's bedside. This is the face seldom seen, seldom shared, yet it plays a great role in the understanding of nursing in general and violence in particular. The relationship with a patient is filled with anxiety, insecurity and emotion. When things go wrong at work, the person behind the uniform has to go home and deal with her emotions alone. Participants explain that emotional detachment at work is essential to being able to continue in this kind of profession, yet they reveal that they are affected deeply by their experiences. Emotional detachment and the depersonalisation of patients function as defences against the anxiety experienced. It is a method for the individual to cope that is instilled through training and the discourse it draws upon. The individual has personality, laughs and cries, feels anger and fear, but must maintain the identity of the in-control nurse at all times.

The second aspect of the nurse identity that I met was the professional caregiver. This is the woman that I know well. She is in control, shows little emotion, remains distant and determines every aspect of your experience in the hospital. She is responsible for the life of her patients and is

in a powerful position of authority. Patients are expected to comply with her demands, must be helpful and friendly, and in return she will provide care and empathy. Unfortunately patients do not follow the script and they probably do not understand all the finer details. I know this role well, having been in a position where I wished I knew what they expected of us so that I could obtain care for my mother. This former experience with nursing is a sore point for me, as researcher, and has been the greatest threat to this research, since it had the potential to bias and influence its findings. Yet, through this experience, I have been able to lay some of those feelings to rest and to approach the data with an open mind. By doing this, I have proved to myself that a balanced approach to research, keeping bias and personal feelings in mind, can allow me to embrace my new identity as 'the researcher' in an attempt to answer questions that have personal significance.

CHAPTER 4

The Final Interpretation – Organisational Discourse

The analysis of the data presented in this research has highlighted a few areas in need of further exploration. In the findings section, I proposed that the institution (hospital) creates a filter for reality through which particular beliefs and practices may be dictated to individuals. This finding had led me towards an investigation into how organisational / institutional behaviour works. Consequently, I had turned to discourse and organisational theory to further explore the meta-themes discovered in the data. This was done in an attempt to understand how nursing reality is constructed by the participants of this study. I intended to explore how this construction is embedded within the organisation of nursing, and how it relates to nurses' understanding of the occurrence of violence. Moreover, I argue that the research question of this study may be explored from this point of view, since the data has revealed the presence of "institutional talk" (Douglas, 1986, cited in Holstein & Gubrium, 1994) which may influence how nurses understand the occurrence of violence toward patients.

4.1 Discourse and Nursing

The role of organisational discourse in determining the behaviour of its members is a much debated issue in recent health care research. One view is that discourse constructs social realities, creates identities, prescribes behaviour, and that it has the power to "produce a social reality that we experience as real and solid" even though it may be "incomplete, ambiguous and contradictory" (Philips & Hardy, 2002, pp. 1-2). Therefore an investigation into how nurses understand nursing and violence would not be adequate without an attempt to illuminate the nature of the discourses that contribute to the construction of their realities. Philips and Hardy (2002) argue that it is through language and narrative that we are able to reconstruct the realities presented in 'talk', as well as underline the discourses that determine this reality. Therefore, we may argue that the stories that nurses choose to tell, the professional identities they embrace, and the social roles and relationships that they develop may be rooted in the 'talk' of the organisation, and that we, as researchers, are able to reconstruct the realities contained within those stories.

4.1.1 Discourse and identity formation - the professional caregiver.

The data revealed that the process of nursing identity formation starts in training, and that the identity of the *professional caregiver* is instilled and developed as students are guided into nursing practice. This identity may involve an idealised expectation of who or what a nurse should be in the hospital, and also in the broader community. The nursing ideal may be internalised so powerfully that individuals may not be able to acquire the distance necessary to challenge it, and may be anxious of the consequences of nonconformity (Deveaux, 1994). Furthermore, these professional identities may become "so powerful that to reject their supporting practices is to reject one's own identity" (Deveaux, 1994, p. 226). The Sisters in Charge in this study are responsible for the training of student nurses, and reported that the development of the professional identity involves the development of an ethical self who follows strict rules with regards to routine, behaviour, interaction with patients, punctuality, control and other codes of conduct in the workplace.

Foucault maintained that the way in which a nurse defines herself and her patients determines how she will behave towards patients (McDonald, 2005). Furthermore, individuals are subject to moral codes – behaviour and attributes that they should strive for; and use technologies of the self – methods used to change the self into the object of moral practice – in order to become the moral role determined by discourse (McDonald, 2005). The participants of this study revealed that their professional roles involve certain moral codes – showing empathy, developing rapport with the patient, being friendly, being in control and ensuring the patient's safety; and that they assume the moral role stipulated by nursing discourse in order to implement their acquired moral codes.

An interesting aspect of this identity is the way in which it simultaneously renders the nurse powerless and powerful. This professional identity is a source of power, yet it limits freedom of expression, and it may, in itself, exert power and control over the individual. As a professional care-giver, the nurse is inundated with moralised expectations. Failure to meet these expectations means a failure to be a nurse. Participant 3 describes a bad nurse: they "come into the profession simply because of the job market … do as little or as much as they wanted to … didn't really have to want to be a nurse, umm (.) and that's bad news … not happy people … they're just working because they need the money, they can get away with as little as they like (.) and not enjoy coming in … does little and *really complains* a lot about the hard work" (participant's emphasis). This quote illustrates how the idealised nature of the organisationally determined professional identity, that involves the ideals of: self-sacrifice, an ever-friendly disposition, the 'calling' to become a nurse and self-control, ignores the very real difficulties of the context and practice of care-giving (Marks, 1994). Other aspects of being a professional: the expectation of remuneration, entering the job market, the need for fair workloads, and expectations of job satisfaction are not included in this

perception of the professional caregiver. Similarly, the extreme demands of providing care in an under-resourced and under-staffed hospital are ignored, since the *professional care-giver* should carry these demands as natural sacrifices involved in being a nurse.

Marks (1994) argues that the nursing identity is historically embedded in the Florence Nightingale ideal, which resulted in tensions between the ideal of nursing and the actual practice of nursing. Similarly, this tension was found in the data presented in this research, and even though the specific definition of the ideal nurse might have changed, the resulting conflict remains. The data revealed participants felt that care-giving involved engagement, empathy and personal care, whilst maintaining what Frenkel (2002) and Menzies Lyth (1960) cited in Frenkel (2002) explain to be socially sanctioned defences involving emotional detachment from the patient. Care-givers are expected to realise that part of the ideal is to switch off towards patients in order to provide the best care. Participant 6 explains: "they *realise* what they're there for, as a *caregiver*, and they're *realising* they can't give what they need to give to all the patients - you just can't cope, especially in maternity where you've got, each patient is *two* patients" (participant's emphasis). Therefore the care-giver should control herself and her patient.

The data suggested the presence of the parent-child relationship between nurses and birthing mothers. The patient also has an expected role - the passive, unquestioning receiver of treatment who is cooperative, self-controlled, helpful, and tries to accommodate the nurse. The nurse then has the added role of instilling discipline and control over 'bad' behaviour (Marks, 1994). From the discourse of the professional care-giver as parent, power-relations may result. Foucault, cited in Deveaux (1994) explains that within these power-relations, patients are expected to personify the 'docile body' which accepts treatment unquestioningly. When patients no longer follow the script of the 'docile body', they pose a threat to the professional identity - where professional safety is found. This results in socially determined ways of dealing with unruly patients to be used to regain 'normality'. These socially sanctioned methods are: ignoring patients, threatening to leave patients, and withdrawing from patients. Participants described these methods as tricks of the trade – the practical knowledge that the *professional care-giver* gains with experience. The data revealed that these measures involve the underlying belief that care – other than medical – is something the nurse may choose to provide and may withhold if the patient is defined as unworthy or manipulative. The *professional caregiver*, therefore, is expected to provide only medical care; personal care is defined as something extra that a patient should receive when they deserve it.

The discourse revealed in the data clearly creates a world that is real and solid for the participants. The identity of the *professional care-giver* is adopted when nurses enter the hospital. It involves routine, care-giving, medical emergencies and all the experiences of day-today nursing practice. Some days are busier than others, Mondays in particular. There are predictable stressors if

it is busy – lack of time, lack of resources, lack of beds and lack of patience. In addition to this, there are unpredictable stressors, such as emergencies and patients' behaviour. In spite of these stressors, one should be pleasant, controlled, predictable and professional at all times, providing the patient with the necessary care. Within the professional role, one should also be in control of oneself and the environment, and has the right and power to assert control where necessary.

This discourse influences me, as researcher and as an outsider, on my visits to the hospital to conduct my interviews. When I enter the hospital on my visits, I enter a familiar world. The "subculture" described by King (1962) cited in Zaman (2004) is deeply entrenched in my experience of the hospital. The atmosphere of the ward hangs in the air, I can feel it entering my being, and I try to behave professionally and quietly in order not to disturb the environment in which I find myself. I cringe at the thought of breaking the calm, quiet feeling and understand why it would be the ideal in a career as stressful as nursing. Listening to the interviews, this feeling is reconstructed by the monotonous, pleasant and controlled voices telling their stories of nursing. Some voices are more tired than others, but constancy and strength is maintained when participants speak as the *professional caregiver*. This picture of nursing does feel solid and it is real. Discourse supports this, as the participants describe their experience of nursing and their understanding of violence, the ways in which their professional conduct, experience and identity is constructed. The individual who has developed the accepted nursing identity is able to follow protocol and orders, cut herself off emotionally, think for herself, be professional and show empathy for her patient. This is the identity of the professional and weaknesses that may threaten this identity are not always acceptable. Yet, the discourse that supports this identity of the professional caregiver is filled with contradictions and ambiguities that cause problems, specifically in the relationship with colleagues and patients.

4.1.2 Discourse and power – the authoritative controller and medical expert.

Recent organisational research has focused on how power and knowledge become linked in the construction of a social reality which is "taken for granted and that advantage some participants at the expense of others" (Philips & Hardy, 2002, p.15). This social reality is not always experienced in the same way by everyone, and some nurses or doctors are advantaged over those in a lower rank or over patients as a result of their knowledge and level of training. The medical knowledge that accompanies the nurse as the *medical expert* places her within a particular position of power from which she has a certain amount of control and responsibility. Participant 6 discussed what would be unacceptable from the nurses: "… inability to make decisions, (.) but then it also depends on what *rank* you're talking about, I'm talking about a professional nurse right here, Umm (..) not *realising*

when (.) a doctor needs to be called, not documenting it, certainly, just basic observations not being done" (participant's emphasis). The power and knowledge of the *medical expert* is accompanied by responsibility. Patients are seen to be untrustworthy and dangerous and lowest in the hierarchy of power, since they lack professional knowledge and expertise. Participant 4 states of her patients: "so you expect that person to listen to you". The nurse must control the environment, her patient and the birthing process in order to be the successful or 'good' nurse. Power plays an important role in this identity and it can be either wielded over others or nurses can become the object over which it is wielded. Sisters, nurses higher in the hierarchy and doctors can exert their power over other staff members, who are relatively powerless in these situations. The presence of this power is accepted as a result of the responsibility that accompanies higher ranks in the hierarchy. Therefore, from the position of the *medical expert*, the nurse may assume the role of the *authoritative controller*.

The questions that arise are: which discourses are maintained in nursing, why they are maintained, and how nurses are constrained by them (Philips & Hardy, 2002). Discourse could lead to empowerment and disempowerment, while it aims to bring about certain outcomes (Philips & Hardy, 2002). The data revealed that nursing in this maternity ward involves the particular outcome of a healthy, successful birth. Medical and nursing discourse dictates how success will be defined in this regard. It involves a mother and baby who are alive, certain behaviour and responses from nurses and patients, certain levels of control maintained, conformity to the nursing ethos, control over emotions, and birthing in a particular, accepted medically determined way. The participants explained that they maintain this definition of their expected outcomes, since it ensures the safety of all involved. Therefore the discourse of responsibility plays an important role in our understanding of other discourses and social roles found in the data.

Terry (1989), cited in Deveaux (1994) argues that there are "regulatory prenatal technologies" that allow the state and health care system to enforce certain testing, life-style monitoring and other forms of medical interfering (p.229). This is argued to have negative implications for childbearing women, since their choices and rights may be overruled if they are seen to be potentially hazardous to the unborn child. These allow practitioners to view the "fetus as separate from the mother who is then subject to a range of suspicions concerning her behaviour during pregnancy" (Deveaux, 1994 p. 229). This was strikingly clear in the data presented by the participants of this study. Participants suggested a belief that they have the right and responsibility, as *medical experts*, to ensure that a birthing mother does not endanger the child. Therefore, when the mother is seen to be potentially hazardous, nurses have the right to enforce certain levels of control and discipline in order to protect the child. The mother may be seen as a separate entity to the child and she is objectified, depersonalised and sometimes "demonised" (Phipher, 1996). This may occur when the mother is not behaving according to the norm, and may be perceived to be a threat to the child's life. This is

the point at which the mother's choices and rights may be repudiated and violence may be defined as a necessary method of protection of the foetus (Terry, 1989, cited in Deveuax, 1994). Therefore, as the *medical expert* and *authoritative controller*, the nurse may exert violent measures to gain cooperation from the mother. Jewkes et al. (1998a) explain that this is done to assert their middle class professional identities. The data in this study reveals that this also involves the maintenance of the professional identity in which there is the responsibility to ensure the safety of the child and the expectation of cooperation do achieve this. Participants revealed that fear of being blamed or being held responsible guide this behaviour. Therefore, the exertion of power may be linked to the feeling of responsibility.

Critical discourse analysis looks at the role discourse plays in constituting and maintaining power relations. Philips (2003) argues that "discursive activity structures the social space within which actors act – how it privileges some actors at the expense of others" (p224). Discourse constitutes three kinds of social entities: concepts, objects and subjects (Philips, 2003). Nursing may involve struggles along a variety of concepts: theories and ideologies regarding medical and personal care-giving, ideas about the relationships with colleagues and patients, and in effect, the way their world in the hospital is understood. Different participants reflected different understandings of their roles, reality, violence, and relationships according to differing views of nursing. Patients may add their own concepts which guide their behaviour and the meaning that they attach to experience. This may be the point at which power struggles begin. From their subject positions as *medical experts*, nurses are able to produce certain kinds of texts (Philips, 2003). These texts may be used to determine the health / safety of the patient, the need for intervention, authenticity of problems experienced by the patient, and the necessity of violence. The patient may be placed in the object position as the receiver of care, intervention and surveillance. Therefore, it may be argued that discourse allows the development of 'talk' that places certain actors in certain positions: the sister, the nurse, the patient, all of which have concepts along which they understand their roles and experiences. Conflict may arise when these positions are challenged or contradicted, and participants revealed that interactions with patients may develop into violence or withdrawal of care when this happens.

The nurse in her subject position has to follow what is expected of her, and the creation of texts that "'break the rules' often results in the agent losing the legitimate right to take up the subject position" (Philips, 2003, p. 226). This is reflected in the data in the revelation of the insider VS outsider subject positions. Here participants described the position of being an insider, adopting the group ethos at a particular moment, becoming the authoritative controller and going along with violent or abusive behaviour towards a patient, since this is expected of the *medical expert* who must protect the child's life. Here one is not allowed to contradict the prevailing discourse used to

justify violent behaviour, which are: the need for violence, the danger to the life of the baby, fear of blame, fear of contradicting the group, control, power, and the untrustworthy or out of control patient and responsibility. Therefore, the nurse may internalise and reiterate concepts such as: necessary violence, the threat to the child's life, professional responsibility, and the untrustworthy patient. Nurses, cannot, then, produce 'talk' or behaviour that contradicts or opposes these discourses, since this would strip them of their 'nursehood', "subject position" and sense of belonging (Philips, 2003). Interestingly, all reports of overt violence in this study entailed groups of nurses or doctors perpetrating violence against patients. This does not indicate that individual acts of violence do not occur, but it may be related to the legitimisation of violence when it is presented as part of organisational behaviour. Participant 7 illustrates the power of this organisational identity as it is instilled top-down: "*the sister involved,* is also scared of nobody". She described her feeling of powerlessness as an individual to contradict the group in an act of violence:

> I STOOD THERE**,** I am maar a nurse, I am so low down in the [ ][CONSULTANT**,** the sister, she's a matron already actually, ja I am the lowest so I just felt so powerless. I WANTED to tell them: "This is not necessary", but just because I *didn't* want to be shouted at as well (.) I just left, but I took, *I didn't know what I was going to do, but that's why I took notice of what's going on*, just in case it became anything … "At that moment I felt that; if I - a*re* they going to listen to me? (participant's emphasis)

This incident highlights not only the group dynamic, but also the hierarchy that are both important in the understanding of violence perpetrated against patients. Whitaker (2002) argues that institutions suggest conformity to a group ethos that makes the possibility of violence greater than when an individual s involved. Conformity, in this data, is to the ethos of the medical expert and authoritative controller. This is an aspect of violence in nursing that could benefit from more attention.

4.1.3 Multiple discourses: contradiction, ambiguity and experience.

As with any discourse, there are contradictions and exceptions within the data. Philips (2003) explains that individuals are frequently rooted within several discourses. The tension produced by this creates a "discursive space in which the agent can play one discourse against another, draw on multiple discourses … to create new forms of interdiscursivity, and otherwise move between and across discourses" (Philips, 2003, p. 226). This is evident in the data where multiple discourses: the professional, the caregiver, the disciplinarian, the good nurse, the bad nurse, the good patient, the

bad patient, violence and non-violence, care and responsibility act to determine the behaviour of the participants and also construct how they see the social setting – the hospital. The participants report that they play different roles, depending on the situation and the discourse drawn from. The same participant, for example, condemns violence when the "unacceptable violence" discourse is used, legitimises her acts of violence when the 'need for violence' discourse is used, and is therefore the insider in one situation, and the outsider in another. The discursive construction of the particular event, role and patient involved determines the behaviour and also the definition of violence, care and responsibility.

Yet, within these multiple discourses, the data also reveals contradictions and ambiguities. As discourse determines the definition of violence in nursing, the participants produce ambiguous and contradicting definitions of care and violence. Consequently, the data has shown that conflicting ideas about violence can be produced within the same organisation, ward, group, and even within the same individual nurse. The finding that the definition of violence can be altered, depending on the context or the individual, provides a little more clarity on the issue of violence in the caring profession. The definition of violence determines when an act is seen as violent and unacceptable, and when it is deemed necessary or acceptable. Participants draw on contradictory discourses in their effort to understand and regulate their experience at work. When the nurse speaks from her care-giver voice, violence towards patients in any form is unacceptable. When the situation prevents the nurse from fulfilling her main objective – a safe birth – violent acts may be redefined as non-violent and acceptable from her role as the medical expert. Philips (2003) describes the process as follows: "institutions are social constructions produced by discourses. Discourse shapes the actions of agents, but agents also act to shape discourse and hence the institutional field in which they act" (p. 226). Therefore, even though violence towards patients is institutionally prohibited, it may be socially sanctioned within the institution. Jewkes et al. (1998a) argue that this social sanctioning of violence is legitimised by the nurse's duty to get compliance from the patient in order to ensure a healthy baby. The participants of this study added to this perspective by stating that the fear of being blamed if something goes wrong, being held responsible for the outcome and the need to exert control contribute towards feelings of anger and consequent violence towards patients. Violence may therefore be situation-specific and sanctioned by nursing discourse.

The major interpretation of the finding of acceptable violence is the *need* for it. Participants reported that it may not be something that an individual would choose, but that it is believed to be necessary. The need for violence may be related to the sense of responsibility that the participants feel for the outcome of the birth. Once the need for violence has been established, the act of violence is redefined as non-violent. Discourse and experience within any field is a twofold process wherein individuals are both the subject and object of discourse, but also create and change the

discourse by interacting with it. The idea of acceptable VS unacceptable violence towards patients is developed through this process, thereby legitimating some forms and prohibiting others. The problem lies in the contradictions amongst participants in their view of what is the acceptable 'norm' as well as the contradictions in the prescriptive discourses.

4.2. Emotion and Discourse in the Organisation

Rowe (2005) argued that emotion is an important part of identity formation in healthcare. Mark further stated that emotion is involved in surviving as an individual, which is important in health-care provision (Mark, 2005). Mark (2005) argues that the emotional relationship between the nurse and her patient is based on empathy and that it ensures the nurse's ability to provide care to a variety of patients, and security in the professional and personal identity. As a result of the role emotion plays in one's functioning, much of what we see as violent or unacceptable may be related to the defence mechanisms used to protect oneself from the negative effects of interaction with patients (Frenkel, 2002, Mark, 2005, Menzies Lyth, 1988).

4.2.1 Violence and withholding care – an individual's defence.

Mark (2005) argues that we need to look at the "dynamic interconnectedness" amongst emotions, individuals and organisations (p. 279). This is the crux of the findings presented in this thesis. The relationship between the organisation, discourse, individuals and emotion within a highly demanding and stressful occupation needs attention. Nursing is not merely a rational, objective, medical orientated arena for providing personal care in a removed, but effective way. It is a setting in which emotion, anxiety and personal experience play a role in the provision of care. The participants of this study related personal narratives of their emotional responses to the practice of nursing. The expectation to be the ever professional caregiver and the dominance of medical rationality did not eliminate the very personal nature of the provision of health care. Participants shared experiences of nursing that were deeply personal and affected them greatly, thereby illustrating that the individual emotional experience cannot be separated from the professional. In spite of the highly emotional elements of nursing practice, nurses reveal that their emotional response to care-giving should be regulated. Therefore, true emotional interaction with patients should be limited, since it is the professional thing to do and allows professional and emotional survival (Frenkel, 2002, McGrath et al., 2003, Menzies Lyth, 1998, Van der Walt & Swartz, 2002). The expectation of control over the self is closely related to both their emotional survival and the practice of "emotional labour" that stipulates the adjustment of personal responses to comply with

the nursing norm (Hochschild, 2003, cited in Brunton, 2005). Switching off, emotional detachment and projection of the irresponsible self onto the patient were reported to be the most common means of maintaining this emotional control.

Mark (2005) and Schwartz (1999) argue that dysfunctional elements of organisational behaviour are manifestations of the organisational defences developed to cope with emotional demands. Conversely, Mark (2005) argues that the "dominance of rationality serves both a scientific and emotional purpose, because the former provides the cognitive means by which emotionally unacceptable procedures and activities are allowed to occur to individuals as patients" (p. 279). This research focused on violence as the dysfunctional element of nursing organisation to be explored, and the data showed that both of the above interpretations of this dysfunction are applicable. As argued earlier, the organisation creates a social reality for its inhabitants (Philips & Hardy, 2003). Nursing is embedded in a rational, medical discourse that may allow acts of violence – the emotionally unacceptable – to occur to patients in the pursuit of positive health care outcomes. Nursing practice may involve behaviour and experiences that individuals find unacceptable. Scolding, raising one's voice, shouting, ignoring, slapping, restraining and insulting the patient were mentioned by the participants of this study as a few such activities. When executed as a logical and necessary part of nursing, they may be allowed to happen. Nurses are able to rationalise and legitimise these actions as necessary aspects of nursing practice. However, nurses may have emotional responses to these practices or other experiences, which are organisationally expected to be suppressed in order to provide good care. Consequently emotional detachment, switching off, focusing on the medical tasks – "robomode" (participant 7) and projection may serve as defences. Withholding care from patients may be intimately linked to these defences, since it provides a way of implementing emotional control over the self and the patient.

Menzies Lyth (1988) argues that the structure of nursing provides a defence against the anxieties evoked in nursing practice. The data revealed that the way in which nursing is constructed on a professional level allows for and expects certain defences to develop. Mark (2005) argues that this is a serious organisational issue that needs research and understanding. Interestingly, the participants further revealed that they could allow for emotion to surface once they had left the hospital, while some revealed the frustration of the emotional demands of nursing: "patients are calling you because they are in pain – what do you do? And eventually you feel like (.1) just going to sit down (.1) pulling your hair out" (Participant 2).

4.2.2 Discourse or emotion?

Mischenko (2005) shared her experience of nursing in her autoethnography. She highlighted similar problems with competing discourses in her first-hand account of nursing. She described that "there is a combination of conflicting organisational discourses: of the need to be the best, of the need to survive, and therefore the need to achieve all my ….organisational objectives … Then there's the clash with my personal discourses of spending time with my family …" (p. 210). This experience is echoed in the data that I have gathered in which participants revealed conflicting feelings and experiences of care, obligation, emotion, control, power, identity and violence. The individual is found in the midst of these discourses and feelings, going along with the processes that advance the self and power, resisting those that do not and trying to make a choice amongst all of the above. Therefore, "individuals interpret and rewrite these various discourses differently" and this results in "the possibility of conflicting organisational identities" (Mischenko, 2005, pp. 212-213). Sveningsson and Avesson (2003) cited in Mischenko (2005) argue that this results in an incongruency between the professional self and the personal self which causes a painful fragmentation of the self. The patient enters this reality when he or she is hospitalised, and may represent the nurse's inner conflict at critical times when they are demanding and may consequently pose a threat to the identity constructed to deal with the role of nursing (Mischenko, 2005). Mark (2005) explains the nursing experience in the following quote:

> Health care provides a setting that juxtaposes emotion and rationality, the individual and the body corporate, the formal and the deeply personal, the public and the private, all of which must be understood better if the changes in expectations and delivery are to remain coherent. (p. 285)

Therefore, nursing may involve the continued struggle between the personal and the professional. Rationality determines that the professional has the responsibility towards her patient to provide a certain kind of care and to ensure a certain kind of outcome. Emotion plays a vital role in the interaction with the patient and the ability to take responsibility for the care of another human being. Yet, the two seem to be interpreted as opposing forces that cannot co-exist within the professional discourse. One's responsibility, as a good nurse, is to control emotion and the medical emergency. Care involves self-sacrifice and professionalism, and emotion therefore hinders the delivery of care.

Grainger (2004) argues that the nurse-patient interaction is a form of institutional discourse where power and solidarity are continuously negotiated as a result of the expectation of the nurse to

be simultaneously controlling and caring. This openness to negotiation was found in this study to be a point of conflict between social roles determined by institutional discourse. The nurse is not always sure of her role as a professional, which involves being both a controller and a carer; and these discourses prose confusing contradictions. Choosing the one would imply sacrificing the other. Violence is at the heart of this conflict, since it has a contextual element. Depending on the context, it may be part of the control discourse where it is a necessary means of caring for the patient. In another context it may fall under caring discourse that prohibits its use as a means to control. Grainger (2004) further argues that the spoken discourse plays a vital role in the construction of a particular 'reality' that allow both personal and institutional goals to be achieved. This is not always the case, since the one may have to be chosen at the expense of the other.

Therefore the issues of violence in nursing are not easily defined and resolved phenomena. They involve both professional and personal elements in the construction of its meaning and occurrence for participants in this study. It is clear, though, that the individual and professional experience of nursing are complex phenomena determined by a reciprocal relationship between discourse and the individual, which is set within a particular nursing or hospital culture. I therefore propose that violence perpetrated against patients by nurses needs to be understood in terms of an inclusive model of nursing.

CHAPTER 5

5.1 Discussion

The relationship between the nurse and patient plays an important role in the development of quality, reliable and constructive care-giving. This study has paid closer attention to the aspects of nursing involved when this relationship degenerates into violence against patients. Both the patient and the nurse play a key role in this relationship that functions on professional, medical, personal and emotional levels, and which is influenced by a reciprocal relationship between the patient and the individual nurse within a particular organisation and its discourses. At this point, I return to my research question, which involved an exploration into how nurses understand and talk about nursing and violence towards patients. The participants of this research have offered rich data concerning their experiences, and the following major findings will be discussed in terms of the research question and available literature:

- The culture of violence in nursing
- The organisational determinants of violence
- The split in the voice of nursing
- The insider / outsider
- Emotional detachment
- Withholding care
- The changing definition of violence
- Power and control in the development of violence

Blaauw et al. (2003) argue that current work on the complicated social world of health systems is limited and that research is needed to develop a deeper understanding of this world. The findings in this research enabled me to participate in current research and debate regarding the social world of nursing. The data provided a clear picture of the presence of the social world in this particular hospital as it is constructed by those who work there, and the society within which it functions. Being a teaching hospital, the focus in some interviews was on the development of this social world, and the roles and identities that are promoted and constructed during training. It is important to note that the nurse's relationship with patients, nursing practice and care-giving is not merely dependent on the individual, but may also be subject to the conditions in which care is provided, organisational practices and protocols. Zaman (2004) argued that the experiences and practices in a particular ward create a culture determined by those who inhabit the space and the

conditions in which the inhabitants find themselves. The data revealed that this social world of nursing, as prescribed by the organisation, is continually redefined and reconstructed by individuals and their experiences. Therefore, a particular nursing culture with a particular way of defining the occurrence of violence may be created by both the organisation and the individual. Furthermore, a health system may be a reflection of the society in which it functions, and may therefore have the same problems that its society struggles with, including problems with violence (Helman, 1994). Within their exploration of this culture or social world, the participants have revealed the presence of a particular understanding of violence.

Some participants revealed an understanding that the culture of violence and aggression in the medical profession is seen to be a South African condition. Participant 2 argued that "I suppose in first world countries … it might be construed as *violence*, but here (.) in Africa, it's certainly (.) normal, *normal* practice really." This finding is of particular significance when viewed within the specific political history within which nursing has grown in our country. Violence perpetrated by nurses in South Africa may be consequential to not only the social sanctioning within the hospital (Jewkes et al., 1998a), but also its legitimising in terms of the culture of violence in our broader society. This may be a particularly important element in understanding how nurses understand their profession in terms of being South African care-givers, and how this may influence care-giving. This finding is strengthened by data that revealed that this culture of violence in South African hospitals has not been experienced in some first world countries; and that it is adopted when nurses work within our hospitals, but is rejected when working in hospitals or societies where it is prohibited. Therefore, violence may be perpetrated against patients simply because it is socially sanctioned, and alternatives are not developed or practised.

Within the medical culture found in this hospital, the participants revealed a duality in identity. On the one hand, there was the professional who maintains control over herself and her environment; asserts power and authority; and provides both personal and emotional care in an emotionally detached way. This professionalism is determined by what Douglas (1986) cited in Holstein and Gubrium (1994) described as 'institutional thinking', a shared mode of understanding and responding to the world. This professional identity involves an idealised role of the care-giver, and the pragmatic role of the authoritative controller. The idealised role prohibits violence, expects empathetic and responsible care-giving in an emotionally detached manner. The pragmatic role prescribes emphatic everyday practices of nursing, which may involve certain activities that contradict the idealised role, but that are determined to be necessary in the provision of safe, responsible health care. These activities may involve acts that are violent or abusive in nature. Importantly, from this professional identity, the nurse must conform to the expected institutional behaviour which, as Mark (2005) explains, enables individuals to tolerate or pursue emotionally

unacceptable actions. Whitaker (2000) offers a further explanation for this finding in terms of violence – that conformity to the "group ethos" may pressure individuals into relinquishing their personal behaviour and values, which are replaced by the organisation's routine way of judging nurses and patients by the standards and practices of the particular nursing culture. When this organisational identity and culture is adopted, violent acts are more likely to be accepted, perpetrated and rationalised as 'normal' and necessary.

The participants revealed a third dimension to their identity – the nurse identity that involves the personal and individual who is fallible, unable to detach herself emotionally from her experiences and deeply affected by them. She experiences confusion about the contradictions in her environment, and has emotional responses to these experiences, particularly experiences of violence. This aspect of the nurse's identity may not be expressed at work, but the data revealed its hidden presence in personal narratives shared during interviews. The split in the voice in the data revealed a split in the understanding of violence and the experience of nursing. This split was reported to bring about contradictions and confusion about role expectations and personal responses to the practices of nursing.

Consequently, participants revealed the experience of what I have called being *the outsider* or *the insider* when abusive or violent acts were perpetrated against patients. When the nurse does not follow the socially prescribed behaviour– the "group ethos", she becomes the outsider (Whitaker, 2000). This experience of being the outsider was described when incidents of group violence were discussed. Participants reported that, as an outsider, they would observe others perpetrating violent or abusive acts against patients. From this position, the individual feels anxious, threatened, powerless and isolated. The insider participates in the group behaviour and becomes involved in violent acts. Participation in acts of violence necessitated justification, which involved the immediate threat to the unborn child's life, the dangerous mother and fear of blame.

Whitaker (2000) suggests that individuals displace feelings of resentment toward the institution and themselves onto outsiders. Therefore, as Menzies Lyth (1988) argued, feelings of anxiety are displaced onto patients or nurses lower in the hierarchy in order for the nurse to attack them and feel empowered once again. Individual participants described being both insiders and outsiders in different situations. This insider/outsider aspect of nursing is related to the hierarchy in nursing, since participants reveal doctors or sisters lead such incidents while nurses have to decide whether to follow. As individuals conform to group violence, it is important to note that incidents of group violence were reported in interviews and these showed resentment being displaced onto patients who suffer the brunt of these acts of violence. It is acknowledged that even though individual acts of violence were not reported, it is not unquestioningly accepted that they do not occur.

The fluid nature of the construction of experience, meaning and specific concepts involved in nursing practice allows for competing discourses to create inconsistency and ambiguity in the understanding of violence against patients. Grainger (2004) argues that it would seem that the institutional discourse found in the hospital is continually open to negotiation between concepts of power and solidarity, since nursing is both controlling (requiring the exertion of power) and caring (requiring the formation of solidary relationships). Care involves the provision of personal, emotional and medical care; yet it also entails control over patients. Responsibility for the well-being of the patient involves taking control of the situation and the patient; yet the nurse also feels responsible for those things she cannot always control and fears being blamed when responsibility cannot be taken. Care does not allow the occurrence of violence, but responsibility necessitates it. Therefore care and responsibility become competing discourses that both allow and forbid the use of violence, which is defined as slapping, shouting, scolding and threatening in this study; and withholding of care in normal day-today nursing practice. Unconstructive and violent relationships with colleagues and patients, resulting from these competing and confusing discourses, have far-reaching consequences other than the immediate trauma experienced by those involved. This may offer an understanding of the changing definition of violence in the data, which involved the same act being defined as both violent and non-violent by the same participant.

This research has suggested that violence is closely related to the appraisal of the patient. If the patient is judged as a danger to the birthing process, manipulative or uncooperative, then violence perpetrated against that patient may be deemed necessary and therefore redefined as non-violent. Foucault (cited in Deveaux, 1994) explains that nurses follow a script and expect patients to follow it as well – participants explained that certain behaviour is expected from patients to ensure a successful outcome. Menzies Lyth (1988) and Frenkel (2002) explain that the relationship with the patient contains high levels of anxiety. Nurses find it difficult to deal with this anxiety, which participants in this study indicated to be exacerbated by: not knowing what to do, the unpredictable nature of the patient, fear of being blamed for negative outcomes, and losing professional status and control. This anxiety is placed outside the individual – onto the patient – where it can be attacked and conquered. This is involved in the process of violence as described by the participants. Patients may be judged to be unpredictable, manipulative, dangerous, out of control and uncooperative, and therefore in need of being controlled. Nurses have the power and responsibility to regain control and cooperation from patients. Therefore, even though, the professional is expected to maintain emotional control and distance, it seems that violence is linked to the deeply emotional experience of fear and anxiety that are compounded by a sense of responsibility. The paradox here is that the responsibility that a nurse has for her patient's well-being allows her to do harm to her patient in some way in order to prevent medical harm to come to her.

Brunton (2005) adds that health organisations involve a complex emotional life. "Emotional labour" is an organisationally determined way of providing care to patients (Hochschild, 2003, cited in Brunton, 2005) Therefore, the culture of nursing prescribes not only how a nurse should think, but what emotions she may express. The data in this research correspond with this analysis of the organisational life in health care. The participants revealed that there is a particular way of making sense of the world and a particular ethical code of conduct that one should always adhere to. In addition to this, participants revealed that the expression of emotion is not acceptable, and that a strict control over emotion should be maintained. This may involve an emotional detachment from one's feelings and the patient. Closely linked to this was the expectation that patients should control their own emotions and needs in a similar way, and that care would be withheld if a patient does not conform to this expectation.

Withholding of care and ignoring the patient were reported as methods of controlling and punishing undesired behaviour, and I argue that this may be linked to issues regarding unsafe birthing practices in hospitals, since the withholding of emotional and personal care from a patient as a means of control and punishment of unwanted behaviour may be related to insufficient observations, the lack of prescribed action, seeming laziness, and not attending to patients. The participants of this study revealed that they were in a position of authority and power, which enabled them to ignore a patient or threaten to leave a patient in order to evoke desired behaviour from patients. Not providing medical care was stated to be unacceptable, but I would like to argue that it may be that medical emergencies are not recognised without the level of attention involved in personal care-giving. Therefore, whilst emotional care is being withheld, the need for medical care or intervention may be overlooked.

5.2 Conclusion

In closing, the major finding of this research involves the split in the voice of nursing. Nurses speak from different identities and roles about their experiences. Each role contains its own discourse and way of attaching meaning to experience. It has been discussed that discourse determines how reality is understood and experienced. Discourse, however, also contains contradictions and ambiguities that filter into reality construction (Philips & Hardy, 2002). This study has looked not only at the major themes highlighted during interviews - the different identities that participants struggle with, the nurse-patient relationship, power, control, care and responsibility – all of which relate to the issue of violence, but it has attempted to, at least superficially, attend to the discourses that determine and are determined by the way in which individuals make sense of the world of work and life.

It is clear that violence against patients is a complex issue, involving highly personal and professional issues that are complicated by competing discourses of power, care and responsibility. Therefore, it is believed that further research is needed to develop an insider's understanding of the world of nursing before steps can be taken to address the problem. Violent acts towards patients must be contextualised within the institutionalisation of such acts that allow them to become legitimate when practiced by those who have assumed institutional identities. This process may lead to the empowerment of some – insiders; and the disempowerment of others – outsiders and patients. It seems that developing further behavioural controls and protocols in an environment where control and surveillance plays such a great role already will only add to the disempowerment of those who are currently vulnerable to the processes involved in the occurrence of violence. Support and understanding has been requested by the participants of this study who are – despite discourse and identity – overworked, tired, demoralised and disempowered. Therefore, in full circle, I suggest a critical view of the occurrence of violence towards patients, taken with a pinch of empathy for all involved. The voice of the individual is suppressed by the regulatory force of the nursing environment and I believe creating a forum for this voice to have an outlet, to find support and develop solutions from an inside-out perspective, rather than from the outside-in will reap greater rewards in the future. Ideally, further research should involve nurses closely, attend to the feelings that such research will evoke, and create not only solutions but a new way of constructing the social reality of a demanding and difficult occupation.

This study has attempted to explore how nurses talk and think about their profession and the occurrence of violence within that profession; and it has investigated the role of discourse in determining how talk and thinking is constructed within nursing. Themes that may benefit from further investigation have been identified and presented. I have not by any means attempted to provide a theoretical model or conclusive answer to the problem of violence perpetrated against patients in our health care system. Rather, I have attempted to provide a forum for both my own voice and the voice of the participants in order to divulge our experiences of the phenomenon in question; and to question how these experiences are constructed. I am fully aware of the limitations of this study: the lack of time and resources which have prevented me from conducting further interviews or triangulating data by means of multiple methods. However, I believe that this study has been able to provide a contribution to current research and debate regarding nursing and violence.

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Appendix A

List of possible interview questions

1. Violence in nursing s an issue that has received much attention recently. What do you think about it?

2. Tell me of any times that you can remember becoming violent with a patient or seeing another nurse become violent with a patient.

- What happened?
- Why did it happen?
- What are your feelings or ideas of these situations?

3. What do you think of nurses who are violent with their patients?

4. How do you explain such behaviour?

- How does it happen?
- Why does it happen?

5. Tell me about a difficult day that you can think of where you may have become frustrated with a patient and wanted to ignore or hurt that patient.

- What happened?
- How were you affected?
- How were your patients affected?
    - Why was it difficult?

6. What do you think are people's opinions about nurses, particularly nurses who are violent with their patients?

- How do you think your community feels about nurses?
- Tell me about any negative experiences from other people?

7. What do you think about nursing?

- Positive?
- Negative?

- How do you see your job?

8. How do you feel about your patients?

- Positive, negative, too demanding?

9. What is a "good" patient and a "bad" patient?

- How do you deal with "good" patents?
- How do you deal with "bad" patients?

10. Tell me about some of your most difficult patients and how you coped with those situations?

11. Tell me about any cases where a patient has become violent with you.

- How did you deal with it?
- How do you feel about the experience?
- How has it changed how you interact with patients?

12. Tell me about the difficult and frustrating things about your job.

13. How do you cope with the negative aspects about your job?

14. What is a "bad" nurse?

- What does she do?
- What characteristics does she have?
- How does she treat her patients?
- Why does it happen?
- What type of patient would a nurse become violent towards?
- What type of nurse would become violent with her patients?

Appendix B

Form of Informed Consent

Dear Participant

My name is Naomi Myburgh and I am studying for a Masters degree at the Stellenbosch University. This study forms part of Professor Khalil's research project on violence and nursing, which you will have heard about. We would like to invite you to participate in a research study that is interested in the nursing profession in general and how nurses make sense of their experiences at work in particular. We would like to find out how you understand your day-to-day work activities and your relationship with your patients. We are particularly interested in whether you have heard about or seen any violence in your ward or in any other setting in which you have worked, particularly violence by nurses towards patients. We are interested in how you understand such violence and what effect it may have had on you.

If you agree to participate in this study, we would like to ask you a few questions about your own experiences at work, both positive and negative as well as any experiences of violence. Interviews will be approximately one hour and will be conducted during your normal working day. We hope that these interviews will be useful and a positive experience. Some questions which are asked may be sensitive or evoke unpleasant feelings or memories. Therefore you reserve the right to refuse to answer any question, to end the interview at any stage and to withdraw from the study at any particular time.

This study is an extension of the research conducted by Professor Khalil on issues of violence in the nurse's workplace. Anonymity is ensured, since you will receive a number from professor Khalil and therefore no actual names will be used on any forms or during the interviews. Your number will be placed on consent forms and you may choose a pseudonym before interviews start, which will further ensure confidentiality. All information, including what you may say about yourself or a colleague, will not be traced back to you and will remain strictly confidential.

If you agree to participate, please read the following statement and sign below.

I understand fully what the above-mentioned research is about and am aware of the possible risks, advantages and consequences of participating in the study. I understand that I may ask any questions at any given time, that I will remain anonymous and that all information I give to the researcher will be treated confidentially. I also understand that I may end interviews and my participation at any time and may also refuse to answer any questions which I do not feel comfortable in answering.

_____ _____

Signature of participant Date

_____ _____

Signature of interviewer Date

Appendix C

Demographic Particulars

Language: _____

Age: _____

Marital Status: _____

Children: _____

Rank: _____

Years of working as qualified nurse: _____

Religion: _____

Race: _____

Socio-economic class: _____

Appendix D
Transcription Convention

The simplified set of transcription symbols provided by Silverman (1993) was used in this research. I have altered a few of the symbols for the purpose of this study.

Transcription Symbols:

[	Left brackets show a point at which the current speaker's talk is overlapped by another's talk.
-	A dash at the end of one line and the beginning of another indicates that there is no gap between the lines.
(.2)	The number in parenthesis indicates elapsed time in silence of a second.
(.)	Indicates a tiny gap.
WORD	Capitals, except at the beginning of lines, indicate especially loud sounds relative to the surrounding talk.
WORD	Italics in capitals indicate emphasis of a loudly spoken word.
Word	Italics in a whole or part of the word indicates that it has been stressed.
.hhh	A row of h's prefixed by a dot indicates an in breath; without the dot, and out breath. The length of the row h's indicates the length of he breath.
( )	Empty parenthesis indicate the transcriber's inability to hear what was said.
(word)	Parenthesised words are possible hearings.

Appendix E

Demographic Particulars

Participant Number	Language	Rank	Years Working	Socio-Economic Class
1	AFR	PN	2.5	Middle
2	ENG	PN	+/- 25	Middle
3	ENG	PN Manager	+/- 34	Middle
4	AFR	PN	5	Middle
5	ENG	PN	19	Middle
6	ENG	PN	30	Middle
7	ENG	Registered Nurse	8	Middle
8	ENG	Reg. Nurse/ Midwife	20	Middle
9	ZULU	Enrolled Auxiliary	8 Months	Lower
10	ENG	Registered Nurse	12	Middle
11	AFR	Student	0	Lower

Note: AFR = Afrikaans; ENG = English; PN= Professional Nurse