ANGLIA RUSKIN UNIVERSITY

SITUATIONAL IMPROPRIETY IN EMERGENCY DEPARTMENTS. A QUALITATIVE FRAME ANALYSIS FROM NURSES’ PERSPECTIVE IN ENGLAND AND ITALY

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Sedo Sed Serio.

ANGLIA RUSKIN UNIVERSITY  
ABSTRACT

FACULTY OF MEDICAL SCIENCE

DOCTOR OF PHILOSOPHY

SITUATIONAL IMPROPRIETY IN EMERGENCY DEPARTMENTS: A QUALITATIVE FRAME ANALYSIS FROM NURSES’ PERSPECTIVE IN ENGLAND AND ITALY

LORENZO GANGITANO

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This thesis explores the frame informing emergency department nurses’ definition of situational impropriety from users and the suitable informal dealing strategies. Despite the dramatic scale of abuses recorded against emergency department nurses, the vast majority of these events go unreported and very little is known about nurses’ informal dealing strategies. Among the identified reasons for this low reporting rate is the suggestion that it is due to the unique definition of unacceptability developed by nurses, which is overlooked in literature and in practice.

Drawing upon Goffman’s social theory, a qualitative, multi-case study research design was implemented. Data was gathered from an English and an Italian hospital using qualitative checklists and semi-structured interviews. The bi-lingual data collection was semantically translated to English and findings were analysed following Ensink’s sociolinguistic frame analysis. Following a within-method triangulation strategy, the frame was explored from two perspectives: a perspective by incongruity, thus through perceived situational improprieties; and a perspective by expectation, thus through informal dealing strategies – or frame-clearing strategies.

Findings suggest that a unique frame is informing both teams’ perceptions, definitions of what is happening and reactions. The definition of unacceptability is strongly informed by nurses’ expectations, in terms of users’ capacity to respect the Parsonian patient-role. Five types of impropriety were identified, all defined as behaviour not in line with nurses’ expectations – independently from the intrinsic nature of the behaviour. Moreover, seven informal dealing strategies aimed at assuaging a perpetrator and preventing escalations were identified.

The thesis casts light on nurses’ informal definitions and social constructions of reality, uncovering discrepancies, with approaches based on non-staff members’ perspectives. Moreover, it provides seven interrelated contributions to knowledge at theoretical and policy level, identifying potential solutions to reduce the impact of users’ situational improprieties on nurses’ wellbeing

Key words: Emergency Department, Frame Analysis, Qualitative study, Interview, Situational Impropriety.

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# Abbreviations

|  |  |
| --- | --- |
| A&E | Accident and Emergency department |
| A&E Frame | Social frame governing A&E nurses’ behaviour and expectation |
| ASB | Anti-Social Behaviour |
| ARU | Anglia Ruskin University |
| D.LGS. | *Decreto Legislativo,* law issued by the Italian government following an authorisation from the parliament. |
| EOHF | Ecological-Occupational Health Framework |
| EU | European Union |
| EuroFound | European Foundation for the Improvement of Living and Working Conditions |
| FMS | Faculty of Medical Science (ARU) |
| FREP | Faculty Research Ethics Panels |
| GOMERS | Get Out of My Emergency Room – unwelcome users |
| HoNCAB | Support creation of pilot network of hospitals related to payment of care for cross border patients |
| IC | Informed Consent (form) |
| ILO | International Labour Office |
| ICN | International Council of Nurses |
| PIS | Participant Information Sheet |
| SPSS | Statistical Package for Social Science |
| UIIPRC | University of Iowa Injury Prevention Research Centre |
| UK | United Kingdom |
| US | United States of America |
|  |  |

# Chapter 1 – Introduction

## 1.1 – Unacceptable Behaviour in Emergency Departments

The aim of this study is to understand how emergency department nurses ascribe meaning to, and informally deal with, unacceptable behaviour exhibited by users, who are defined as patients, their family or other companions. This thesis aims to generate such insight by adopting a qualitative frame analysis approach in two culturally different settings: an emergency department in Essex, England and one in Veneto, Italy.

This thesis originates from two different, unrelated experiences that equally contributed to my decision to undertake this Ph.D. journey: my Masters dissertation in Sociology and the European project HoNCAB (Support creation of pilot network of hospitals related to payment of care for cross border patients) on cross-border patients. From the former, I developed a growing interest in Goffman’s social theory as an instrument to gain insight into the taken for granted understanding of social reality. More precisely, I have applied it to qualitatively investigate how Padua University students frame their recreational alcohol consumption, exploring their shift from a Mediterranean culture to a Northern European binge-drinking one. From the latter I developed an interest in healthcare systems, especially in their interactions with users and how users perceive them. This project explored the phenomenon of European citizens seeking urgent and planned healthcare in Member States other than those of their affiliation (cross-border patients). As Assistant Project Manager, I performed several tasks, one of which was to train staff members from hospital partners to enrol and collect data from eligible patients according to the project’s protocol. Since the vast majority of cross-border patients access foreign healthcare systems via emergency departments, I mostly interacted with their staff members. Thanks to this experience, I started to become familiar with this environment and its issues.

In January 2013, while I was still working on HoNCAB, I became aware of a fully funded Ph.D. position at Anglia Ruskin University (henceforth, ARU) to investigate how nurses, doctors, and receptionist staff in emergency settings in England and Italy define certain behaviour as unacceptable and how they decide on appropriate, informal strategies to address such situations. Due to the studentship provided, the research topic was fixed, and it was not possible to deviate from its main aim. For instance, at first, I was not convinced by the one-way perspective (staff members only) of the research commissioned. Nevertheless, I felt that this was the right occasion to further investigate a sociological topic that interests me, the social construction of proper conduct, in a context I became increasingly familiar with: emergency departments. Based on this, I submitted my application and, several weeks later, was offered the position.

During the first few months, as I read around the subject and the social dynamics between professionals and users, I felt the need to reduce my investigation to one category of professionals only, due to the fact that users change their approach and behaviour according to the healthcare professional category with which they interact. Several nurses, doctors, receptionists, and security officers in different Member States confirmed this difference during informal chats. Thus, drawing upon these conversations and a short list of academic articles and international reports, I decided to focus my interest on nurses only, since this category was the most interested in users’ unacceptable behaviour.

Through my reading, I identified four main interrelated gaps in the literature: the lack of understanding of nurses’ perspectives, the lack of a clear working definition for unacceptable behaviour, the absence of an exploration of nurses’ informal strategies in such situations, and an absence of cross-cultural qualitative studies that could confirm the transferability of findings collected in different settings. Concerning the first topic, I soon noted the divergence between nurses’ and researchers’ definitions of ‘unacceptable behaviour’. Concepts such as workplace violence, anti-social behaviour, or abuse, which are usually used in literature, seemed to be defined differently by the former. Nevertheless, scholars were often oblivious to such differences, which caused a distorted representation of the real issues and, thus, they often suggested ineffective solutions and policies. In this thesis, I therefore focus my attention on nurses’ definitions of the phenomenon, and I overcome this gap by adopting a qualitative approach focused on nurses’ vocabulary and their unique definition and understanding of reality.

Concerning the second main gap, a literature review revealed that researchers have failed to develop a common technical and academic terminology to define the concept of ‘unacceptable behaviour’. This has resulted in general confusion and incomparable findings, outcomes that could have seriously endangered my thesis due to its bi-lingual and comparative nature. Therefore, due to the lack of suitable operational concepts able to support my qualitative approach, I have adopted Goffman’s concept of ‘situational impropriety’ (Goffman, 1963a, p.193). This allowed me to leave the definition open, constructing it together with my participants through a two-step exploration. Specifically, I first collected nurses’ original definitions and vocabularies through qualitative checklists, and I then discussed and validated them in each interview.

The third main gap, which results from the lack of interest in nurses’ perspectives, is represented by the absence of information on nurses’ informal strategies. Although authors are well aware of nurses’ tendency not to report users’ unacceptable behaviour, and thus their reluctance to use formal strategies, very few authors have explored nurses’ informal approaches (Luck et al, 2009; Tan et al, 2015). The topic thus remains largely unexplored.

Finally, the fourth gap is demonstrated by the complete absence of qualitative cross-cultural studies; at least, none have been published in English or Italian. This poses a significant issue in terms of the transferability of the findings. In fact, previous research often relies on studies conducted in different countries, or it compares its findings with studies from different settings. Scholars thus implicitly assume that their findings are not influenced by their cultural stance, and that cultural differences between research settings do not significantly affect the findings’ transferability, an assumption that has never been verified. Therefore, taking advantage of the multicultural nature of my research, I decided to explore the commonalities rather than differences of my research settings, aiming to explore the claimed transferability of findings based on the uniqueness of the emergency department context.

Drawing upon my Master thesis, I reinvestigated the approaches developed in the social constructionist field and, driven by my theoretical interest in Goffman and my ontological and epistemological stances, I argue that Goffman’s social theory and terminology are the most apt for the purposes of this research. Specifically, I believe that the concept of frame allows me to make sense of the differences between staff and researchers’ perspectives in terms of what is unacceptable; to understand nurses’ low rates of formal reporting; to clarify nurses’ use of informal strategies to restore and reinforce acceptable forms of social interactions; and, most importantly, to make sense of nurses’ original understanding of events. Due to the lack of methodological guidance that characterises Goffman’s intellectual production, I investigated Goffman’s concept of ‘situational impropriety’ through Ensink’s frame analysis methodology (Ensink, 2003). Moreover, unlike other forms of frame analysis that draw on Goffman’s work, or at least with reference to those published in English or Italian, I have adopted a within-method triangulation (Denzin, 1978, pp.301-02) to answer my research question: How do emergency department nurses frame their interaction with users? This means that I adopted the same method (semi-structured interview) to explore the phenomenon from two different, complementary perspectives. This resulted in two sub-research questions that explore 1) what constitutes a situational impropriety (or unacceptable behaviour) and 2) what users perceive as proper behavioural conduct. This approach allowed me to identify a shared, guiding frame adopted by nurses in both groups (English and Italian) to define their role of caring medical experts, as well as that of users as passive laypersons in need of help. Moreover, I identified how perceived users’ social identity strongly influences nurses’ interactional expectations, differentiating between ‘justifiable’ or ‘unjustifiable’ users and, thus, between acceptable and unacceptable behaviour.

Thanks to my theoretical stance and to the specific qualitative methodology adopted, I believe that my research contributes to knowledge on seven grounds. First, it bridges a gap in the exploration of nurses’ perspectives by investigating the meaning nurses ascribe to violence and aggression and draws upon their spoken and original definitions. This result is made possible by adopting Goffman’s concept of situational impropriety, which allows me to overcome the previously indicated issues of detachment between researchers’ and nurses’ definitions of unacceptability and also reveals the role of users’ perceived identity as ‘justifiable’ and ‘unjustifiable’.

Such a qualitative approach allows me to identify three new forms of impropriety, attitudinal, emotional and interactional, thus overcoming the canonical verbal-physical dichotomy. This casts light on a set of deviant-but-not-illegal behaviours that have been overlooked in the literature.

In response to the lack of studies on nurses’ informal dealing strategies, I have identified and discussed seven of them. Drawing upon these, I produce potentially relevant recommendations for policy makers, suggesting both the provision of communicational training to improve nurses’ interactional skills and re-shaping departments’ spatial organisation in order to create symbolic spaces for conflict resolution.

In addition, my thesis addresses the last main gap identified: the absence of qualitative, cross-cultural studies. In relation to this, my cross-cultural approach validates the supposed transferability of data collected in different Emergency Departments, stressing the uniqueness of this research context and suggesting a more conscious, informed use of data. Finally, the originality of my theoretical and methodological approach of combining Goffman’s theory, within-method triangulation, sociolinguistic analysis, and Ensink’s (2003) data analysis constitutes, I believe, a significant contribution to knowledge, since such a methodology has never been adopted before, or at least has never been discussed in the English or Italian literature.

In conclusion, this thesis is characterised by the adoption of nurses’ perspectives and terminology, limiting any theoretical- or researcher-driven terminological or conceptual imposition as much as possible, to explore what I call the Accident and Emergency Frame that guides their interactions with users. An example of my use of nurses’ original terminology is represented by adopting the ‘old’ definition of ‘Accident and Emergency Department’ (henceforth, A&E) instead of the current ‘Emergency Department’, in agreement with participants’ preference for the former.

## 1.2 – Structure of the Thesis

The following nine chapters describe and discuss my Ph.D. journey. Although they appear in a logical sequence, the development of each was influenced by the others. This is represented by the several internal cross-references, which show the contributions of each chapter to the others.

Chapter 2 discusses my exploration of the available literature on unacceptable behaviour in A&E. Here, I offer a critique of the literature by discussing the different theoretical perspectives, definitions, and methodologies adopted by the scholars identified. The above-cited lack of exploration on nurses’ perspective, of a common terminology, and of cross-cultural studies are discussed, together with the other gaps in literature that informed both my research question and my methodology.

Chapter 3 offers an exploration of the main sociological terms and approaches to the concept of unacceptable behaviour. Here, I critically discuss the concepts of violence, deviance, and incivility and their most recent developments in terms of my research aim. Although these concepts are dismissed because they cannot fully explore unacceptability, they all contributed to identifying the concept adopted: Goffman’s situational impropriety.

Chapter 4 establishes my theoretical framework based on Ensink’s development of Goffman’s frame analysis. The chapter starts with a discussion of my idealist ontology and my weak social constructionist epistemology. These provide insight into my personal perspective on social reality and form the basis of my theoretical framework. Here, I discuss the most relevant topics of Goffman’s theory in relation to the object of my research and close the chapter with a detailed discussion of Ensink’s qualitative frame analysis. I also lay the foundation of my methodological procedures, describing how a frame can be qualitatively explored and also be based on actors’ reflection on tacit expectations and on what constitutes a violation of such expectations. At the theoretical and conceptual level, I discuss the two perspectives (perspective by incongruity and frame clearing) that operationalise my within-method triangulation and that inform both my data collection and data analysis.

Chapter 5 presents the context of my research, both at the national and local level in terms of formal organisation and the implementation of zero-tolerance policies. This chapter has a twofold purpose: to support my claim of the transferability of the findings by discussing and highlighting the many similarities between the two settings; and to offer a detailed description of the two research settings in terms of internal organisation, access, involvement, and limitations.

Chapter 6 presents and discusses my research question and the original methodology developed in order to answer it. The chapter opens with the definition of my research question, ‘How do accident and emergency department nurses frame their professional interaction with users?’, and investigates this through two sub-research questions, ‘Under what conditions are users’ performances perceived as situationally improper?’ and ‘What informal strategies are adopted to deal with situational improprieties?’. Then, drawing upon the previous chapters, I discuss in detail the multi-case study research design I have developed. Here, I offer a precise description of my data collection methods: qualitative checklists and semi-structured interviews. In this chapter, I also discuss the performative translation methodology adopted in this thesis and offer practical examples of my operative decisions to handle a bi-lingual data collection. The chapter ends with a detailed discussion of the main ethical and methodological concerns related to my methodology. The issue of validity in qualitative studies is presented and critically discussed in the last section.

Chapters 7, 8, and 9 present my findings. In agreement with Ensink’s (2003) methodology, in Chapter 7, I critically assess the influence of the research background frames on my data collection, the categories of actors operating in the A&E and how these are perceived by nurses, and, finally, I fill a gap in Goffman’s frame analysis by investigating nurses’ personal motivation to work in A&E. In doing so, I provide the reader with background information to better follow and understand the following chapters on the findings and my conclusion.

In Chapter 8, I present my findings relative to the definition of what constitutes a situational impropriety, with a focus on the perpetrator’s identity. This chapter offers all the information collected to answer my first sub-research question. Meanwhile, in Chapter 9, I present my findings in terms of informal dealing strategies and shared definitions between nurses to answer my second sub-research question. In agreement with the purposes of this thesis, I discuss my findings in order to identify similarities between the two research settings. Nevertheless, discrepancies are appraised, too, in order to identify structural differences that might have influenced my data collection.

In Chapter 10, I review and discuss my findings as if they belonged to a unique body of data, offering a detailed discussion in light of the overarching research question, and offering a visual representation of A&E nurses’ guiding frame. In addition, in this chapter, I discuss the strengths and weaknesses of my research, my original contributions to knowledge and practice, and to conclude, suggestions for topics for further research topics that emerged from my discussion.

# Chapter 2 - Literature Review on Unacceptable Behaviour in A&E

## 2.1 – Introduction

In this chapter, organised in four main sections, I offer a critical review of the literature on unacceptable behaviour from users in A&Es. Section 2.2 presents the methodology adopted to collect valid, significant bibliographical sources, with a focus on my exclusion and inclusion criteria. Section 2.3 offers a general overview of the identified literature and its main flaws. Based on this, Section 2.4 offers a more detailed critical review of the selected literature, presenting it as organised in three non-mutually exclusive groups of bibliographical sources according to the main focus: practical solutions, profiling of the perpetrator, and nurse-perpetrator interactions. Finally, Section 2.5 combines my critical review of the three groups, defining and discussing both criticalities and gaps in the literature. This section drives me toward identifying the most suitable sociological definition of unacceptable behaviour, discussed in Chapter 3, and lays the foundation of my theoretical approach, which is discussed in Chapter 4. Thus, here, I build my claim for a constructionist stance to explore A&E nurses’ perceptions of, definitions of, and informal dealing strategies toward users’ unacceptable behaviour.

## 2.2 – Literature Review Methodology

Before embarking on this Ph.D., I was employed in the administrative department of the Italian hospital involved in this research, a position that allowed me to have contact with several A&E departments in different European hospitals. Nevertheless, at that time, I had no fundamental grasp of the issue of unacceptable behaviour and had only a superficial knowledge of the problem. Taking advantage of my close working relationship with A&E nurses around Europe, my first step was to organise several informal chats with them. They presented the A&E as a stressful workplace, often overcrowded because of frequent, improper access that resulted in long, frustrating waiting times; these were perceived as the main cause of users’ unacceptable behaviour. This constantly tense atmosphere was reported to cause severe work-related stress in staff members, who perceived themselves as trapped between poor management, improper use of the service, and unnecessarily abusive users. Finally, my interlocutors reported physical aggressions to be less frequent than verbal ones and identified users with unrealistic expectations as the main source of trouble, along with drunk and intoxicated users. Based on this information, following Webster and Watson (2002), I started a concept-centric literature review to identify significant articles and relevant key words to allow for a more rigorous identification of meaningful articles.

As summarised in Figure 2.1 below (p.10), I first searched on Google Scholar for the general, but meaningful at that stage, key sentence ‘“Violence” AND “Emergency department” AND “Staff”’ in publications from 2005 onward. Of the 360,000 results, I focused on the first 15 pages to identify articles that were relevant in scope based on title and abstracts. From these, I drew 12 relevant key words: ‘Emergency department’, ‘Triage’, ‘Aggression’, ‘Aggressiveness’, ‘Violence’, ‘Violent behaviours’, ‘Verbal violence’, ‘Physical violence’, ‘Abuse’, ‘Workplace violence’, ‘Violence at work’ and ‘Patient’. Based on these, I designed the research key sentence ‘“Emergency” OR “Triage” AND “Patient” AND “Aggressi\*” OR “Violen\*” OR “Abuse”’ and searched for it on three databases: CINAHL, PubMed, and Scopus (Elsevier). The criteria of ‘full-text available’, published after the year 2000, and written in English or Italian were adopted as filters. Based on the title and abstract, I identified a total of 345 relevant articles: 268 from CINAHL (out of 38,883), 37 from PubMed (out of 1,151), and 40 from Scopus (out of 10,847). Please note that differences in databases’ contributions are due to the presence of the selected articles in more than one database. Databases were accessed in the presented order, and articles previously selected were not counted twice.

I then narrowed my results to exclude articles that were out of scope. This selection was based on three criteria: setting, perspective, and type of interaction. In terms of setting, in agreement with the International Labour Organisation’s (ILO, 2003) definition of the workplace,[[1]](#footnote-1) some authors extended their analysis to areas not identifiable as A&E, such as other wards, parking lots, or public transportation, such as buses to commute between home and the workplace. However, based on my personal knowledge of hospital wards from the narratives collected during my first, informal exploration, and in agreement with the literature (Fernandes et al, 1999; Luck et al, 2009; Belayachi et al, 2010), it is my understanding that the A&E is a highly specific context with unique structural characteristics, such as access flow, the range of medical services provided, and waiting time management, which call for exceptional dealing strategies that are not compatible with other wards. Thus, I decided to exclude articles that did not primarily focus on the A&E setting.

Figure 2.1 – Process of literature search

‘Violence’ AND ‘Emergency department’ AND ‘Staff’ AND published from 2005 on Google Scholar

Relevant key words: ‘Emergency department’, ‘Triage’, ‘Aggression’, ‘Aggressiveness’, ‘Violence’, ‘Violent

behaviour’, ‘Verbal violence’, ‘Physical

violence’, ‘Abuse’, ‘Workplace

violence’, ‘Violence at work’

and ‘Patient’

Final research key sentence: ‘Emergency’ OR ‘Triage’ AND ‘patient’ AND ‘Aggressi\*’ OR ‘Violen\*’ OR ‘Abuse’

PubMed

Scopus

CINAHL

‘A&E setting only’ AND ‘nurses only’ AND ‘Type 2 event’

56 articles, mostly quantitative, evaluated on a scale from 1 to 5

Snow-ball

>= 3 only

Final data collection of 138 sources, including 97 articles, 31 official reports, and 10 Ph.D. Theses

Source: Self-produced

In terms of perspective, this thesis limits its investigation to nurses’ perspectives only. This decision is based on studies that explore the power dynamics between professionals within A&Es. Following the work of Svensson (1996), who explored how nurses and doctors negotiate the work-related hierarchy in informal interactions, medical dominance is an acknowledged structural feature of the division of labour in healthcare. This dominance is recognised and respected by users, too, who act differently towards the two categories, leading to two quite different professional experiences in terms of unacceptable behaviour from users (Allen, 2001, p.125-28). In agreement with this and my research interest, I decided to exclude articles not primarily focused on nurses.

Finally, according to the University of Iowa Injury Prevention Research Centre (UIIPRC, 2001), four types of work-related unacceptable events can be identified: Type 1 or criminal intent, when the perpetrator has no legitimate relationship to the workplace but is rather moved by criminal intent, such as a someone who accesses an A&E to steal drugs; Type 2 or customer/client, when the perpetrator is a customer/client/user who shows unacceptable manners while being served/treated in the workplace; Type 3 or worker-on-worker, when the perpetrator is a current or past employee of the workplace; and Type 4 or personal relationship, when the perpetrator has no relationship with the workplace but has a personal relationship with the victim, such as a former partner. Although A&E nurses could experience all these types, in accordance with the scope of this research, only articles focused on Type 2, work-related unacceptable events, were included.

Of the 345 identified articles, only 56 were eligible. This resulted in a literature collection composed mostly of quantitative primary research and literature reviews. Only a few were qualitative studies focused on staff's perceptions and informal dealing strategies. Therefore, in agreement with my research interest in nurses’ perceptions and definitions, I felt the need to search for additional qualitative studies. Running a manual qualitative evaluation, I assessed the relevance of the 56 articles identified to the thesis’s scope, and thus their ability to provide significant information on nurses’ perspectives and informal dealing strategies, on a 1 to 5 scale. Although the assessment of identified valid resources was mainly qualitative and personal, I applied the following criteria: adoption of a qualitative methodology; theoretical clarity; exploration of nurses’ perspectives; direct relevance to my thesis; logical connection between methodology, findings, and conclusion; journal relevance; and data collection held in England or Italy. Those ranked from 3 to 5 were included in the selected literature. Of these I both explored their bibliographical sources and searched for more recent publications citing them, thus identifying additional relevant articles based on the above-cited selection criteria (setting, perspective, and type of interaction). Additional articles were again evaluated on a 1 to 5 scale, repeating the above described process per snow-ball methodology. However, this second search failed to significantly increase the number of qualitative studies and a third round was considered not necessary. In total, 82 new bibliographical sources were identified (49 articles, 23 official reports from national and international organisations, and 10 Ph.D. theses), resulting in a total of 138 sources.

## 2.3 – Overview of the Literature

Although the majority of primary research was based in Australia and the United States, with a minor presence of England-based and Italy-based research, the literature presented A&E nurses around the world as dramatically exposed to unacceptable behaviour from users. Scholars and international organisations have reported that A&E nurses are more likely to be abused than any other healthcare professionals (Gates et al, 2011; Spector et al, 2014; Park et al, 2015). In addition, they are more likely to be attacked than prison guards or police officers (ICN, 2009). The US National Emergency Department of Safety Study, gathering data from 65 A&Es, reported that only 12% of nurses consider their work environment safe, whereas 26% perceive it as never or sometimes safe (Kansagra et al, 2008). Further, Pinar and Ucmak (2011) have reported that, of the 255 Turkish nurses they surveyed, 65% felt safe ‘none of the time’ in their workplace, whereas 89% were concerned about potential violent behaviours from patients and their companions (Ibid, p.513).

According to the literature, verbal abuse seems to be more likely to occur than physical abuse, and the most commonly reported perpetrators are young male patients with low socio-economic status (Cameron, 1998; Ferns, 2005b; James et al, 2006; Zampieron et al, 2010; Alameddine et al, 2011; Esmaeilpour et al, 2011; Pinar and Ucmak, 2011; Pich et al, 2013). Perpetrators are usually described as incapable of self-control due to substance abuse, pre-existing mental health conditions, or because they are upset by the long waiting time (Crowley, 2000; May and Grubbs, 2002; Lau et al, 2004; Kansagra, et al, 2008). Moreover, the literature suggests that nurses are more vulnerable to users’ abuse during evening and night shifts and between 15:00 and 23:00 (Dalphond et al, 2000; Crilly et al, 2004; Ferns, 2005a; Knott et al, 2005; Pich et al, 2010), with higher rates of abuse during the weekends (Knott et al, 2005; Sands, 2007; El-Gilany et al, 2010; Esmaeilpour et al, 2011).

Nevertheless, despite the general agreement upon the dramatic dimension of the phenomenon and the identity of the most frequent perpetrators, scholars’ findings often lead to contradictory results, and reviewers have complained of a general incomparability of results (Jones and Lyneham, 2000; Lau et al, 2004; Ferns, 2005a; 2005b; Chapman and Styles, 2006; Luck et al, 2007b; Anderson et al, 2010; Pich et al, 2010). As Luck and colleagues (2007b) have described, although many studies have been conducted on the issue of users’ aggression towards nurses, differences in definitions prevent consistent comparisons between findings. For instance, the terms ‘violence’ and ‘workplace violence’ are used interchangeably with terms such as abuse, assault, and aggression (Ibid). Drawing upon the work of several authors, it is my understanding that such discordant findings are caused by four factors: the absence of a common terminology to define unacceptable behaviour (Lau et al, 2004; Ferns, 2005a; Luck et al, 2007b; Anderson et al, 2010); the lack of clarity concerning the guiding theoretical framework of many studies (Ferns, 2005a, 2007; Chapman and Styles, 2006); the excessive focus on physical violence, which results in overlooking unacceptable verbal behaviour (Ferns, 2005a; 2005b); the influence of the so-called ‘culture of silence’, meaning the tendency not to report the vast majority of the abuse suffered (which is rarely properly investigated), which undermines the credibility of many studies (Jones and Lyneham, 2000; Pich et al, 2010).

Concerning the lack of clarity of what makes interactions unacceptable, as Ferns (2005a) has argued, authors often use opportunistic definitions that suit their research question and methodology, and these differ from those of other researchers with different interests or methodologies. For instance, although the most frequently adopted concept is that of ‘workplace violence’, an umbrella concept that indicates any type of verbal, psychological, or physical unacceptable behaviour that occurs in the workplace (Bernstein and Saldino, 2007; Hahn et al, 2010; Sicora, 2013), within my literature collection, I have identified 47 different definitions of unacceptable behaviour. Some of these are broad and unspecific, such as incivility (Edward et al, 2014; Touzet et al, 2014) or actions that erode the staff’s ‘wellbeing and job satisfaction’ (Anderson et al, 2010, p.2521), whereas others are highly descriptive, such as specific types of physical violence (Petzäll et al, 2011; Speroni et al, 2014) or violence involving specific tools (Belayachi et al, 2010). Finally, despite the fact that the ILO provides an official definition of workplace violence (Chappel and Di Martino, 2006, p.30), authors adopt and interpret this in different ways (Pich et al, 2010; Lau et al, 2012a).

Concerning the second factor, as Ferns (2005a; 2007) and Chapman and Styles (2006) have examined, scholars rarely discuss the theoretical framework that informs their definition of unacceptable behaviour. Those who offer a description of their theoretical stance mainly adopt a positivistic one (Crilly et al, 2004; Kerrison and Chapman, 2007; Rintoul et al, 2009), drawing upon theories such as the ‘broken window theory’ perspective (El-Gilany et al, 2010; Strickler, 2013) or the social learning perspective (Hislop and Melby, 2003; Crilly et al, 2004; El-Gilany et al, 2010; Gillespie et al, 2013). The vast majority of authors do not specify their theoretical stance and, in some cases, they do not describe the context of their study. As Anderson and colleagues (2010) have discussed, this limits replicability, thus undermining the robustness of the findings and preventing comparison with other studies.

Concerning the third factor, almost all studies focused on the ‘presumed causative, predictive, or descriptive reasons for violence’, and only a few attempted to ‘understand how nurses ascribe meaning and, therefore, respond, to violence’ (Luck et al, 2007b, p.1072). This led to an excessive focus on observable forms of supposed ontologically unacceptable behaviour, such as acts of physical violence (Ferns, 2005a; 2005b; Zampieron et al, 2010; Alameddine et al, 2011; Esmaeilpour et al, 2011; Pinar and Ucmak, 2011; Pich et al, 2013). According to Ferns (2005a), this is due to the often-vague use of the term ‘violence’, which inevitably directs attention to physical violence because this is the more relevant form from the hospital manager’s perspective. In fact, physical violence represents a direct cause of immediate, tangible organisational loss, such as sick leave or increased turnover of staff. My literature review offers an example of this major focus on physical unacceptable behaviour: three of my four selected sources are primarily focused on physical violence.

Regarding the authors’ tendency to ignore the so-called ‘culture of silence’, this happens although it is widely agreed that this phenomenon seriously undermines our understanding of the extension of this issue (Luck et al, 2007b; Gacki-Smith et al, 2009; Pich et al, 2013). For instance, after collecting data from six Turkish hospitals, Pinar and Ucmak (2011) discovered that 79% of verbal abuse and 81% of physical abuse were not reported to hospital managers nor to local authorities. Moreover, Pawlin (2008, p.21) has reported that almost 75% of his participants admitted that they usually do not report accidents in which they are involved. The few authors who have investigated this culture have identified three main causes: organisational issues, too long and complex report forms, and nurses’ professional culture. Concerning the first, the literature describes how the systematic lack of support for victimised workers produces the feeling that reporting will not produce any tangible organisational improvement (Crilly et al, 2004; Pawlin, 2008; Pich et al, 2010). Concerning the second cause identified, Ferns (2005a, p.181) has suggested that hospitals’ report forms and research data collection tools are often quantitative, thus providing a predefined range of possible unacceptable interactions that nurses are expected to experience. However, these options do not necessarily reflect nurses’ experience; rather, they offer insight into what researches and hospital managers already seek: mostly acts of physical violence for the reasons discussed above. Nurses thus struggle to report what they believe is unacceptable and, implicitly, receive the message that their perspective is not relevant. This terminological issue leads to the third consideration of a cultural nature. From a social constructionist stance, it can be argued that words and definitions always carry an intrinsic cultural value, and that we use or understand words and definitions in accordance with our cultural background (Wortham, 1996). According to a few dedicated studies (Luck et al, 2007b; Pawlin, 2008; Pinar and Ucmak, 2011; Lau et al, 2012b; Pich et al., 2013; Hyland et al, 2016), A&E nurses socially construct their own specific definition of unacceptability. For instance, behaviour generally defined as unacceptable, such as a punching or spitting, could instead be deemed acceptable within the A&E context because it is perceived as ‘in line’ with the perpetrator’s health/mental health condition or stress level (Pawlin, 2008; Lau et al, 2012b; Pich et al., 2013). According to these scholars, ontologically unacceptable behaviour does not exist in A&E; rather, unacceptability is socially constructed and considers perpetrators’ medical, stress, or psychological condition (Pawlin, 2008; Lau et al, 2012b; Pich et al., 2013) and the perceived intention to harm, insult, or disturb (Luck et al, 2007b).

## 2.4 – Analysis of the Literature

As discussed in the previous section, the literature on unacceptable behaviour from users in A&E has reported findings that are unclear, contradictory and, generally speaking, difficult to compare and analyse. Nevertheless, based on the scope of these studies and their research questions, I have organised the selected literature into three non-mutually exclusive groups: practical solutions, profiling of the perpetrator, and nurse-perpetrator interactions. Studies of the first group evaluate and suggest practical solutions to reduce the diffusion of workplace violence in A&E, such as the introduction of technological devices (i.e., metal detectors) or new organisational protocols (i.e., reduction of waiting time); studies of the second group explore perpetrators’ identity, from the individual characteristics to the socio-economic characteristics of the area served, such as crime rates, average income, and mental health rate; finally, articles of the third group explore how the nature of nurse-perpetrator interactions affects the chances of unacceptable behaviour in A&E.

Figure 2.2 – Conceptual re-organisation of the identified bibliographic sources

Source: self- produced

Before proceeding with the detailed description of the three groups, I believe that a terminological clarification is needed. In this thesis, I use the term ‘perpetrator’ to indicate a user who performs behaviour defined as unacceptable by the involved/observing A&E nurses. Although some authors prefer the term ‘abuser’ (Keely, 2002; Pawlin, 2008; Esmaeilpour et al, 2011), I believe that this word might deceive the reader, as well as my participants, and suggest either that perpetrators are drunk or on drugs, or that some form of sexual abuse took place. Some have instead adopted the term ‘aggressor’, or ‘*aggressore’* in Italian (Cooper and Swanson, 2002; Lau et al, 2004; Ramacciati e Ceccagnoli, 2012; Tan et al, 2015), but, per the above, I believed this could lead to an excessive focus on physical or verbal aggressions at the expense of other forms of unacceptable behaviour, such as being rude or discourteous. Therefore, following other authors (specifically, Crilly et al, 2004; Pich et al, 2010; 2013; Pinar and Ucmak, 2011; Wolf et al, 2014), I decided to adopt the term ‘perpetrator’, defined by the Collins Dictionary (2015) as someone who perpetrates a ‘crime or other immoral or harmful act’, allowing for an extension of unacceptability to immoral or harmful acts. The Italian version of the term was adopted for research in that context (‘*trasgressore’*), although it has a more formal value. Therefore, I believe that this concept holds a more neutral value in both contexts, preventing implicit and undesired deviation of my participants’ understanding of the nature of my research.

### 2.4.1 – Practical Solutions

These studies consider unacceptable behaviour as unavoidable and job-related, without questioning or exploring its origin; instead, they focus on how to address it by implementing new passive-defensive structures and protocols. These interventions are mostly focused on the enhancement of access control to either allow for the early identification of potential perpetrators, or to better manage incoming users and reduce waiting times. These studies are mostly quantitative primary research aimed at (I) testing the efficiency of practical solutions, such as metal detectors, additional security guards, or other passive-defensive systems; (II) improving formal internal protocols to identify and deal with users suspected of being potentially dangerous.

In relation to my research aim, I believe that studies of the first sub-set, whose suggestions have been implemented in several hospitals, have two main flaws: first, they are too focused on physical violence; second, due to the different definitions of unacceptable behaviour adopted, they often provide conflicting findings. Emblematic of this is the evaluation of metal detectors’ usefulness and of the distribution trend of unacceptable behaviour in the last decade. For instance, Kansagra and colleagues (2008) have suggested that A&Es equipped with metal detectors are more likely to be interested by higher levels of physical abuse, whereas May and Grubbs (2002) have concluded that metal detectors prevent physical abuse. Concerning the distribution trend of unacceptable behaviour, Hilliar (2008) has reported an increase of 50% in assaults in Australian hospitals between 1996 and 2006, whereas Harrell (2011) has reported that Australia enjoyed a decline of 35% in violent incidents against health-care workers from 1993 to 2009. The discrepancies are even greater when comparing research from different countries, which suggests that cultural factors affect both perpetrators’ behaviour as well as researchers’ interest and analysis (Budd, 1999; Farrel, 1999; Wells and Bowers, 2002; Ferns, 2005a; Ryan and Maguire, 2006; Belayachi et al, 2010). In both examples, the discrepancy is a consequence of the different definition of workplace violence adopted, as well as of the different methodologies used.

Regarding the second sub-set, formal management protocols are suggested and tested for different purposes, such as to improve nurses’ personal defence skills (Woollam, 2007), to improve coordination between security officers and medical staff (Gillespie et al, 2012), to flag and track patients who repeatedly become verbally or physically aggressive (Henderson and Colen-Himes, 2013), to improve staff's ability to identify possible abusive users (Luck et al, 2007a), and to reduce waiting time and overcrowding (Angland et al, 2014). Although these findings are more consistent compared to the previous sub-set, they are still difficult to compare and replicate due to the specificities of the settings observed and, consequently, of the strong customisation of the solutions provided (Pich et al, 2011; Taylor and Rew, 2011). Moreover, the real impact of these protocols remains unclear. For instance, the vast majority aim to reduce waiting times, starting from the assumption that this is the main triggering factor (Lau and Magarey, 2006; Lipley, 2012; Pich et al, 2013; Angland et al, 2014). However, the connection between waiting times and unacceptable behaviour is questionable. According to Morgan and Steedman (1985), the vast majority of violent events occur within 30 minutes of patient access, whereas Lavoie and colleagues (1988) have reported that 78% of violent incidents occurred within one hour of users’ presentation; finally, Crilly and colleagues (2004) have found that the average waiting time for patients reported to be violent was 66.2 minutes. What instead seems to emerge from the literature is the importance of perceived waiting times, which are influenced by users' impatience and desire for individualised, immediate attention (Ferns, 2005b; Angland et al, 2014). Regarding the implementation of other formal protocols aimed at improving the identification of flustered patients and staff’s de-escalating techniques, the literature reports that their application reduces the frequency of unacceptable episodes more efficiently than structural safety measures (Kamchuchat et al, 2008).

In conclusion, with respect to the aim of my thesis, I believe that this group of studies offers an extensive, albeit confused, overview of the situation in contemporary A&Es, and its contribution is limited by unclear, divergent findings due to the adoption of opportunistic definitions of unacceptable behaviour. For instance, articles that investigate the usefulness of metal detectors limit their focus to aggressions with guns or knives. Finally, all authors present unacceptable behaviour as unavoidable, describing nurses as passive agents unable to influence the nature of their interactions with users. These assumptions are incompatible with my social constructionist stance.

### 2.4.2 – Profiling of the Perpetrator

Per the previous group, the studies here collected focus on practical, passive-defensive solutions and consider the phenomenon under study as unavoidable and job-related. However, they differ from the previous ones in their focus on the surrounding social environment and their attempt to define the profile of the most problematic social groups. These studies offer an analysis of the population served, specifically, users’ average socio-economic level, rate of substance abuse, accessibility to weapons, and the rate of violence in the surrounding community (Levin et al, 1998; Pich et al, 2011, 2013) to highlight connections between certain social groups and some forms of unacceptable behaviour (Hislop and Melby, 2003; Crilly et al, 2004; El-Gilany et al, 2010). It is my understanding that they draw theoretical support from Bandura’s social learning theory (Bandura, 1963; 1977).

According to Bandura (1963), unacceptable behaviour is socially learned and subject to stimuli, reinforcement, and cognitive control. Therefore, what happens in healthcare facilities is a reflection of the unacceptable behaviour that characterises the neighbourhood in which the hospital is located (Ness et al, 2000). Poverty and the presence of street weapons, such as knives or other tools used in gang fights, are considered the two main facilitating factors (Ness et al, 2000; Ferns, 2005b; James at a., 2006; Pich et al, 2011; 2013). In support of this thesis, it has been reported that hospitals that serve deprived neighbourhoods or areas with high crime rates are more likely to attract victims of physical violence, gang members, and intoxicated subjects. The presence of these users is considered to be likely to increase the odds of abuse against nurses. For instance, James and colleagues (2006) have reported that the majority of perpetrators live in deprived areas which, in turn, are often inhabited by people with mental health conditions, learning difficulties, and/or alcohol or drug problems; these are generally identified in literature as the most aggressive users (Ferns et al, 2005; Pich et al, 2011; Houghton and Hughes, 2013).

In terms of perpetrators’ profiling, Kansagra and colleagues (2008) have performed a qualitative study on 65 US A&E departments and reported that perpetrators are young males who are mostly confused due to alcohol or drug consumption. Another problematic social group is users with mental health conditions, who are considered to be ‘two-to-three times more likely to exhibit aggressive behaviour than the general population’ (Friedman, 2006, p.2064). This position is supported by Pich and colleagues (2010; 2011), who have reported that nurses are particularly concerned about patients with mental health conditions because of their unpredictability, and because nurses are rarely trained to deal with them. In fact, Ferns (2005b) has suggested, strategies of communication that are usually successful with other agitated users, such as a gentle touch, might produce unexpected and violent reactions from those with mental health conditions. In addition, A&Es are usually noisy, busy, overcrowded, and without privacy, factors that may easily frighten these patients, leading to unpredictable, violent reactions when workers approach them (Crowley, 2000).

In conclusion, these studies explore and discuss how perpetrators’ characteristics and the socio-economical level of the surrounding area influence the occurrence of unacceptable interactions. Articles in this group suggest a more comprehensive approach to this phenomenon and cite, without further investigation, the role played by the staff’s interactional skills. However, like the previous set, they lack a shared definition of what is unacceptable and adopt opportunistic definitions and methodologies. As a result, their findings still mainly focus on physical abuse and are difficult to compare. Nevertheless, they recognise, without exploring in detail, the interactional nature of several episodes of unacceptable behaviour. In addition, they recognise the pivotal role of nurses’ interactional skills, and more generally those of the actors involved.

### 2.4.3 – Nurse-Perpetrator Interactions

Studies in this third group differ from the previous ones on two grounds: first, they portray A&E nurses as active agents and, without denying the role of structural and external factors, they suggest that appropriate social interactions can significantly reduce the occurrence of unacceptable behaviour. This interactional perspective leads to the second major contribution and distinction with the previous sets of studies: a detailed analysis of the previously identified culture of silence. These two contributions often intersect.

As discussed above, the literature on unacceptable behaviour in A&E departments often fails to specify the theoretical framework that guides researchers’ assumptions. In this group, the authors generally adopt a holistic perspective, and some (Levin et al, 2003, 2006; WHO, 2005; Chapman and Styles, 2006; MacKinnon, 2009; Gillespie et al, 2013) openly refer to the Ecological-Occupational Health Framework (EOHF) developed by Levin and colleagues in 1998 (Levin et al, 1998). Based on four focus groups with 22 nurses from 15 different US A&Es, Levin and colleagues (Ibid) suggested that the occurrence of unacceptable behaviour in A&Es is influenced by three objective factors and one dynamic dimension. The first objective factor is defined as personal factors or nurses’ physical characteristics, such as gender, age, build, years of experience, and attitude toward users. The second is defined as workplace factors, such as the presence of metal detectors and security staff, or of specific organisational strategies to ensure both staff’s safety and a more efficient service. The third, environmental factors, indicates exogenous factors that are out of workers’ control, such as the geographical location of the hospital, users’ socio-economic level, the rate of abuse of substances among the served population, the accessibility of weapons, and the rate of physical violence in the surrounding community (Ibid, p.252). Finally, the dynamic dimension ‘solutions’ (Ibid, p.253) indicates the informal interactional strategies that are creatively implemented to prevent or mitigate the effect of workplace-related physical and verbal assaults. Strategies can be activated before the assault situation to prevent it, or after it to reduce physical and psychological consequences (Levin et al, 2003; 2006).

As visually described by the use of red in Figure 2.3 below, in agreement with the research aim assigned, my interest focuses on the ‘solutions’ dimension, and the studies in this third group provide relevant information on it. However, although the EOHF helps understand the complexity of the phenomenon and allows for the integration of the findings in my three groups of bibliographical sources; however, I will not use it as a theoretical framework. I believe that it cannot provide further insight into how such solutions are socially constructed because it was conceived to identify and evaluate implemented solutions and not to understand the social construction of unacceptability.

Figure 2.3 – The Ecological-Organisational Theoretical Framework

Environmental factors

Personal factors

Workplace factors

Assault situation

Consequence of assault

Source: adaptation of the scheme presented in Levin et al, 2003, p.30

With the scope of this third collection of studies defined, it is now possible to analyse it. However, in order to do so, it is necessary to start from an analysis of the culture of silence because it provides relevant indications of the nature of the nurse-user interaction. As previously discussed, one of the causes of the significant lack of reporting is the discrepancy between nurses’ definitions of unacceptability and those provided in formal reports (Jones and Lyneham, 2000; Luck et al, 2007b; Pich et al, 2010). Although the specific investigations included in this third group did not produce solid conclusions, scholars agree that nurses’ definition of reality is socially constructed, and that unacceptability is not an ontological characteristic of certain behaviour (Luck et al, 2007b; Pawlin, 2008; Pinar and Ucmak, 2011; Lau et al, 2012b; Pich et al., 2013). Instead, Luck and colleagues (2007b) have suggested that unacceptability is informed by informal definitions against which users’ behaviour is tested and evaluated. Specifically, the perceived mental or physical condition of the perpetrator, and the perceived intentionality to offend, frighten, or harm. The former suggests that users perceived as mentally impaired, in significant physical pain, or under major psychological stress are generally treated with greater empathy and tolerance. Therefore, a nurse would probably file a report for a violent patient with minor injuries, whereas s/he would refrain from doing so if the patient were diagnosed as mentally impaired (Lanza and Carifo, 1991; Jones and Lyneham, 2000; Pawlin, 2008; Lau et al, 2012b; Pich et al., 2013). As discussed by Jones and Lyneham (2000), ‘it seems that when nurses perceive that the perpetrator of violence is of diminished capacity their actions should be tolerated’ (Ibid, p.30). This means that nurses’ perceptions and definitions are primarily informed by the characteristics of who performs an act, rather than by the nature of it.

Concerning the second process of evaluation, perceived intentionality, Luck and colleagues (2007b) have argued that a personal insult could be forgiven or ignored if the act is perceived as an outburst toward the healthcare system, rather than aimed at offending a nurse who unfortunately happens to be present. Moreover, it has been reported that sometimes nurses do not report because they believe that their own improper conduct of that of their colleagues provoked the unacceptable behaviour (Jones and Lyneham, 2000). In support of this, Pich and colleagues (2010) and Lau and colleagues (2012b) have reported that staff members admitted that some in the profession are more likely to incite or exacerbate instances of abuse. Drawing upon these findings, Wolf and colleagues (2014) have suggested that victimised nurses might decide not to report either because they feel guilty for what happened or, despite being aware that it was not their fault, because they are afraid of being considered responsible by their colleagues and thus being labelled poor co-workers. Crilly and colleagues (2004) and Albashtawy (2013) share this position and have discovered instances of ‘peer pressure not to report’ and ‘fear of blame’ in cases of aggression (Crilly et al, 2004, p.68). In support of these findings, other researchers have found differences between nurses regarding the most appropriate dealing strategy (solution) to use, suggesting that nurses who are deemed to over-react might be informally sanctioned by their peers (Hegney et al, 2003; Pich et al, 2010; 2011; Pinar and Ucmak, 2011).

These findings lead to two considerations: first, nurses are expected to adapt their definition of unacceptability to that of the group through ‘peer pressure’ (Albashtawy, 2013, p.554). Second, nurses might have to adapt their reactions (solutions) to those considered appropriate by their group of peers (Pich et al, 2010; 2011). However, the literature on this is scarce and does not clarify how this peer pressure works, nor does it offer significant evidence of it. Nevertheless, based on the information presented above, such peer pressure recalls what is defined as ‘organisational culture’ in nursing studies (Person et al, 2013, p.222). Distinguishing between the formal – local/national regulations defining proper nurse-user interactions – and informal organisational culture – defined by Schein (2004, pp.29-31) as a common value system interiorised over time that informs team members’ problem definition, environment definition, and selection of interactional strategies – in agreement with my research aim, it is my intent to explore the role played by the latter on A&E nurses’ definition of, and dealing strategies toward, unacceptable behaviour from users.

Drawing upon the discussion offered above, and thus making sense of the scattered findings offered in the literature, my understanding is that the way nurses approach users can significantly influence the occurrence of unacceptable behaviour. Although the literature has mostly ignored this point, Jeffrey first introduced the identification of nurses as a source of unacceptable interaction from users in 1979. He observed that A&E health professionals were more interested in patients whose health conditions allowed them to practise their skills, or to test the general competence and maturity of the staff. Patients who did not fall into these two categories, such as users with minor health conditions, drunks, those with overdoses, and the homeless, were considered time-wasters (‘rubbish’ in his article, Ibid, p.92) and treated with far less compassion and with verbal hostility. Jeffrey’s findings were further confirmed by others (Lyneham, 2000; Pich et al, 2012b; Lau et al, 2012b) who reported that nurses tended to define the above categories of users as ‘GOMERS’ (Get Out of My Emergency Room). This leads to the identification of a third process of evaluation from nurses, precisely, users’ entitlement to access the A&E, and it casts a shadow on the validity of the identity of the average perpetrator discussed in the second group (Section 2.4.2). In fact, drawing upon Jeffrey (1979) and Lyneham (2000), Quintal (2002) and Ferns (2005b) have questioned this image of the usual perpetrator, claiming that any user can potentially become aggressive if improperly approached. They have suggested that the major aggressiveness of such users might be a consequence of nurses’ dislike for them.

Finally, in support of this interactional perspective of nurses as instigators, studies on the usefulness of training programmes aimed at improving staff’s emphatic interaction and communicational skills have reported that such courses help reduce the odds of verbal and physical abuse (Gates et al, 2011; Henderson and Colen-Himes, 2013).

Resuming the discussion this section offers, several useful pieces of information can be drawn from this third group of studies, both in support of a constructionist approach to the phenomenon under study, and in terms of the analysis of the culture of silence. Drawing upon this, Levin and colleagues’ (1998) dynamic dimension ‘solutions’ is informed by four evaluations – see Figure 2.4 below – that help nurses discern acceptable and unacceptable acts: (I) users’ mental/physical condition (Pawlin, 2008; Lau et al, 2012b; Pich et al., 2013); (II) perpetrators’ perceived intentionality (Luck et al, 2007b); (III) perceived users’ entitlement to access the A&E (Jeffrey, 1979; Lyneham, 2000; Pich et al, 2010; Lau et al, 2012b); and (IV) nurses’ self-perception that their improper conduct caused the unacceptable behaviour, thus creating the fear of being blamed by peers (Hegney et al, 2003; Crilly et al, 2004; Pich et al, 2010; 2011; Pinar and Ucmak, 2011; Albashtawy, 2013). These processes of distinction between acceptable and unacceptable behaviour also inform nurses’ decisions on whether to report behaviour that, outside of this context-related logic, would probably be considered acts of physical or verbal violence.

Figure 2.4 – Nurses’ evaluation process of unacceptability

Formal dealing strategies / reporting

Mental or physical condition

Potentially unacceptable behaviour

Perceived intentionality

Perceived entitlement

Informal dealing strategies / culture of silence

Nurses as responsible

Source: Self-produced

In conclusion, this third group gathers the most relevant studies and contributes to my research on three grounds: first, it demonstrates the socially constructed nature of unacceptable behaviour; second, it introduces – without discussing it – the concept of informal dealing strategies driven by, third, an informal group culture. As evidenced by the use of red, the organisation and structure of this ‘informal organisation culture’ remains unclear, and thus it is the primary focus of my study.

## 2.5 – Gaps in Literature

As can be observed from the discussion in the previous sections, drawing definitive conclusions from the literature is a complicated task. Authors’ findings often result in contradictions due to the different definitions and theoretical perspectives adopted. Moreover, the insufficient effort made in the literature to investigate nurses’ perspectives limits the understanding of both what occurs and of the origin of the culture of silence (Luck et al, 2007b). Drawing upon my critical review of the literature presented in this chapter, five main issues undermine the clarity and final validity of the literature identified: (I) the absence of a unique, neutral term able to include and describe all forms of unacceptable behaviour identified in the literature (verbal, psychological, physical, intentional, etc.); (II) the excessive focus on physical violence, even though verbal unacceptable behaviour is predominant; (III) the lack of interest in nurses’ perspectives and definitions in favour of researchers’; (IV) the paucity of efforts to understand the causes of the ‘culture of silence’, which has led many studies to be characterised by poor response rates; and (V) the unclear theoretical stances that guide published studies. Although these five issues do not necessarily apply to each study, I believe that they are related to and influence each other. For instance, Luck and colleagues (2007b) have discussed how the theoretical frameworks’ lack of clarity affects readers’ and participants’ understanding of the research aim as well as of the chosen terminology, thus overlooking certain behaviour while contributing to the diffusion of the culture of silence. In addition, according to some authors (Luck et al, 2007b; Pich et al, 2010; Hyland et al, 2016), the excessive focus on physical interaction is strongly influenced by the low relevance the literature grants to nurses’ perspectives in favour of those of hospital managers.

Based on my critical review, I believe that the above-listed issues are strongly connected because they are all consequences of four main, interrelated gaps in the literature: the lack of understanding of nurses’ perspectives; the lack of a clear definition for unacceptable behaviour; the absence of explorations of nurses’ informal dealing strategies; and the absence of cross-cultural studies, especially qualitative ones, that can confirm the transferability of findings collected in different settings. Concerning the first gap, the lack of understanding of nurses’ perspectives, as Pich and colleagues (2010) have discussed, authors often impose their understanding of events over that of nurses, causing a discrepancy that results in poor reporting performances because what they perceive as inappropriate is actually out of scope. I believe that this has two consequences: first, it remains unclear what unacceptable behaviour in real life interactions in A&E means, which has severe consequences on our understanding of the culture of silence; second, it distances the researchers’ interest from the micro-sociological observation of user-nurse relations. It is therefore likely that, due to this gap, today, policies are erroneously informed and are thus less effective than desired. I believe that more attention should be given to nurses’ perceptions of this phenomenon, and that it is necessary to better understand the phenomenon, its real dimensions, and its causes.

Second, the literature lacks a clear definition of unacceptable behaviour. As discussed in Section 2.4.1, scholars have used a variety of discordant definitions, leading to incomparable findings. I believe that this is caused by adopting unspecified positivistic theoretical frameworks that deny the socially constructed nature of unacceptability and instead promote the use of super-imposed ontological definitions, primarily those of researchers, as discussed above. In contrast, I believe that a clear definition of the concept of ‘unacceptable behaviour’ that can appraise its socially constructed nature would allow for more reliable explorations as well as more reliable data collection tools, thus enhancing findings’ validity, credibility, and transferability. Moreover, drawing upon the work of Phillips and Smith (2003) on urban incivility, the use of legal definitions implicitly shifted scholars’ attention from those ‘deviant-but-not-illegal behaviours that cannot be easily detected by outsiders’ (Ibid, pp.87-8). Behaviours such as rudeness or arrogance, which can negatively affect an interaction and lead to physical confrontations (Ibid), are completely absent from the literature.

Third, as a consequence of the first gap, the lack of interest in nurses’ perspectives has left an important question unanswered: assuming that most of the unacceptable interactions are unreported, what do nurses do in order to continue with their job-related activities? What informal strategies do they implement to deal with perpetrators? As Tan and colleagues (2015) have discussed, the need to further investigate this topic is real and this would allow the implementation of policies aimed to reduce

‘the adverse effect on nurses and identify the impediments for the required changes by organizations or individual healthcare professionals’ (Ibid, p.308).

Finally, the fourth gap is represented by the complete absence of qualitative cross-cultural studies; at least, I was not able to find any published in English or Italian. Specifically, this poses a significant issue in terms of the transferability of findings. The bibliographical sources included in my literature and discussed in this chapter often rely on studies conducted in different countries, or they compare their findings with studies from different settings. Thus, scholars implicitly sustain that their findings are not influenced by their cultural stance or by the culture of the setting, thus claiming that cultural differences do not affect results’ transferability, although this has never been investigated. Even though I might agree that studies conducted in different countries can be compared due to the specificity of the research setting, I still believe that scholars should pursue a more critical approach. For instance, studies held in Muslim countries (El-Gilany et al, 2010; Esmaeilpour et al, 2011; Albashtawy, 2013) report that male nurses are the most likely to be physically assaulted, whereas studies in Western cultures generally suggest that female nurses are more exposed to verbal and physical abuse (Chappel and Di Martino, 2006; Zampieron et al, 2010; Kowalenko et al, 2013).

## 2.6 – Chapter Conclusion

In this chapter, I have discussed the most relevant literature on acceptable behaviour in A&Es. Moreover, I have defined the scope of my study through the adoption of three criteria of exclusion: setting, within the A&E premises only; actors’ perspective, nurses’ only; and type of interaction, UIIPRC Type 2 only. Finally, I have defined the general aim of this thesis: to investigate A&E nurses’ perspectives of, definition of, and dealing strategies against users’ unacceptable behaviour.

Adopting a two-phase conceptual literature review, I identified and critically discussed 138 relevant bibliographical sources, organising them in three non-mutually exclusive groups: practical solutions, profiling of the perpetrator, and nurse-perpetrator interactions. Research from the first group focused on practical solutions adopted in different countries to reduce the number of or minimise the potential damage of users’ unacceptable behaviour. The studies here collected do not provide any significant contribution to my exploration of nurses’ informal organisational culture, although they did support the identification of some of the gaps in literature, which are discussed in Section 2.5.

The studies from the second group offered a description of the average perpetrator. However, due to the use of opportunistic definitions and methodologies, the reported findings are difficult to compare. Nevertheless, some conclusions can be drawn, such as that verbal abuse seems more likely to occur than physical abuse (Ryan and Maguire, 2006; Speroni et al, 2014; Partridge and Affleck, 2017); perpetrators are often drunk, on drugs, or mentally impaired (Crowley, 2000; May and Grubbs, 2002; Lau et al, 2004; Kansagra, et al, 2008); and the most aggressive social group is that of intoxicated young males with low socio-economic status (Cameron, 1998; Ferns, 2005b; Zampieron et al, 2010; Alameddine et al, 2011; Esmaeilpour et al, 2011; Pinar and Ucmak, 2011; Pich et al, 2013). However, this collection of studies did not provide noteworthy contributions in relation to my research goal.

Finally, the studies of the third group offer an interactional perspective and discuss how unacceptable behaviour from users can be minimised and prevented by adopting proper interactional strategies (Gates et al, 2011; Lau et al, 2012b; Henderson and Colen-Himes, 2013). They suggest that perpetrators are also users who have not been treated according to their expectation, based on their self-perceived health status or priority level (Hoag-Apel, 1998; Pich et al, 2011; Pinar and Ucmak, 2011; Eslamian et al, 2010), whereas nurses are defined as key players who can influence the distribution and containment of unacceptable behaviour through interactional strategies (Lyneham, 2000; Pich et al, 2010; Lau et al, 2012a). Drawing upon these studies, I have identified the existence of an informal organisational culture that guides nurses’ perception, definition, and dealing strategies. This informal culture is poorly explored, and my final aim is to provide a detailed critical analysis of it.

The critical review offered in this chapter suggests that unacceptable behaviours from A&E users have been extensively but chaotically studied. Drawing upon this literature, I have identified four gaps in knowledge that that this thesis aims to fill, or, at least, to contribute to. The first is the lack of studies on nurses’ informal organisational culture, which guides their definition of unacceptability. The second gap is a consequence of the first, since the described opportunistic definitions of unacceptability led to numerous, non-comparable, ad-hoc operationalisations and conceptualisations of unacceptable behaviour. A theoretically robust umbrella definition that can include any form of unacceptable behaviour is thus missing. Third, nurses’ informal dealing strategies have not been investigated in literature. Despite the acknowledgement that the vast majority of unacceptable behaviour is unreported, scholars have overlooked informal strategies nurses use to deal with perpetrators that enable them to continue with their working tasks. Finally, in the fourth gap, authors have often compared their results with studies held in culturally different settings without questioning the transferability of the findings. Cross-cultural qualitative studies are needed because quantitative ones held in culturally different settings have suggested that unacceptable behaviour is culturally shaped (See Section 2.5).

Drawing upon the literature, I have discussed how the concept of unacceptability is socially constructed and context-related, which suggests that a qualitative approach is necessary to properly investigate the four identified gaps. In Chapter 3, I critically discuss the concept of unacceptable behaviour and test the most relevant sociological definitions against my research aim. I argue that the definition that best suit my thesis is that of Goffman’s situational impropriety (1963a, p.193). Based on this, in Chapter 4, I discuss the chosen goffmanesque theoretical framework that supports my qualitative analysis, in particular, Ensink’s (2003) socio-linguistic expansion of Goffman’s frame analysis. Then, in Chapter 5, I discuss my research question and the specific methodology chosen to answer it.

# Chapter 3 – Literature Review on the Conceptualisation of Unacceptable Behaviour in the Sociological Literature. From Violence to Situational Improprieties

## 3.1 – Introduction

In the previous chapter, I discussed how the literature on unacceptable behaviour in A&Es is mostly focused on physical violence and thus overlooks other forms of unacceptable behaviour. In Section 2.5, I argued for a suitable concept that can embrace all forms of unacceptable behaviour to allow scholars to fully understand what happens in A&Es. In order to find a more inclusive concept in this chapter, I explore, discuss, and test against my research needs the most relevant sociological ones, which have previously been adopted to research unacceptable behaviour in different contexts. The guiding principle of my review is that the concept I adopt must be able to acknowledge the social and interactional nature of unacceptability.

The chapter opens with the concept of violence and its major forms but, as was discussed in Section 2.3, due to its relation to violence, the concept of workplace violence is not included. In Section 3.3, I discuss the concept of deviance and that of anti-social behaviour, its most recent adaptation. In Section 3.4, I discuss the concept of incivility as elaborated by Elias (1982), followed by its two more recent re-elaborations: rudeness by Phillips and Smith (2003; 2004; 2006) and workplace incivility by Andersson and Pearson (1999). Finally, in Section 3.5, I introduce the concept of ‘situational impropriety’ by Erving Goffman (1963a, p.193).

Other concepts could have been discussed in this chapter, and some of them were adopted in the body of literature critically reviewed in Chapter 2, such as abuse and threat. However, my decision on what to include and discuss has two grounds: the concept’s ability to substitute other terms, for example, as ‘violence’ is adopted in the literature to include ‘workplace violence’, ‘abuse’, ‘assault’, or ‘aggression’ (Luck et al. 2007b); and their sociological relevance, as concepts such as ‘assault' draw their meaning from legal acts rather than sociological theories.

## 3.2 – Violence, a Brief Literature Review

The concept of violence is widely adopted in the literature previously discussed, often as workplace violence, to indicate that the victim was at work when the violence occurred (Di Martino, 2003). Moreover, this concept can be found in almost any body of literature that investigates conflictual interaction or unacceptable behaviour (Stanko, 2001). Nevertheless, a clear and shared definition of it does not exist in sociology or criminology, and violence is instead adopted as a self-explanatory concept. As Staudigl (2007) has argued, sociologists even use violence as a primordial concept that cannot be further described or broken down; it is an objectively existing phenomenon, unproblematic because it is self-evident. In consequence, the sociology of violence is rather the sociology of its reasons (Ibid, p236).

Violence is thus differently defined based on authors’ understanding, focus, and methodology, which results in an abundance of definitions that are difficult to summarise. Nevertheless, these can be organised along a continuum that spans the ‘minimalist conception of violence’ to the ‘comprehensive conception of violence’ poles (Bufacchi, 2005, p.197).

### 3.2.1 – The Minimalist Conception of Violence

Violence is here defined within its physical and intentional terms, and it etymologically derives from the translation of the Latin word *violentia*: vehemence, a passionate and uncontrolled force. Violence is thus mostly understood as physical and defined within a legal and criminological framework focused on

‘the outcome – how badly the person was hurt – injury, proof of identity of the particular assailant and so forth – and the intention, *mens rea* of the violent act.’ (Stanko, 2001, pp315-16)

Other forms of violence, such as verbal (in the case of an insult), psychological (in the case of mobbing), emotional (as with domestic abuse), or structural (as with unequal wealth distribution), are all bereft of bodily contact and are thus ignored, regardless of their destructive outcome.

This minimalist understanding of violence is often adopted by authors of articles grouped in ‘Practical Solutions’ (Section 2.4.1) and ‘Profiling of the Perpetrator’ (Section 2.4.2), where the focus is mostly on physical violence or other behaviour that might lead to physical trauma or injury.

The origin of this conception can be traced to the founding fathers of the social sciences, who conceptualised it as a natural, unavoidable part of human nature (Hobbes, 1651, p78; Locke, 1823). They both discussed violence as proper to the anarchic state of nature, suggesting that men escaped their unpleasant and dangerous natural life by adopting a social contract. Men must renounce part of their freedom of action in favour of a more organised, limitative, and structured order of interaction. Violence is thus primordial and natural, a mostly direct physical act against someone who becomes a victim to limit someone’s freedom of action, either by harming the victim or seizing the victims’ resources.

Sociologists and other scholars of social sciences did not significantly distance themselves from this position until the Second World War. Neither Weber (1970) nor Simmel (1903) offered a definition of violence; rather, they considered it a residual category of power (Sannella, 2017, p24), a self-explanatory concept roughly defined through its physical and tangible consequences and identifiable with illicit physical acts committed outside the state authority and monopoly of physical coercion. Nevertheless, it is through this analytical distinction between the legitimate and illicit use of physical force (violence) that new definitions of it emerged in the sociological field. Following the Second World War and the Holocaust, the licit-illicit distinction faded, and new and non-physical forms of violence became increasingly evident. Minimalist conceptions lost their position within academia and, at a much slower pace, among legislators, and contactless and indirect forms of violence were recognised and acknowledged, while the state’s authority and legitimacy to use any form of coercion was questioned. The analytical focus shifted to the unequal distribution of resources and the identification of repressive and discriminatory forms of social organisation (McKie, 2006).

Nevertheless, despite this intellectual and juridical shift, the minimalist perspective still holds great importance in today’s conceptualisation of violence. It can be defined as the ‘traditional’ one since it still resonates in Western legal, popular, and academic narratives (Stanko, 2001, pp315-16). An example of this is that three out of the four studies discussed in Chapter 2 limit their description of violence to acts of physical aggression. Moreover, this resonance can clearly be observed in both the English and Italian legal frameworks. Starting with the former, the legal definition of violence is predominantly oriented toward the identification of the use of physical force or of negative physical outcomes for the victim (Stateva, 2009). In fact, the Crown Prosecution Service defines violent crime as ‘Murder and manslaughter’, ‘Throwing corrosive substances’, ‘Assaulting, or physically hurting another person’, ‘Gun and knife crimes’, and ‘Robbery’ ([CPS,](https://www.cps.gov.uk/violent-crime) 2017). In addition, according to the Office for National Statistics ([ONS,](https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/methodologies/userguidetocrimestatisticsforenglandandwales#offence-types) 2019), until the 1998 revision, violent crimes were characterised by, or linked to, the use, or threatened use, of physical force.

Concerning Italian legislation, similar to the English system, it only recently opened its definition of violence to non-physical interactions, although this link is still quite ambiguous (Macrì, 2016). Violence is still broadly defined as a physical interaction that leaves observable and diagnosable outcomes, such as punching or knifing, and if these are not evident, violence is generally excluded. However, it has recently been extended to certain forms of verbal and psychological violence, although this is limited to highly specific words and behaviours (Zanasi, 2006).

### 3.2.2 – The Comprehensive Approach to violence

Comprehensive approaches to violence extend the definition of violence to non-physical interactions, focusing on verbal abuse, psychological pressure, and structural or institutional forms of deprivation and segregation. Although these definitions have found acceptance in academic, political, and social discourses (for instance, stalking has recently been incorporated into Italian law), elaborate definitions still lack clear boundaries because they stretch the meaning of violence to include ‘anything avoidable that impedes human realization’ (Keane, 1996, p.66). In this perspective, the concept of violence becomes too vague, and it is indistinguishable from concepts such as oppression, misery, or alienation.

From the analytical perspective, comprehensive approaches shift the definition of the victim from a single person to social groups. Among the first to develop a convincing, comprehensive definition is Foucault (1961), who introduced the concept of institutional violence to denounce how the modern state exercises violence on its citizens. The French philosopher claimed that, through the abuse of legitimate power, the state institutionalised a pervasive, constant control over social irregularities, such as madness or specific forms of sexuality, to suppress differences and to push those considered ‘different’ to the margins of society (Foucault, 1961; 1963).

Galtung (1969) further developed the idea of violence as the systematic institutionalisation of the limitative propriety of violence – that is, the limitation of the victim’s freedom of action or the seizure of his/her resources – into the concept of structural violence. According to the author, arrangements that cause harm and injury to certain groups of social actors are embedded in the political, economic, legal, religious, or cultural structures. Violence thus becomes the

‘avoidable impairment of fundamental human needs; the impairment of human life, which lowers the actual degree to which someone is able to meet their needs below that which would otherwise be possible.’ (Galtung, 1993, p.106)

Examples of such articulated limitations imposed on specific social groups, or even societies, are poverty and hunger, as well as racism and sexism. Structural violence manifests as unequal power distribution and, consequently, as unequal life chances (Galtung, 1990).

Finally, similar to structural violence is the concept of symbolic violence that Bourdieu developed (Bourdieu and Passeron, 1977; Bourdieu and Passeron, 1990). With this concept, the French sociologist described social actors’ unconscious perspective on social relations, a consequence of unequal power distribution proper to the social context in which they grow up. Here, the limitations societies impose on victims consist of an ideology that

‘impose[s] the means for comprehending and adapting to the social world by representing economic and political power in disguised, taken-for-granted forms.’ (Swartz, 1997:89)

Symbolic violence is thus externalised and made actual through interpersonal violence, since the latter is guided and justified by the former (Grosz, 1993). The concept of symbolic violence is best explored by feminist authors who study violence against women not as sporadic events attributable to few men, but as the consequence of a patriarchist culture that sees women as men’s propriety (Andermahr et al, 1997, p.234).

### 3.2.3 – Final Remarks on Violence

To recapitulate, violence is a powerful and complex concept and has been widely adopted in studies on unacceptable behaviour in the workplace (Di Martino, 2003). It is mainly assumed to be physically aggressive interaction, but it can also indicate verbal abuse such as “shouting” or “ranting” (O’Bernie et al 2004) or “verbal sexual transgression” and “no respect for sexual orientation” (Hahn et al, 2008). However, such broad use creates confusion, and the concept itself is difficult to treat because it has never been clearly and univocally defined. Different and contrasting definitions co-exist (see Section 2.3 with regard to workplace violence), and social scientists adopt it as self-explaining concept that is generally defined as limitations imposed on the victim’s freedom of action (Staudigl, 2007).

Based on the discussion offered above, I believe that using violence, in its minimalist definition, would allow me to provide a clear definition of unacceptable behaviour. This would support the further comparison of data (for instance, with the British Crime Survey) and would promote precise policies aimed at reducing the diffusion of physical aggression. However, as previously discussed in Chapter 2, physical aggressions are less frequent than verbal ones or other non-physical behaviour that is perceived as unacceptable. Thus, its adoption would limit my exploration, narrowing it to only unwelcome physical interactions. Moreover, although broader definitions of violence are available in the literature (Speroni et al, 2014, Wolf et al, 2017), in agreement with Stanko’s claim of the perseverance of the traditional definition of violence (Stanko, 2001, McKie, 2006), I believe that the use of this word could improperly point the participants’ attention to physical confrontations. This would reproduce the excessive focus on physical violence evidenced in the literature (Ferns 2005a, Lau et al, 2012b), resulting in overlooking other unacceptable behaviour, such as acts of rudeness or incivility. Finally, the minimalist conception of violence describes violence as an interpersonal act, limiting its applicability to broader groups of actors. Although this could be solved by opening the concept of violence to a comprehensive definition, which would allow for an exploration of informal institutional limitations imposed on specific groups of actors such as the GOMERS (Jeffery, 1979), it would then become impossible to use violence univocally. In conclusion, in agreement with Staudigl (2007), I believe that it is impossible to comprehend the meaning different actors assign to violence. This is incompatible with my aim to research the informal group culture of A&E nurses. Therefore, the concept of violence is unsuitable to support my study.

## 3.3 – Deviance

Although the concept of ‘deviance’ is rarely adopted in my selected literature (only by Jeffery, 1979 and Blando et al., 2013), it is a powerful concept, that social scientists and scholars from different disciplines often adopt to describe behaviour perceived as not in line with expected social standards. Introduced by the mathematician Adolphe Quetelet (1835) to indicate the difference between the ‘average’ (or ‘normal’) and the ‘deviant’ man, his attempt failed due to the impossibility of defining ‘normality’. Nevertheless, his conceptualisation of deviance as detachment from a hypothetical normal conduct of behaviour is still present (Landau and Lazarsfeld, 1968).

Durkheim (Poggi, 2000, pp.85-95) reinterpreted the concept and rejected the image of the deviant as abnormal, instead proposing deviancy as normal human characteristics, endogenous of the social body. He argued that a behaviour is not ontologically deviant; rather, it becomes so when so defined by a social group with sufficient social capital to impose its own evaluation, and it can be observed based on the reaction it provokes in bystanders who observe it (audience). Contrary to Quetelet’s definition, Durkheim theorised that deviancy can also be positive, such as in cases of heroism or extraordinary, pro-social behaviour. Finally, evaluations can change over time due to new societal predispositions toward certain acts, and the behaviour can be judged differently by different audiences, or according to the specific social occasion. Thus, a deviant behaviour can instead be accepted or even encouraged by different social groups or on different social occasions.

More recently, Howard Becker (1963) has elaborated on Durkheim’s work, reconnecting it to that of Quetelet. He further explored Durkheim’s idea of deviancy as a social definition attached to certain behaviour, an idea that developed the famous labelling theory (Ibid), but focused his interest on negative cases only. Becker has suggested that social groups establish norms whose violation constitutes deviance, labelling those who fail to respect them as deviant. Actors who receive this label must prove their social redemption to have it removed, but it is possible that they might fail to redeem themselves, might be unable to do so, or may even be denied redemption. For these, the label becomes a permanent stigma (Goffman, 1963), attracting implicit negative expectations toward them, independently of their actual deviations from social standards (Henry, 2009, pp.297-98). An example of this can be observed in Section 2.4.3, where I discuss how A&E nurses show minor empathy toward the so-called GOMERS (Jeffery, 1979; Lyneham, 2000; Ferns, 2005b).

The above example drawn from my literature review also supports the claim that, today, most accepted definition of deviance refers to that of Quetelet (Liazos, 1972) which designates

‘social behaviours, practices, acts, demeanours, attitudes, beliefs, styles or statuses which are culturally believed to deviate significantly from the norms, ethics, standards and expectations of society. […] Deviance is a culturally unacceptable level of difference which is subject to constant suspicion and surveillance from social control agencies.’ (Sumner, 2001, p.89)

At the theoretical level, the concept of deviancy is more flexible than that of violence, as it can be extended to a larger group of behaviours without losing clarity, as with the comprehensive definitions of violence. In fact, any deviant behaviour can be quite easily retraced to a failure to meet an audience’s expectation. It also allows for the definition of acts of violence (in their minimalist conception) as non-deviant if performed by children or users with mental disabilities, which is in agreement with the literature (Luck et al, 2007b) and my constructionist stance, because an audience would still evaluate these as acceptable. Moreover, contrary to violence, this concept allows for the understanding of nurses’ explicit hostility toward certain groups of users, thus making sense of the discussion of nurses as perpetrators offered in Section 2.4.3 (Hegney et al, 2003; Pich et al, 2010; 2011; Pinar and Ucmak, 2011). This would further allow for the exploration of nurses’ informal culture and expectations in terms of users’ behaviour (Levine et al, 1998; 2003; 2006; Ferns, 2005b; Gillespie et al, 2013).

However, once tested against my research aim, the concept of deviance presents significant flaws that prevent its application in my thesis. First, since Becker reworking of Durkheim’s idea of deviancy, social scientists have focused more on the process itself rather than investigating how these labels are created or the basis of this idea of normality (Misztal, 2001). Different social groups promote different ideas of normality and thus of deviancy and, although scholars have acknowledged these differences, the vast majority of them deliberately choose to ignore its intrinsic qualitative nature. A more normative and quantitative approach based on observable law-breaking behaviour is thus preferred in the literature (Phillips and Smith, 2003). This impacts current studies on deviancy, imposing formal definitions (or definitions produced by the most powerful social groups) over local or group-specific definitions. This shift toward the formal definition of deviance is discussed in the literature as the on-going process of the criminalisation of deviance (McSherry et al, 2008; Muncie, 2008), which started in the 1970s when governments expanded the definition of crime to include many unsanctioned, unacceptable behaviours (Sumner, 1994; Miller et al, 2001; Goode 2004). The state’s interest in deviant behaviour that was easy to define and identify impacted academic research, shifting the focus toward physical and observable behaviour, such as physical violence or street-level crime (Liazos, 1972; Phillips and Smith, 2003) or deviant sexual behaviour (Gagnon and Simon, 1968; Goode, 2015; Worthen, 2016). This ignored deviant but not illegal behaviour, such as acts of rudeness or incivility, which are deviant by definition since they do not conform to expected, normal, and acceptable behaviour.

With reference to my literature review, I believe that this resonates with my analysis of the so-called discussion on the ‘culture of silence’ (Jones and Lyneham, 2000; Luck et al, 2007b; Pich et al, 2010) offered in Section 2.4.3. What emerges from the literature is that nurses and researchers define unacceptability differently, but, in agreement with the claim made by Liazos (1972), the definition of the former is excluded from formal reports, which are conceived by the latter, resulting in a focus on physically violent behaviour, which is easier to record and assess and is of greater interest for the hospital administration. The concept of deviance is thus emptied of its original meaning, and it becomes more of a legal concept than a sociological one.

### 3.3.1 – Anti-Social Behaviour

Following the analysis of deviancy traced above, I believe that anti-social behaviour represents its most recent evolution. Introduced in the UK in the 1990s, Anti-Social Behaviour Orders aimed to provide local authorities and police officers with an effective tool to address unacceptable behaviour that escaped legal definition or was almost impossible to prosecute in court. The concept was thus introduced to contrast with unspecified behaviour that caused major distress and represented a sign of moral decay (Burney, 2005, p.7). The concept of anti-social behaviour implies a paradigmatic shift: instead of focusing on the performed behaviour, which is often difficult to define, it draws its legitimacy from the victim’s perception and definition of what is unacceptable. In agreement with its procedural and legal purpose, the definition of what is antisocial was at first deliberately lacking, making it flexible and, according to its supporters, effective (Field, 2003; Squires, 2008).

However, similar to the criticisms of the comprehensive approach to violence, many scholars have noted that such an open definition can allow almost anything to be defined as antisocial, leaving the burden to prove what is antisocial to the individual, which soon becomes what those with higher social capital define as antisocial at the expense of immigrants, the homeless, minorities, and the young (Squires, 2006; Millie, 2008; Prior, 2009). Police officers also shared this position and reported being unsure about when and how anti-social behaviour orders were supposed to be applied (Bland and Read, 2000). Following these criticisms, the legislature produced a more detailed definition of anti-social behaviour, including a list of typical cases. However, the definition remains open to interpretation, and anti-social behaviour is still imprecisely defined as a persistent

‘(a) conduct that has caused, or is likely to cause, harassment, alarm or distress to any person, (b) conduct capable of causing nuisance or annoyance to a person in relation to that person’s occupation of residential premises, or (c) conduct capable of causing housing-related nuisance or annoyance to any person.’ (Anti-Social Behaviour, Crime and Policing Act 2014)

As result, due to the low criminal relevance of many of the behaviours prosecuted, the concept of anti-social behaviour blurs the fundamental boundaries between civil and criminal law. It incorporates both the punitive purpose of criminal law, such as physical restrictions, and the compensatory purpose of civil law, such as parental supervisors for those unable to deal with their problematic children.

Despite the recent improvements, the concept remains vague and unclear, and it is unrelated to specific legal, ethical, and theoretical backgrounds. According to Millie (2006), this has caused significant confusion that has resulted in the criminalisation of the usual suspects (Burney, 2002; Wood, 2004; Burton, 2008; Jacobson et al, 2008; Moore, 2008; 2010; 2012). With reference to my analysis of the literature on unacceptable behaviour in A&E, the targeting of the usual suspect fits, again, with the victimisation of GOMERS (Lynehams, 2000; Quintal, 2002).

### 3.3.2 – Final Remarks on Deviance and Anti-Social Behaviour

In conclusion, I believe that, although the concepts of deviance and anti-social behaviour largely represent a suitable constructionist definition of unacceptability, they do not fully suit my research aim. Although they can overcome the major issues that characterise the concept of violence, such as the excessive focus on physical interactions, two main flaws prevent their adoption: the lack of exploration of the social definition of unacceptability, and the lack of distinction between voluntary and involuntary behaviour. Concerning the former, both concepts acknowledge the intrinsically social nature of unacceptability, but they do not allow for an exploration of the basis of the expected normality. This retrospective analysis is vital to my exploration since, as discussed in Section 2.4.3, staff members tend to standardise their personal definition to that of the group. In fact, one of the reported causes of the culture of silence is that A&E nurses are afraid to be considered poor co-workers who cannot deal with certain types of patients. Staff members thus find it necessary to orient their definition and reactions toward the group definition of what is unacceptable. An exploration of this tacit expectation is therefore necessary, but neither of the two concepts allows for it.

Concerning the second flaw, the voluntary or involuntary nature of unacceptable behaviour is not considered. Even if it is not voluntary, a behaviour might still be considered deviant or antisocial. The nature of the behaviour and, especially for anti-social behaviour, the effects of distress it produces are the only relevant characteristics. However, as previously discussed in Section 2.4.3, a behaviour that actually causes distress may not be perceived as unacceptable. For instance, aggressive patients with mental health conditions clearly create alarm and distress, but their behaviour is considered acceptable because it is in line with their medical condition (Luck et al., 2007). The perceived clear intention behind an act results is one of the four main drivers of staff’s definition of unacceptability (see Figure 2.4, p.26), whereas the concept that most suits my research aim must be able to address this specificity.

## 3.4 – Incivility

A concept that fascinated me during my search for the most appropriate concept is that of incivility presented by Norbert Elias in his seminal work *The Civilizing Process* (1982 [1969]). In this book, Elias recalls the sociogenesis of modern Western civilisations through the analysis of ‘advice books’ and ‘courtesy’ manuals of the last nine centuries. He argues that, with the end of the Middle Ages, Western societies became more complex and interconnected, with a significant increase in interactions between men of different social extractions. The new societal and economical organisations increased the level of interdependence, requiring more peaceful and stable relations between members of different social groups. If, at the political level, the slow process of the monopolization of violence by the new centralised state reduced inter-group conflicts, according to Elias, what allowed for more stable social interactions was a ‘psicogenetic’ transformation: an increasing level of self-restraint and self-regulation to be exercised by individuals (Ibid, 35-7). The psychological ethos of Western people was gradually readjusted, promoting empathy toward others with whom it was now necessary to live (Brown et al, 2015). This change, internal to the social actor, took place following the re-elaboration, at the social level, of the emotion of disgust (Phillips and Smith, 2004). Disgust become the natural reaction to behaviour that was inappropriate to members of civilised social groups, such as some violent interactions (in their minimalist conception), loud public behaviour, or the public performance of certain bodily functions (Elias, 1982, p.85-89). The new Western inhabitants thus self-restrained their public behaviour to avoid causing disgust in others, or they would have been considered members of lower, uncivil classes (Ibid). In fact, due to the increasing occasions of social interaction, the upper classes felt the need to visibly differentiate themselves from the lower ones with whom they were now forced to interact (Vaughan, 2000). This distinction was predominantly behavioural and focused on manners and public performances, since the rising nobility of sword, first, and middle class, later, were now becoming rich enough to challenge the nobility of land in terms of expensive clothes or other signs of wealth.

In the present day, drawing upon the work of Elias, incivility is a social construction adopted to define behaviour not suited for civilised actors, the behaviour proper to less respectable classes such as those identified in Chapter 2 with the acronym GOMERS – usually drunks, addicts, homeless people, or others whose condition should not require them to be in an A&E (Lyneham, 2000). This is in line with Phillips and Smith’s (2003, p87) analysis of current discourses around incivility, a term often adopted to indicate ‘behaviour usually involving strangers and considered threatening’, which is generally performed by members of less socially powerful groups when they enter normal or respectable social environments (Sampson and Raudenbush, 1999, p603). This definition explains the focus, in current literature on incivility, on young people, migrants, the homeless, minorities, and, more generally, those lacking social resources (Taylor, 1999; Sennet, 2003; Reisig and Cancino, 2004; Mackenzie, 2005; Rosenstein and O’Daniel, 2008; Brown et al, 2015).

The concept of incivility is therefore suitable to explore the definition of unacceptability, since it allows for the inclusion of any behaviour independent of its nature. However, its application is limited to those studies aimed at identifying such behaviour. However, I believe and argue in this section that it loses its analytical strength if the aim is to explore the reason for such incivility. I believe that this concept suffers from a limitation similar to that of the first definition of anti-social behaviour: it lacks a stable and (roughly) understandable-to-all definition. Incivility is fully based on what the audience judges to be so, which is also its main strength in guiding behavioural changes. Similar to deviance and anti-social behaviour, this indissoluble dependence on audience’ definitions leads to the questions of who the audience is and where it acquires the legitimacy to assess the uncivil nature of an act.

Moreover, Elias’ idea of incivility finds its actualisation in the disgusted reaction that it causes in the observing actors. However, as Phillips and Smith have discussed (2004, pp.382-83), disgust is no longer a common reaction to unacceptable behaviour in today’s society. Rather, feelings of fear, frustration, anger, or coldness seem to be more common in Western societies (Ibid, pp.392-93), as well as among A&E nurses (see Section 2.4.3). This, of course, does not indicate that Elias’ work is no longer applicable; rather, a re-elaboration of it is necessary. Two more recent developments in Elias’ work emerged from my search for a suitable concept, and both attempt to develop a more precise definition of current uncivil, and thus unacceptable, behaviour: rudeness, by Phillips and Smith (2003, 2004, 2006; Smith, Phillips and King, 2010), and workplace incivility, by Andersson and Pearson (1999). These are presented and discussed in the following sections.

### 3.4.1 – Rudeness

One of the most recent investigations on incivility is that proposed by Phillips and Smith (2003, 2004, 2006; Smith, Phillips and King, 2010). The authors suggest that contemporary studies on unacceptable behaviour are excessively focused on

‘infractions of the law … [leaving unexplored] … the varieties of deviant-but-not-illegal behaviour that cannot be easily detected by outsiders.’ (Phillips and Smith, 2003, pp.87-8)

Offering a criticism similar to that of Pich and colleagues (2004), Phillips and Smith (2003) have suggested that this gap is due to the increasing focus on observable and easily recordable acts of low-level deviancy caused by a convergence of international political agendas toward the punishment of physical incivilities such as vandalism, loitering, and graffiti (Ibid, pp.85-6). Since these incivilities are easily recordable and are of interest to policy-makers, scholars focused on a new, policy-informed definition of incivility, excluding from the research agenda ‘the full range of incivil experiences as these are deﬁned by ordinary social actors’ in public places (Ibid, p.88). Aiming to fill this gap, Phillips and Smith developed the Melbourne Everyday Incivility Project (Phillips and Smith, 2003, 2004), which has evolved into the ELIAS project – the Everyday Life Incivility in Australia Survey (Phillips and Smith, 2006; Smith, Phillips and King, 2010). Adopting a qualitative methodology, they explored the topic of incivility (rudeness) through the viva-voce of Melbourne citizens, identifying several forms of rudeness usually overlooked by research on crime and deviancy (Ibid, p.88). However, their categorisation of rude behaviour did not overcome the classic dichotomy of physical/verbal. Based on the examples the authors provided (Smith, Phillips and King, 2010, pp.23-26), they actually identified behaviour that escapes this dichotomy, but they failed to follow up and distinguish between direct and indirect acts of rudeness (for instance, they do not differentiate between inadvertently ignoring or voluntarily ignoring a bystander), thus failing to explore non-verbal and non-physical behaviour, such as being careless of others. In addition, from their work, it is not possible to understand whether what makes a verbal interaction as rude, i.e., an answer, is the message or the way the message is communicated, such as the voice tone or the actor’s attitude. Moreover, it remains unclear if physical contact should be considered rude because of the invasion of physical space it implies, or because it happens in a place in which conditions would have made it preventable.

Another behaviour that escapes Phillips and Smith’s definition of rudeness is the voluntary absence of action or communication of an actor. For instance, parents who deliberately avoid taking action toward their over-excited children might be sanctioned under the ASB legislation, but they would escape rudeness. Similarly, the lack of a public servant’s engrossment, for instance a nurse, might be considered rude by a father bringing his child to the A&E (Hegney et al, 2003; Pich et al, 2010; 2011; Pinar and Ucmak, 2011), but it would still escape Phillips and Smith’s definition. Finally, like the other concepts discussed thus far, rudeness is considered unidirectional. Thus, the concept does not consider the possibility that the observer or narrator might have negatively influenced the interaction and be the real cause of someone else’s rudeness. Similarly to my criticisms of those articles and research discussed in Sections 2.4.1 and 2.4.2, unacceptable behaviour cannot be considered something that simply happens, or at least not always. I further discuss this point in the following section on workplace incivility.

Following the last consideration above, I believe that Phillips and Smith’s limited attention to non-verbal and non-physical social aspects of interpersonal communication is due to their focus on interactions in public places. Contrary to workplace interactions, which require the acknowledgement of the social occasion and a correct demeanour, as per Elias’ definition of incivility, encounters in public places are mostly brief and casual, and there is no need for structured, intense, or prolonged interactions.

In conclusion, Phillips and Smith’s concept of rudeness is certainly an interesting concept, and it allowed me to critically reflect upon my research aim; however, it bears the same limitations of that of incivility. Although the authors explored the criminological perspective and definition of what is unacceptable from the ordinary social actor’s perspective, they did not manage to delve into the vast range of unacceptable behaviour that actors experience in their everyday lives. Moreover, they overlooked definitions of unacceptability driven by the specific nature of the setting of interaction, and they did not consider the mutual expectations of the actors involved.

### 3.4.2 – Workplace Incivility

Based on the work of Norbert Elias, Erving Goffman, and the interactionist school, the concept of ‘workplace incivility’ was developed in 1999 by Andersson and Pearson to indicate those unacceptable behaviours, common in workplaces, that are not serious enough to be defined as workplace violence, mobbing, or bullying. They defined them as

‘low-intensity deviant behaviour with ambiguous intent to harm the target, in violation of workplace norms for mutual respect. Uncivil behaviours are characteristically rude and discourteous, displaying a lack of regard for others.’ (Andersson and Pearson, 1999, p457)

Conceived as preceding more serious unacceptable behaviour, workplace incivilities are acts that might be perceived as rude or disrespectful and that, despite being quite irrelevant per se, might cause a reply of greater intensity. In Andersson and Pearson’s model, workplace violence is the natural consequence of an interactive process that starts with a perceived workplace incivility. Violence (in its minimalist or traditional conception) is the final consequence of an escalation that sees both the parties involved as co-responsible: the one who started it and the one who reacted with another incivility. This negative, self-reinforcing interaction is represented with the concept of the ‘incivility spiral’ (Ibid, p458). Similar to a vortex, it gains more power with each twist, leading to more serious confrontations (Pearson, Andersson, and Wegner, 2001).

The ‘ambiguous intent to harm’ is thus central in the definition of workplace incivility (Andersson and Pearson, 1999, p457). Contrary to the concepts previously discussed in this section, unacceptability is no longer socially defined, as it was for deviance or incivility. Rather it is defined in interaction, since unacceptability lies in the perceived intent to harm, insult, or simply annoy. For instance, for a patient to be demanding is neither a crime nor a socially defined act of deviance. Rather, from the user perspective, it would be a positive attitude since it might ensure better services. However, nurses might perceive such behaviour as unreasonable, especially if the patient’s condition does not require specific care or attention. However, to define such behaviour as acceptable (reasonable) or not is a decision that rests in the nurse’s hands: it could either be that the patient is scared and does not understand his/her real condition, or that the patient is trying to bully the nurse or take undeserved advantage of his condition – e.g., to obtain an extra dose of opioids. The intention to harm, or in this case to misbehave, is in fact ambiguous.

By introducing the concept of ambiguity, Andersson and Pearson reveal the importance of victims’ perceptions since, similar to anti-social behaviour, only the nurse involved can define a behaviour as unacceptable independently of the real intention to harm. Based on this definition of the situation, a nurse can implement a vast range of interactional solutions. If a malicious intent is perceived, s/he might abruptly ask the patient to stop; however, this could start an incivility spiral that might lead to unknown, worse consequences. Otherwise, if an intent is not perceived, the nurse might dedicate more time to explain his/her medical decision, and s/he might even make a joke about it. This would give the perpetrator the opportunity to hide the intention to harm, to correct his/her behaviour, or to apologise (Andersson and Pearson, 1999, p461).

Contrary to the concepts previously discussed in this chapter, victims are conceived here as active subjects capable of interactional solutions that might both affect the on-going situation as well as their status of victim, thus becoming the real perpetrator if the intention to harm is found where none exists. This recalls the ‘Solutions’ category of the Ecological-Occupational Health Framework (Levine et al, 1998 – see Section 2.4.3), which indicates victims’ ability to influence the outcomes of unacceptable interactions. Similarly, with workplace incivility, actors can doubt or ignore the intention to harm, independently of its real presence, and initiate interactions that will prevent the development of an incivility spiral. Workplace incivility is therefore the only concept discussed here that allows for an understanding of the interactional nature of unacceptable behaviour.

This concept was conceived to explore workplace horizontal interactions, and it provided significant insight to scholars of organisational studies (Hutton and Gates, 2008; Guidroz et al., 2010). However, as was discussed in section 2.2, I am interested in worker-customer interactions, or Type 2 (UIIPRC, 2001), and this concept has never been adapted to this purpose. Andersson and Pearson’s approach is in fact intrinsically limited to horizontal incivility, since it relies on ‘workplace norms for mutual respect’ (1999, p.457). These norms might be unknown to service users, patients, or customers, or they simply might not apply to them. For instance, the standard rule ‘do not scream or shout’, which generally promotes a healthy work environment, might be inapplicable for a patient in severe pain, as well as for some overly stressed companions. Thus, formal workplace rules might be valid for, or applied to, staff members only.

Furthermore, in relation to the point above, workplace incivility cannot consider informal rules that guide actors’ perspectives and understandings of the situation. As was previously discussed (see Section 2.4.3), it is reported in the literature that nurses’ definitions and reactions are guided by informal group rules (Crilly et al, 2004; Albashtawy 2013; Wolf et al, 2014). For instance, a nurse might perceive a behaviour as unacceptable, but the rest of the team might see it as legitimate in that specific case or because of that specific patient. In this case, the initial victim (nurse) might start a spiral that would appear senseless to his/her co-workers, who would perceive him/her as the real perpetrator: someone who provokes or overreacts, putting the whole department in danger by causing incivility spirals that could lead to more serious unacceptable behaviour.

In conclusion, of the concepts discussed, the concept of workplace incivility is the closest to the overarching concept I need to explore the vast range of unacceptable behaviour. However, it is not apt to support my exploration because a formal benchmark is not always applicable in nurse-user interactions and because it cannot consider work-group cultures, informal rules, and social pressure. Nevertheless, workplace incivility played a significant role in my identification of the concept adopted in this thesis, since it allowed me to reflect upon the ambiguous and interactional nature of unacceptable behaviour, as well as on the active role of all the actors involved that strongly relate with Levine and colleagues’ dynamic category of ‘solutions’ (Levine et al, 1998).

## 3.5 – Situational Improprieties: Unacceptability as Violation of the Expected Contextual Normality

From the literature discussed in Chapter 2, I have concluded that the distinction between what is acceptable and what is not is both socially constructed and context-related. In this Chapter, I have discussed and tested the most relevant sociological concepts adopted in literature against the specific reality of A&Es to indicate unacceptable behaviour. Each of these contributed to my understanding of what unacceptability is, although none of them were ultimately fully suitable to pursue my research interest. The most significant issue with these concepts is their inability to take into account the contextual characteristics of each interaction, and they overlook the specific behavioural expectations related to the specific context in which the interaction takes place.

Drawing upon the potential acceptability of physical violence in A&E, and in agreement with my search for a constructivist approach, it is my understanding that, to investigate unacceptability, it is first necessary to investigate the expected acceptability. More precisely, in order to understand what A&E nurses define as unacceptable behaviour from users, it is also necessary to investigate what they consider normal and acceptable. This perspective finds support in the work of Misztal (2001) who argues that an analysis of unacceptability inevitably implies a critical analysis of what is to be considered acceptable and normal because these concepts are ‘invariably normative and […] always a social construct.’ (Ibid, p.313) Normality, according to her, does not stand alone; rather, it is defined by a set of taken-for-granted values, definitions of the situation, and performances. These must be shared and acknowledged by the actors involved and their audience, thus allowing for the mutual reinforcement of the shared definition of what is normal and what is not. Reinforcing and satisfying each other’s expectations, actors make the surrounding world predictable and acceptable:

‘actors sustain each other’s expectation of ‘things as usual’, which leads them to judge such a situation as normal. When we sense that everything seems in proper order.’ (Lewis and Weigert, 1985, p.974)

It is therefore possible to assert that an unacceptable behaviour is one that deviates from the constant flow of normal, acceptable events. If normality is based on taken-for-granted assumptions, which are by definition unquestioned, abnormalities can offer the key to accessing the taken-for-granted normality, which in turn provides further understanding of perceived unacceptability (Stenberg, 2009, p.439).

The most notable theorist of perspective on unacceptable behaviour is Erving Goffman who, as discussed by Verhoeven (1985), was an acute observer of taken-for-granted normalities and their rituals, of that tacit and unquestioned proper public conduct misbehaver fails to conform to. In order to access such unspoken assumptions that regulate actors’ everyday life, Goffman developed a negative approach based on the study of ‘inappropriate behaviour’, ‘misconduct’, and ‘situational impropriety’ (Stenberg, 2009, p439). Using them as leverage to break the taken-for-granted social order, he was then able to make sense of unacceptability. Goffman developed a coherent analytical framework of micro-sociology of everyday life, discussed in Chapter 4, that allows for the exploration of both expected normality and unexpected, unacceptable behaviour. Central to his analysis is the concept of ‘situational impropriety’, behaviours performed in a social occasion, not necessarily directed at someone, that come across as ill-suited according to the frame that gives sense to that social occasion, or that is used to make sense of that behaviour (Goffman, 1963a, p.193). To these, he opposes ‘situational proprieties’, which are defined as

‘common courtesies and culturally learned, practical knowledge about posture, spatial arrangements, tone of voice and so forth appropriate to a situation.’ (Smith, 2006, p.37)

A thorough presentation of Goffman’s sociology appears in the next chapter; nevertheless, I believe that the above-presented concept of situational impropriety is the most apt to support my research. First, unlike concepts such as violence, it does not imply the existence of a victim nor a specific nature of the act (e.g., physical or verbal). Moreover, contrary to concepts such as deviance or incivility, it does not imply that its evaluation fully rests in the audience’s definition. Rather, it refers to the frame that gives sense to the social occasion, meaning the broader social definition of that occasion, which has more relevance than audience’s opinion. This does not imply that the audience has no role in defining what is acceptable; rather, its definition must be supported both by natural conditions (independent of human activity), as well as by social definitions of what is happening; these pre-exist the observing audience. At the same time, unlike concepts such as anti-social behaviour or workplace incivility, situational impropriety does not strictly refer to any formal regulation or legislation, thus leaving ample space for informal arrangements and agreements between actors on what is unacceptable. In addition, it is context-centred, allowing for an understanding of normality in a specific social setting rather than imposing broader social definitions; it allows for a distinction between voluntary and involuntary unacceptable behaviour; and, finally, it conceives of unacceptability as the result of an interaction; this allows for an understanding of nurses as perpetrators, as discussed in Section 2.4.3.

## 3.6 – Chapter Conclusion

Drawing upon the literature discussed in Chapter 2, A&E nurses’ definition of unacceptability seems to escape formal existing definitions; instead, it is a complex social construction that is specific to the A&E context. In order to identify a suitable concept able to support my research, in this chapter, I have presented the most sociologically relevant concepts other scholars have adopted to investigate unacceptable behaviour in healthcare and in other contexts. The first concept I have explored is that of violence, both in its comprehensive and minimalist conceptualisations. This concept resulted in a difficult definition in sociological terms, and many adopted it as primordial, as objectively existing and unproblematic because it was considered self-evident. Concerning its two conceptualisations, the comprehensive one was not applicable to my specific research because it lacked a proper definition and could not investigate micro-social interactions; meanwhile, the minimalist conceptualisation was too narrow, and it was fully focused on behaviour involving physical contact. Moreover, since the minimalist conceptualisation sufficiently well established in Western culture to be defined as the ‘traditional definition of violence’ (Stanko, 2001, pp315-16), the use of the concept of violence would involuntarily drive my participants’ attention toward physical confrontations or aggressions. An example of this consequence is observable in the major focus on physical forms of workplace violence in the literature critically discussed in Chapter 2.

The second concept explored is that of deviance. It was substantially relevant to my purpose due to its recognition of the socially constructed nature of unacceptability; however, it presents three main flaws. First, it lacks an analysis of the informal social benchmark (the expected, acceptable, and normal conduct broken by the deviant act), and instead focuses on the audience’s answer to certain acts, that is, the labelling process. This position is incompatible with that of A&E nurses, who reported being limited in their definition of unacceptability by informal group benchmarks (Pich et al, 2010; 2011; Albashtawy, 2013). Second, it ignores distinctions between voluntary and involuntary acts. Third, following the political and academic interests around this concept and its use, it is also misleading because it is often adopted to indicate a formal and legal definition of unacceptability, such as low-level crimes. Similar considerations can be applied to the concept of anti-social behaviour, its most recent re-elaboration, with the exception that in this case, a benchmark, or a social definition of unacceptability, is missing both at the formal and informal levels (Millie, 2010a; 2010b; 2010c).

Incivility is the third main concept critically reviewed in this chapter, together with its more recent developments: rudeness and workplace incivility. Based on Elias’ (1982) work, despite appearing initially promising, it was ultimately too difficult to define because it was too vague and excessively linked to dominant social groups’ definition of it, such as anti-social behaviour. Moreover, contrary to what Elias has suggested (Ibid), the emotional reaction that unacceptable behaviour provokes in those who observe it should be that of disgust. However, recent studies (Phillips and Smith, 2006; Smith, Phillips and King, 2010) have demonstrated that other emotional reactions play a major role, such as fear, frustration, anger, or coldness. All of these reactions escape Elias’ sociology, with the exception of coldness (Elias, 1996 [1989]; Goudsblom, 1994), thus partially calling into question the applicability of his theorisation; for this reason, I explored its two principal contemporary re-elaborations. Concerning the concept of rudeness, discussed in Section 3.4.1, I believe that this concept is too focused on physical and verbal unacceptable behaviour, and it overlooks other categories. Moreover, it has been developed to explore unacceptable behaviour in public places, and it seems unable to support an exploration of interactions that take place in specific, socially defined settings.

Regarding the concept of workplace incivility, it seemed promising at first, since it uniquely allows for an interactional analysis of unacceptable behaviour. However, its application was limited to horizontal forms of incivility only due to the use of workplace formal rules as a benchmark; these might be of unclear value in nurse-user interactions. In addition, as a result, it excludes informal group cultures, informal rules, and social pressure from its analytical framework.

In conclusion, in agreement with my analysis of the relevant literature offered in Chapter 2 and the final aim of my research, each concept discussed in this chapter was highly valuable since it supported my critical thinking, but none of them can fully support my research. In addition, I believe that none of them is suitable for analysis of the unmet or violated expected normality experienced by victims or witnesses of unacceptable behaviour. Rather, these concepts tend to consider unacceptability as intrinsic to certain behaviour, and even theories that originally attempted an exploration of unacceptability as an absence of expected normality, such as Durkheim’s deviance or anti-social behaviour, today, they refer to formally recognised violations of an unquestioned, taken-for-granted reality (Liazos, 1972; Phillips and Smith, 2003). Therefore, in agreement with my need for a social constructionist concept, as introduced in Section 3.5, I adopt Goffman’s concept of situational impropriety (1963a), which defines unacceptability as the betrayal of the contextually and socially defined expected normality.

# Chapter 4 – Theoretical Framework

## 4.1 – Introduction

Based on the critical literature review discussed in Chapter 2, I have identified the need for a qualitative exploration of nurses’ informal organisation culture. In the previous Chapter, I have tested the most relevant sociological concepts previously adopted against my research aim to explore the idea of unacceptable behaviour. Although each of them allowed me to understand my research needs better, none of the traditional concepts, nor any of their most recent developments, fully satisfied my research need. Therefore, I decided to adopt Goffman’s concept of ‘situational impropriety’ (1963a), since, I am convinced, it allows for a full understanding of A&E nurses’ expected normality and, as a consequence, a definition of unexpected, unacceptable behaviour. However, although Goffman is a well-known and respected sociologist, his theoretical framework escapes the classical epistemological distinctions. Because of this, in order to prevent misunderstandings, I describe what situational impropriety means within a broader discussion of Goffman’s sociological theory. Moreover, since his methodology often remains unclear, I take guidance from Ensink’s socio-linguistic expansion of Goffman (Ensink, 2003). Goffman’s sociology, situational improprieties, and Ensink’s frame analysis are thus discussed here.

This chapter, composed of three sections, starts by laying the foundations for my qualitative exploration and my use of Ensink’s socio-linguistic frame analysis by presenting and discussing my ontological and epistemological stances and their alignment with Goffman’s. In Section 4.3, I present and discuss Goffman’s social theory, addressing his theoretical concepts of greater relevance for this thesis: social actors, interactional order, frame, normality, situational impropriety, and footing. Finally, in Section 4.4, I discuss the most significant theoretical and methodological developments in Goffman’s frame analysis, concluding with that of Ensink, which guides my qualitative methodology and my data analysis.

## 4.2 – Ontology and Epistemology

As Blaikie (2007) has discussed, ontology can be defined as the answers to the question ‘What is the nature of social reality?’ (Ibid, p.16) Social scientists have developed several answers, leading to a complex debate articulated on two major poles: idealism and realism. The former, idealism, assumes that what we perceive as reality is actually mere appearance with no independent existence from our thoughts. Whereas, the latter, realism, sustains that both natural and social phenomena are assumed to exist independently of human observation of them. Like the vast majority of social scientists who place themselves along the continuum of ontological stances that span one pole to the other, I do not embrace either of the two poles. Rather, I place myself closer to the idealist position. More precisely, following Blaikie’s terminology, I position myself among the ‘perspective idealists’ (Ibid, p.17) because I regard the social construction of reality as one of the possible ways of perceiving and making sense of an external world, which exists independently from social activity or the human perception of it. Therefore, I acknowledge the existence of an external, real, and natural world that limits human activity while enabling it. Nevertheless, I believe that our definition and understanding of what is real is mainly socially constructed and socially informed.

In relation to my use of Goffman’s social theory, and consequently of Ensink (2003), I am confident in saying that my ontological stance is reflected in his work. In fact, as discussed by Verhoeven (1985) and confirmed by Goffman himself in his unique, official interview (Verhoeven, 1993), Goffman defines reality as pre-existing the social actor independently of his understanding of it. The social actor thus acts toward natural reality and makes sense of it by applying ‘laminations’ of socially constructed definitions of reality – frames – that guide the actor’s understanding (Goffman, 1974). A more detailed presentation of Goffman’s concept of frame is offered in Section 4.3.3.

Epistemology, according to Blaikie (2007), is defined as the

‘theory of how human beings come to have knowledge of the world around them (however this is regarded), of how we know what we know.’ (Ibid, p.18)

In line with my ‘perspective idealist’ ontological stance, I embrace a social constructionist epistemology. According to Berger and Luckmann (1966), social constructionism argues that many aspects of our everyday experience are based on implicit social agreements, institutional practices, or collective social actions. Most of what we consider objective and real would thus not exist outside the context of such social constructions, and what we define and perceive as reality is, often, the product of human inter-subjectivity.

In the last 50 years, scholars have developed different constructionist epistemologies that span two philosophical stances: strong and weak constructionism (Crotty, 1998, pp43-4). The former suggests that reality is built on and defined by language, and since this is a social construction, reality is therefore primarily socially constructed (Searle, 1997, p.60-3). For instance, the reason we call a mountain a mass of Earth is purely social, as is the difference between stating that a house is on the upper part of a plain or the lower part of a hill. On the other side, weak social constructionists argue that a mountain would exist independently of our definition of it, and that its non-socially constructed features would impact human activity independently of what an actor might think. For instance, it is likely that warmer clothes would be necessary in order to survive on a mountain, independently of how we define it. Weak constructionists thus differentiate between ‘brute facts’ (natural facts that exist independently of language and human recognition of them) and ‘institutional facts’, so called because ‘they require human institutions for their existence’ (Ibid, 2). However, strong social constructionism does recognise the existence of brute facts, but it assigns them low relevance. Meanwhile, weak constructionism considers brute facts prior to institutional ones because they limit social activity (ibid, 55-6): the natural world is out there, and although it might seem meaningless, it provides actors with the tools they use to build perceived reality. Within this philosophical duality, I position myself among the weak constructionists since, like Goffman (1974, pp1-5), I believe that brute facts impact human activities independently of their recognition or acknowledgment, limiting while enabling social construction.

Last, the concept of social constructionism is sometimes confused with that of social constructivism. However, as Crotty has discussed, the latter focuses on the ‘meaning-making activity of the individual mind’, whereas the former addresses ‘the collective generation [and transmission] of meaning’ (Ibid, p.58). Social constructionism thus stresses the primary role that shared cultural resources play in actors’ understanding and definition of reality. Therefore, I believe that culture shapes how the actor sees and feels the surrounding reality, giving him/her a quite definite view of the world. S/He sees other actors replicated this perspective, and they interact in a similar way with brute and institutional facts, thus reinforcing and replicating the shared social construction of reality. As I soon discuss, Goffman offers a close discussion in Frame Analysis (1974, p27), arguing that the existences of shared cultural resources among members of the same cultural group allows for the stability of the perceived reality.

## 4.3 – Goffman’s Social Theory

Erving Goffman, one of the most prominent sociologists of the last century, is mostly known for his dramaturgical analysis of micro-interactions, the innumerable, every day, mundane face-to-face encounters that constitute social life. However, key to Goffman’s intellectual production is the book *Frame Analysis* (1974), which followed on and expanded his dramaturgical approach by arguing how human interactions, meticulously explored and analysed in his previous works, become meaningful and understandable to other actors only if framed, that is, if they are performed within a socially constructed cognitive structure (frame) that provides social meaning to human activities and natural facts (Goffman’s equivalent of brute facts, since these are independent of human activity and human comprehension of them).

Frame Analysis starts by clarifying Goffman’s idealist ontological and weak constructivist epistemology, criticising Thomas’ most famous dictum: ‘if men define situations as real, they are real in their consequence’ (Ibid, p.1). Goffman argues that even though agreements on what is real can produce real consequences, these can produce insignificant results because reality exists independently of the social actor; He thus anticipates Searle distinction between brutal and institutional facts. Goffman claims that the reality in which we live is a complex, stratified natural-social composition. Precisely, nature pre-exists the social and is itself a background independent of human understanding or comprehension. The social, instead, consists of artificially, socially constructed definitions attached to natural events (Goffman, 1974, pp.21-6). Therefore, according to Goffman, social activity can radically change our perception of what is real, meaning that we act toward it as if it is a brute fact, but social constructions are always limited by natural reality and cannot exist without it. For instance, human verbal communication is possible only through a vocal apparatus and a natural medium to transmit our voice, as much as we need feet and solid ground to walk. Natural events such as the transmission of sound waves are socially transformed into meaningful events by social actors who agree upon the meaning assigned to them. For instance, the same sound waves that produce the sound ‘kəʊld’ are interpreted by English speakers as ‘cold’, whereas Italian speakers might confuse it with ‘caldo’, hot. Therefore, according to Goffman, reality is mostly a social construction built on natural reality, and its construction, replication, reconstruction, and interpretation take place in social actors’ minds (Verhoeven, 1985, p.76). Based on this brief resume of Goffman’s ontology and epistemology, I can now assert that my ontological and epistemological stances are consistent with his work. This provides a working consensus between my research approach and his theoretical framework, allowing my use of his work.

Goffman’s theory is complex and often not completely clear, mostly due to his opposition to have his work analysed or discussed while he was still alive (Smith, 2003, pp.255-56). Therefore, his legacy is still debated, and my analysis and use of his work might, I am afraid, cause more than one raised eyebrow. This is why, in this and the following sections, I do not venture into complex, abstract discussion of his work; instead, I focus on the concepts most relevant for my thesis. In addition, I coherently and logically link them to reinforce and make explicit my interpretation of his work; in addition, as much as possible, I refer directly to his work.

The theoretical framework of my thesis is rooted in five of Goffman’s key theoretical concepts: the social actor, interactional order (and face-work), frame, situational impropriety, and footing.

### 4.3.1 – The Social Actor

Goffman’s conception of the social actor is based on the inter-related and inter-dependant triad ‘social actor – self – role’, also known as the biological, psychological, and social dimensions of the human being. Concerning the biological dimension, as discussed by Verhoeven (1985, p.81), Goffman considers the social actor to be a specific biological entity able to learn, store, use, and innovate upon the information learnt in everyday social interactions (see Goffman, 1974, pp.513-14, p.524). During life, the social actor gains both a memory and a biography, which, together with his/her physical characteristics, affect the roles s/he wants to and can perform (Ibid, pp.128-29). In fact, due to social constraints, each role requires certain biological characteristics necessary to perform it (Ibid). For instance, at present, only males can be elected pope.

Concerning the self, the psychological dimension, Goffman draws his definition from Freud’s concepts of ego and superego (Hancock and Garner, 2015). He argues that the self is a psychological entity that evolves according to the above-described combination of flesh and knowledge, while being in constant need of identification with a specific social role (Goffman, 1974, pp.128-29). Thus, we identify with and become the social role we dress.

Finally, the role, or social dimension, is a social construction with which the social actor identifies him/herself and through which s/he is identified in society. A borderline example is the role of mother, a natural fact that is socially re-constructed differently by different cultures and in different times. The role constitutes the face[[2]](#footnote-2) actors use to enter any social situation, to be recognised as part of the social order, and to demand certain forms of interaction toward them. At the social level, the role makes a biological and psychological entity ‘exist’ in society. Negative examples of this are the outcasts, or slaves, to which any social right is denied; they are thus de-humanised and considered animals, or even less. However, Goffman does not suggest that physical (natural or brutal) characteristics are less important than social ones; rather, he suggests that they might go unnoticed if they are considered irrelevant at the social level, such as, for instance, the pope’s hair colour.

Central to Goffman’s social theory are two facts: human beings are social animals, and they seek external confirmation of triad alignment. Social actors need an audience that recognises their performance and that confirms that their self (what they think they are) is in line with the social role they perform (Goffman, 1963a, p.73). Therefore, social roles have a twofold nature: one is constructed by the actor in his/her own mind (cognitive nature, self) and one is assigned by the audience based on their evaluation of the actor’s performance (social nature). This distinction between cognitive and social role allows for different interpretations of the same role, which is often the case when the same social role is interpreted by actors with different social biographies. However, although actors self-perceive roles differently, the final judge of any performance remains the audience. Should the audience reject the actor’s performance, thus indicating a misalignment between the cognitive and social nature of a role, or should the actor fail to ‘fit in’ (Goffman, 1963a, p.35), social actors lose their triad’s alignment (lose their face), leading to potentially extremely negative psychological and social consequences (Verhoeven, 1985; Stenberg, 2009). An example taken from the literature discussed in Chapter 2 is that of the patient who believes him/herself to be seriously ill but has to wait in the A&E because the triage nurse perceived his/her condition as not urgent (Pich et al, 2013).

Finally, roles are social constructions that not only define performance obligations to those who interpret them, but also allow other actors to build expectations of what is happening, to give social meaning to what that actor does, and, possibly, to foresee what s/he will do. Since mistakes are always possible, especially in situations where two roles are covered, such as a nurse triaging a user who is also a friend, interactions are always potentially dangerous. Thus, in order to minimise the risk of misrepresentation, human societies have developed strategies and non-written rules that guide actors’ interactions (Goffman, 1974, p.27). This set of rules and strategies produces expectations and routines composed of what Goffman calls the ‘interaction order’, whose exploration was his final aim (Goffman, 1983).

### 4.3.2 – The Interactional Order and Face-Work

Goffman’s study of the interaction order started with his first book*, The Presentation of Self in the Everyday Life* (1959), and it continued throughout his life. In his first book, he discussed how the social actor in

‘ordinary work situations presents himself and his activity to others, the ways in which he guides and controls the impression they form of him, and the kinds of things he may and may not do while sustaining his performance before them.’ (Ibid, p.8)

This book explores the strategies actors use to ensure that the audience recognises their triad alignment by analysing actors’ interactional strategy in the constant and unavoidable need/desire to control the impression that others form of them.

According to Goffman, social actors are in constant communication with each other, either via information voluntarily given or via information involuntarily given. The former indicates the verbal or nonverbal communication actors consciously use in order to convey specific meanings (1959, pp.137-38). For instance, explicit sentences or statements, or the use of symbols to support a role performance, such as a coat, stethoscope, and medical jargon to build the figure of a doctor in the eyes of A&E users. The latter, involuntarily given information, consists of signs and expressions unwittingly and unconsciously emitted. These are the signs that the audience expects from certain performances, such as the light in the eyes of lovers (Goffman, 1959, p.14) or the genuine engrossment of a triage nurse while evaluating a patient’s symptoms. Thus, actors reciprocally form an impression of each other by noting the many pieces of consciously and unconsciously emitted information (Ibid).

The interactional order is therefore composed of, and realised through, performances and the necessary face-work operations adopted to convince the audience of the proposed triad alignment. A performance, therefore, is about making an impression on those in ‘visual or aural range of one another’ (Goffman, 1981, p.84), asserting (to oneself and to the others) that we are who we pretend to be, or we believe we are. However, as previously discussed, Goffman’s roles are ideal-types; they are subject to idealisation and individually interpreted (Manning, 1992, p.21). This means that the same socially constructed role can be performed differently through agential activity, with the attending audience as the final judge. The role of ‘patient in severe pain’ can be performed by anyone, but every actor performs it differently according to their physical characteristics, their social biography, and the role with which they identify themselves. Some might opt for stoic silence, others for loud cries, and others for blasphemous cursing. Nevertheless, the audience (in my case, the A&E triage nurse) might perceive some of these performances as false because they are not in line with the audience’s expectations of how a patient with those symptoms should act, move, and speak.

The discussion offered thus far leads to two considerations: first, should the audience’s expectation not be met, the actor will see his/her performance rejected and will not be treated according to his/her expectations. Second, actors can try to deceive the audience by performing a role that does not belong to them, such as a drug addict pretending to be in severe pain to receive painkillers (false representation). Face-work therefore includes strategies actors use to fulfil the audience’s expectations, to demonstrate engrossment in the interaction, to send positive messages of agreement and support, or to apologise and make amends for eventual mistakes without losing face (Goffman, 1959). In addition, concerning the issue of false representations, since it is extremely difficult to recognise a bluff, society has developed anchors to limit the possibility of deceiving the audience (Goffman, 1974, p.247). These can be either natural or social objects (brute facts or institutional facts) that sustain or refute a performance. For instance, in the healthcare setting, doctors and nurses dress differently to represent their different roles. As Allen (2001) has discussed, their dress code influences users, who act differently toward those recognised as doctors or nurses and fully base their understanding of the role of such actors on their visual recognition of social anchors; they do not do this, for example, by requesting material proof of someone’s degree in medicine (Ibid, p.117).

In conclusion, Goffman’s social order is fragile, easy to manipulate, disputable, and thus in constant need of protection and the reiteration of its expected “normality”.

### 4.3.3 – Frames and Frame Layering

As previously stated, interactions take place on social occasions. The simple fact of being in co-presence with other social actors implies that everyone is expected to act toward the other(s) (Goffman, 1981, p.84), at least to communicate neutrality and lack of interest in further engagements – namely ‘civil inattention*’* (Goffman, 1971, p.219). According to Goffman, these unavoidable interactions and performances are socially pre-organised and pre-defined. Here, ‘pre-defined’ means that the definition of what happens is not agreed upon between actors at every encounter; rather, actors apply social definitions that pre-exist them: social structures (frames) to which they have been socialised during the development of their biography. Meanwhile, ‘pre-organised’ indicates that interactions are organised in rituals (patterns of behaviour) that participants have to perform in agreement with the role they cover (Verhoeven, 1985, p.76).

Goffman defined frames as

‘principle[s] of organization which govern events – at least social ones – and our subjective involvement in them.’ (Goffman, 1974, p.10)

They are society’s answer to the actors’ question, ‘What it is that’s going on here?’ (Ibid, p.8). They can be visualised as ‘conceptual scaffolding’ or socially constructed, basic cognitive structures that guide actors’ perceptions and representations of reality by defining which part of reality becomes relevant (Snow and Benford, 1988, p.213). Frames are unconsciously adopted but not unconsciously manufactured since

‘those who are in the situation ordinarily do not create this definition, even though their society can often be said to do so; ordinarily all they do is to assess correctly what the situation ought to be for them and then act accordingly.’ (Goffman, 1974, pp.1-2)

Thus, frames, or unconsciously adopted social structures, define actors’ expectations in terms of roles (Ibid, p.129), power distribution (Rogers, 1977; 1979; Jenkins, 2008), involvement (Goffman, 1974, p.345), and situational proprieties and improprieties (Ibid, pp.345-77).

Frames can be divided into two categories: social and natural. Consistent with the ontological stance used in this thesis, Goffman defines reality as a human interpretation of what naturally pre-exists the human mind (Ibid, p.1). Consistent with the epistemological stance, Goffman defines natural frames (or the natural primary framework) as brute or irrefutable natural facts, such as tides; meanwhile, social frames, or institutional facts (stretching Searle’s definition to some extent) are social constructions that give meaning to actors’ actions that take place in a natural context (Ibid, pp.21-2). This means that whatever social frame an actor decides to use, it must be consistent with the natural frame in which the social activity takes place.

In addition, social frames rarely stand alone; rather, they are often dependent on and connected to other social frames, lower and more generic ones. Goffman represents this relation through the concept of lamination (Ibid, p.82, pp.156-57, p.182, p.564). This is represented in Figure 4.1 below (p,68), where each frame is represented by a layer (rectangle), and each of them, with the exception of the natural one, is rooted in the lower and must deal with its proprieties and limitations. This means that upper frames cannot completely contradict lower ones; rather, they must deal with the restrictions lower ones imply (Ibid, p.81). An apt example is that of a kiss, which is a social construction founded on the natural event of lips coming into contact. Thus, a specific physical contact (natural frame) has a social meaning applied to it (kiss), which is the first and lower social frame. What actors perceive as real, and thus what guides their actions, is the external layer, the so-called ‘rim’ (Ibid, p.82); in the kiss example, this is the first social frame. Despite its socially constructed nature, the rim looks natural and normal to the eventual audience, which confines the lower layers to the domain of the taken-for-granted. However, the precondition of this is that both of the actors involved must be aware of the ‘kiss frame’ and know how to act.

Despite the simplicity of the kiss example, the social construction of reality is often far more complex and composed of multiple layers. Using the same example, many social actors are aware that a kiss in not always a sign of love; it might be, for instance, a staged movie kiss. In this case, a ‘key’ is applied, defined by Goffman as

‘the set of conventions by which a given activity, one already meaningful in terms of some [social or natural] primary framework, is transformed into something patterned on this activity but seen by the participants to be something quite else.’ (Ibid, pp.43-4)

Therefore, a sign of love can be defined as something quite different, allowing, for instance, two movie actors to not be considered unfaithful by their real-life partners. At the natural level, the action is the same, but at the social level, its meaning changes due to the key applied to the primary social frame. Moreover, keyed frames can be rekeyed several times, thus adding new laminations. For instance, two movie actors might stage the famous kiss between Breznew (former URSS president) and Honecker (former DDR president). In this case, there is a natural event of lips’ touch (natural primary framework), a social event (kiss, primary social framework[[3]](#footnote-3)), a first key (they are actors staging a kiss), and a second re-key that gives the kiss a political significance, thus distinguishing it from a kiss between same-gender lovers. What the viewer sees and perceives as real is a staged political kiss: the rim. Although this example might seem complex, it is actually quite simple compared to everyday reality.

The fact that both actors agree upon what they communicate (a staged political kiss) does not necessarily mean that the audience will adopt the same frame to make sense of what they see. For instance, a fundamentalist Catholic audience might perceive it as a same-sex kiss and publicly protest or dislike those actors; for this reason, many male movie actors perceive homosexual roles as a danger for their careers (Summers, 2005). In order to prevent such misunderstanding, actors must adopt specific facework techniques or anchors to constantly communicate to their audience the frame they use and their role in it. Moving to an A&E example, a nurse might use a playful tone of voice to frame a hospital admission as a game for the admitted child, whereas a different tone and attitude must be used with the children’s parents.

Figure 4.1 – Example of layering process

Second keying, rim or perceived reality

Political staged kiss

Set of available socially constructed frames

Staged kiss

First keying

Primary social framework

Kiss

Primary natural framework

Physical contact

Source: Self-produced

Although reality looks simple and plain to actors, participants in any simple social interaction can, unknowingly and even happily, actually be ‘in several complex layers of situational definition at the same time’ (Collins, 1988, p.58). According to Goffman, actors can bear this complexity because, as previously indicated, frames are shared cultural resources, and actors from the same cultural background share the same pool of frames learnt through direct experience (Goffman, 1974, p.27). If so, what occurs seems normal to everyone, thus reinforcing the perception of absolute normality.

At this point, it might seem that Goffman conceives of the social actor as a passive subject who is only capable of applying what s/he has learnt during his/her life, but such an understanding is far from correct. Goffman’s social actor is instead an active agent who tries to fit in the situation while trying to manipulate and modify the definition of the situation to gain some strategic advantage (Verhoeven, 1985, 81). Actors try to achieve their goals by modifying the social understanding and imposing their perspective on it, adding or removing layers of socially constructed reality in order to obtain a frame in which they can guarantee the alignment of their triad. These operations of addition and removal of social reality are social activities respectively defined as ‘keying’, ‘fabrication’, and ‘downkeying’. Keying, as discussed above, and fabrication both indicate the transformation of an already meaningful activity into something ‘quite else’ (Goffman, 1974, p.44). The difference between the two is that keying is always operated through a transparent and open process, whereas fabrications always imply that an additional layer is added for the benefit of one party so that ‘one or more others will be induced to have a false belief about what is that is going on’ (Ibid, p.83). Nevertheless, fabrications are not necessarily exploitative, such as when parents protect their children from potentially traumatic events or information by framing them playfully. Returning to the kiss example, and borrowing from Hollywood, an example of fabrication would be when two actors stage a fake kiss to look like lovers in order to mislead a third actor, usually the villain looking for them.

Downkeying instead indicates the opposite process of removing one or more layers of reality. As discussed above, this might be the case of a Christian fundamentalist who ignores the historical aspect of the staged kiss, focusing instead on the primary social framework. Similarly to keying activities, downkeyings can also be opportunistically used to re-establish a more favourable organisation of social interactions proposed by the lower frame. For instance, when actors who are usually in powerful positions find themselves powerless, they might decide to suggest a re-frame of the situation through an operation of downkeying. Examples of this, as I discuss later in this thesis, include off-duty doctors accessing an A&E as users. On this occasion, they find themselves ruled by the decision of a triage nurse, a figure (that of nurse) they are used to commanding and not being commanded by. In this case, it is not unusual for doctors to try to reframe, downkeying the nurse-user interaction to that of doctor-nurse, since for them this is them convenient. A detailed discussion of this process and of how this is perceived by A&E nurses is offered in Section 8.2.3.2.

### 4.3.4 – Situational Proprieties and Situational Improprieties

In Goffman’s terms, an acceptable and expected behaviour is defined as ‘situational propriety’ because it fits the audience’s expectations and is thus perceived as being in line with the frame’s tacit expectations (Goffman, 1963a, pp.23-4). According to Smith (2006), situational proprieties are culturally learnt and constitute a moral code represented by common courtesy, posture, voice tone, spatial arrangement, and so forth (Ibid, p.37). Of great relevance for this thesis, situational proprieties are mostly informal, implicit, internalised, and unconscious, rather than being explicit laws and regulations that govern public behaviour in the judicial sense.

Situational improprieties, instead, are those behaviours performed in a social occasion, not necessarily directed at someone, that come across as ill-suited according to the frame that gives sense to that social occasion, or that is used to make sense of that behaviour (Goffman, 1963a, p.193). Situational improprieties are likely to be sanctioned by the audience in order to cause a deep feeling of embarrassment and shame in the transgressor, who might even lose face and thus his/her triad alignment (Scheff, 2007, pp.3-5). Additionally, situational improprieties call for reparatory activities that aim to communicate the misbehaver’s contrition and to obtain forgiveness from the audience.

However, actors rarely reflect upon the socially constructed nature of what they believe reality is; only when an impropriety occurs do actors reflect upon the taken-for-granted situational proprieties. This is the reason, as discussed in the contemporary Frame Analysis literature (Manning, 1992; Cresswell and Hawn, 2012; Archibald et al, 2015), Goffman used negative examples to understand the expected normativity and normality. This approach is derived from Burke’s ‘perspective by incongruity’ (Burke, 1965, see also Smith, 2006, p.141 and Maseda, 2017, p.36) and assumes that actors observe the real world by filtering some aspects of it, thus unconsciously reducing its complexity through frames to act in a simplified world (Goffman, 1974, pp.250-51). However, when substantial incongruities arise, these attract actors’ attention, forcing them to reflect upon their own filters and uncovering the socially constructed nature of reality. Therefore, an operative solution to understand a frame’s tacit expectations is to observe its violations, exploring the reason why a behaviour is considered situationally inappropriate. In this why, as suggested in Section 3.5, the concept of situational improprieties allows me to explore nurses’ original perspectives without imposing external definitions; see also the discussion offered in Section 2.5. Therefore, from now on, I refer to the undefined concept of unacceptable behaviour with the defined one of situational impropriety.

### 4.3.5 – Frame Disputes and Frame-Clearing Strategies

As discussed in the section above, although actors generally share an understanding of what occurs and use different resources to frame social encounters (anchors, impression management strategies, non-verbal communications, etc.), actors do not necessarily agree on the definition of the situation. To quote Goffman,

‘when participant roles in an activity are differentiated – a common circumstance – the view that one person has of what is going on is likely to be quite different from that of another.’ (Goffman, 1974, p.8).

It is in fact not uncommon that users and nurses disagree about what is going on, if a certain condition should be considered urgent or not, or how urgent it should be considered. Such different perspectives lead to frame disputes, meaning interactions aimed to clarify which of the participants’ proposed frames should be applied (Ibid, pp.321-4). When disputes occur, each actor attempts to convince the audience of the correctness of his/her own definition of reality:

‘with immense frequency, individuals who feel they may be (or have been) misunderstood will provide accounts, explanations, and other interventions in order to clarify the situation.’ (Ibid, p.339)

Goffman defines these interactions as ‘clearing the frame’ (Ibid, p.338), and they can either consist of attempting to convince the other party of the correctness of the proposed framing, as well as, in the case of an acknowledged misunderstanding, justifying a mis-framing. In the latter case, frame-clearing strategies are implemented to justify the non-voluntary nature of a mistake, preventing possible sanctions due to the inevitably committed situational improprieties.

Actors involved in frame disputes tend to make explicit their ‘tacit theories about what exists, what happens, and what matters’ that characterise the frame they would like to apply (Gitlin, 1980, p.7). It is through these positive explanations, as opposed to the negative ones suggested by reflections on perceived situational improprieties, that a second form of frame analysis can begin. Using these descriptions of what was expected, I can I analyse the frame that guides nurses’ perceptions of, definitions of, and dealing strategies toward users’ situational improprieties.

Last, frame-clearing explanations are offered to those who join a specific social group, such as a team of nurses, by experienced members, or ‘training specialists’ (Goffman, 1956, pp.100-101). These specialists are expected to invest time and resources in training the new member to sustain the team’s representation, especially in terms of tacit, taken-for-granted situational proprieties. Therefore, when a nurse joins a team, s/he has to adapt his/her behaviour to that of the team in order to avoid violating the informal organisation culture, especially in front of users.

### 4.3.6 – Footing

Goffman dedicated the last chapter of *Frame Analysis* (Goffman, 1974, pp.496-559) to discussing how the vast majority of keying and downkeying operations are performed through verbal communication. He pursued this study until his last book, *Forms of Talk* (Goffman, 1981). As previously discussed, Goffman theorised that reality is dynamically recreated by social actors within natural and social constraints. Leaving aside the natural aspect of reality, on which actors have no influence, if not that of assessing its social relevance, he described ‘footing’ as the mechanism actors use to negotiate ‘interpersonal relationships, or alignments, as they dynamically frame an interaction’ (Kendall, 2011, p.118). He thus defined footing as the verbal and linguistic mechanisms actors use to convey their understanding of the on-going social reality and of how to operate within a frame.

Goffman elucidated the concept of footing and its role in frame analysis by studying Richard Nixon’s keying of an official encounter in a playful situation. In 1973, during an official bill-signing ceremony, the (at that time) President of the United States of America questioned the journalist Helen Thomas, the only attending woman, about her clothes, asking why she wore pants instead of skirt. He then asked Thomas to pirouette like a ballerina in a context far from that of a ballet stage, keying the interaction from ‘official bill signing’ to ‘joke’ (Goffman, 1981, pp.124-25). On that specific occasion, Nixon re-keyed an already keyed encounter by changing his and Thomas’s roles: from ‘president’, he became ‘simply Richard Nixon’, whereas Thomas shifted from ‘journalist’ to ‘known woman’. However, footing encompasses not only alignments between speakers, but also how the speaker aligns him/herself toward the pronounced utterances. Introducing the concept of production format, Goffman (1981) argued that a speaker is a tripartite entity composed of an ‘animator’, the actor who physically produces the utterance; ‘the principal’, the actor whose position or beliefs are represented by the utterance; and the ‘author’, the actor responsible for the selection of the words and sentiments (Ibid, pp.144-5). In his official role, Nixon covered only the animator position, since formal speeches are often authored by ghost-writers, and the principal often encompasses more subjects (such as the members of the government). As simply Richard Nixon, he covered all the three roles simultaneously, so the joke would have not been interpreted as an official presidential request. The ‘participations status’ represents the relation of members of a social gathering to an utterance, including both the production format and the participation framework. Declaring the participation status an actor openly defines how s/he framed a social situation, that in which the utterance takes place or to which the utterance refers.

In addition, footing also encompasses the alignments of hearers. Goffman discussed how some participants are ‘ratified’, or intentionally included in the encounter, whereas other are ‘unratified’, or excluded from the encounter (Ibid). Last, among those ratified, some are addressed while others may be unaddressed. As Gordon (2015) has discussed, these distinctions indicate that speakers and hearers are multifaceted. In the bill-signing example, Thomas was the only addressed recipient, whereas the male bystanders were ratified but unaddressed members of the audience.

In conclusion, ‘footing’ indicates the stance actors take in regard to a communicative act, defining their position and that of the other participants in it. Doing so, they frame, key, and re-key encounters; they define what is going on and, thus, they create social reality.

## 4.4 – Recent Development in Frame Analysis

Goffman never fully explained how to practically ‘do’ frame analysis, so, after his premature death, scholars in his tradition developed different and sometimes conflicting forms of frame analysis. These can be organised in two categories: those who adopted quantitative methodologies (Snow and Benford, 1998, Ferree et al, 2002; Koenig, 2004a, 2006; Peng 2014; Pelak, 2016) and those who further cultivated the qualitative sociolinguistic approach of his last works, starting from the final chapter of *Frame Analysis* (Tannen, 1993; van den Berg, 1996; Ensink and Sauer, 2003; Ensink, 2003; Gordon, 2015).

Quantitative scholars focus their interest on large bodies of written text, developing recursive methodologies (Recursive Frame Analysis or RFA) aimed at identifying ‘keywords, key phrases, and possibly audial or visual symbols’ that indicate the use of a frame (Koenig, 2004a, p.1). Although their methodologies produce interesting findings and have been used in semi-qualitative exercises of cross-national, cross-cultural, and multi-lingual frame analysis (Koopmans and Statham, 1999; Semetko and Valkenburg, 2000; de Vreese et al, 2001; Trenz, 2004; Van Os et al, 2008), these remain theoretically weak. As discussed by de Vreese (2005), they adopt a deductive approach that investigates ‘frames that are deﬁned and operationalized prior to the investigation’ (Ibid, p.54). Thus, although this leaves ample space for ‘the creativity of individual scholars’ (Maher, 2001, p.84), it implies that identified frames and sociological categories are constructed a priori and then confirmed through cross-verification. Therefore, the validity of such interpretations remains unclear, as the process that led researchers to intuitively identify such frames remains obscure (Tankard et al. 1991, p.5; Tankard 2001, p.98). Consequently, these studies are often characterised by scarce analytical clarity, and the findings are severely influenced by researchers’ a priori perspectives (Vliegenthart and van Zoonen, 2011).

On the other side of the epistemological dichotomy, qualitative students focused on the connection between framing, footing, and language, following Goffman’s invitation to do so:

‘I believe linguistics provides us with the cues and markers through which […] footings become manifest, helping us to find our way to a structural basis for analyzing them.’ (Goffman, 1979, p.157)

Although Goffman often referred to linguistic studies (his intellectual relation with his former student Harvey Sacks was famous), it is only in the quotation above that he officially recognised discourses as ‘the summation of symbolic interchange’ (Johnston and Kalandermans, 2004, p.218).

As discussed by Gordon (2015, pp.324-45), Goffman’s interest in linguistics was informed by, among others, Tannen and Wallat’s work (at that time in production and finally published in 1987, see Goffman, 1981, p.156) on the use of linguistic resources to switch from one frame to another. In this paper, the two authors analysed a video-recorded medical encounter involving a paediatrician, a cerebral palsied child, and her mother. They demonstrated how the paediatrician used language and other para-verbal resources to switch from three different frames, constantly re-defining the same interaction as a medical examination, playful encounter, and consultation. Thus, she interacted with and involved three different audiences: her colleagues, who would have used the recording for training purposes; the child; and the mother (Gordon, 2015, p.327).

A second notable contribution from Tannen and Wallat (1987) is their re-elaboration of Goffman’s concept of frame. According to them, frames should be divided into two distinct categories: mental schemata, to indicate actors’ personal expectations ‘about people, objects, events, and settings in the world’; and social frames, defined as ‘alignments being negotiated in a particular interaction’ (Tannen, 1993, p.60) and thus between actors. Tannen and Wallat (1987) concluded their analysis by suggesting that sociologists should limit their analysis to social frames, leaving the exploration of mental schemata to psychologists (Ibid).

### 4.4.1 – Ensink’s Frame Analysis

Drawing upon the work of Tannen and Wallat’s (1987), Ensink suggested instead that mental schemata, cognitive frames in his work, and social frames are two faces of the same coin, and both are of interest to sociologists. He reconnected the definition of cognitive frames to that of Goffman (1974, p.322): actors’ perspectives on social frames. These gain social validity, meaning they are adopted to organise an interaction, when they are shared at the cognitive level among actors who use them to make sense of the social occasion in which they are involved.

Based on this indivisible connection between cognitive and social frames, Ensink (2003) has developed a technique to explore social frames through interviewees’ descriptions of their cognitive understanding of them (Ibid, pp. 161-62). Following Goffman, he claims that our everyday actions are largely based on taken-for-granted assumptions that everyone interprets and acts toward “reality” in a culturally pre-defined order, thus adopting the same frame to make sense of what is going on. When this expectation is not met, actors reflect upon the detachment between their cognitive schemata and what is going on, engaging in frame disputes followed by frame-clearing activities. In doing so, they describe their perspective to others of how the situation should be framed, thus openly discussing their cognitive frame.

Drawing upon the work of van den Berg (1996), Ensink has suggested that activities of frame-clearing can also be initiated by questioning an actor about his/her tacit expectations regarding a given social occasion. This research activity is commonly performed through interviews, in line with the constructionist sociolinguistic assumption that actors use discourses to construct and shape the social reality (Goffman, 1974, pp.500-02; Tannen and Wallat, 1987). Nevertheless, interviews themselves are framed social interactions and can thus influence the exploration of the interviewee’s cognitive frame. Thus, to better understand the information collected, following van den Berg (1996), Ensink has identified four frames to be analysed in any interview: the interview frame, the social research frame, the mutual relational frame, and the topic-related cognitive frame (Ensink, 2003, pp. 158-61).

The interview frame, which is of a social nature because it is shared between interviewer and interviewee, regulates and structures the specific social interaction called an interview. It assigns precise roles and gives order to the conversation. However, how participants interpret it can influence the final outcome. Moreover, as discussed by Goffman (1974), frames do not operate as isolated social structures; rather, they are influenced by eventual lower frames and by the surrounding natural environment, thus potentially affecting the interview outcomes. Although it is almost impossible to fully analyse these influences, it is good practice to reflect upon them in order to ensure a higher validity for the study.

The social research frame, also of a social nature, is defined as a cognitive awareness that the interview occasion is only one among several. This frame is usually ignored and treated as mere background noise by qualitative researchers, but it can affect both the researcher and the interviewee (Ensink, 2003, p. 159). In fact, the former can use information previously collected through informal chat, qualitative checklists, or previous interviews to stimulate the conversation, whereas the latter can recall situations described in previous parts of the research (for instance, a checklist); or, knowing that his/her answers might be read as by relevant others, the interviewee might feel intimidated by the activity itself.

The third frame, the mutual relational frame, is directly drawn from Goffman’s definition of social categorisation, which is composed of ‘four critical diffuse statues: age, gender, class, and race’ (Goffman, 1983, p.14). These are used by actors to form expectations about the others involved, since both the researcher and the interviewee enter the interview social occasion with a complex, layered identity. The interview occasion brings together two actors who

‘may or may not like each other, who show inevitably some form of social accommodation related to each other’s age, sex, ethnicity, pronunciation, appearance, and so on.’ (Ensink, 2003, p.164)

At the interactional level, this frame can be a resource as well as a concern. On the one hand, it may help establish a positive relationship with the respondent who, due to shared social characteristics, might feel confident enough to disclose sensitive information (Babbie, 1995). On the other hand, it might interfere with the methodological demands of neutrality and stability (Moser and Kalton 1971, p.299).

Last, the fourth frame, or the ‘topic-related cognitive frame’, represents the goal of the interview. This frame is of a cognitive nature because it only exists in the interviewee’s mind and cannot be applied to the interview situation. It refers to a different social situation about which the researcher tries to gather information, and thus it does not have interactional value because it has no normative effects on the on-going interaction.

Finally, concerning the concept of footing and its use to create reality through language, Ensink draw upon the work of Wortham (1996) based on the analysis of the personal, temporal, and spatial deictics employed by the interviewee. However, since this discussion is of a methodological nature, I offer a detailed presentation of it in Section 6.5.2.1 of the Methodology Chapter.

In conclusion, drawing upon Tannen and Wallat’s (1987) development of Goffman’s concepts of frame and footing, and van den Berg’s (1996) frame layering, Ensink developed a theoretical framework suitable for the analysis of cognitive frames through interviews. Ensink’s (2003) framework is deeply rooted in Goffman’s social theory; thus, it does not conflict with the previously discussed concepts.

## 4.5 – Chapter Conclusion

Following my critical review of the literature on users’ unacceptable behaviour against A&E nurses discussed in Chapter 2, I have identified four main gaps, the first two being the paucity of studies based on nurses’ perspectives and the need for a new term to define and investigate the concept of ‘unacceptable behaviour’. In the previous Chapter, I have explored the most relevant sociological concepts adopted to explore unacceptable behaviour, arguing how Goffman’s situational improprieties best suit my research aim. In this chapter, I have discussed my thesis’ theoretical framework based on the work of Goffman and Ensink’s further development.

In this chapter, I have delineated two approaches to study the A&E nurses’ perspectives on unacceptable behaviour from users: i) through situational improprieties, and thus through nurses’ definitions of behaviour that does not fit their expectations; and ii) through frame-clearing strategies, that is, nurse-user or nurse-nurse open communication on how interactions should be. Drawing upon this, in Chapter 6 – Methodology, I discuss my research question as informed by the triangulation of information collected through the two perspectives cited above. I also describe in detail the qualitative multi-case study methodology and the methods – qualitative checklists and semi-structured interviews – that allow me to answer my research question. A detailed discussion of the practicalities of my data collection, and on the translation issues related to the collection of qualitative data from two linguistically different settings, is also offered. However, before discussing my methodology, in the following Chapter, I provide a description of the two research contexts. Here, I discuss their characteristics and how they enabled as well as limited my research activity.

# Chapter 5 – The Research Context

## 5.1 – Introduction

In this chapter, I present and discuss my research setting and my two cases of study, offering a discussion of the issues that arose before and during my data collection, such as the negotiations process with the hospitals and the resulting limitations of data collection.

The chapter is organised in two main sections. The first offers a national-level overview of how the healthcare system works and how it deals with situational improprieties against nurses. The second details the characteristics of the research setting in terms of organisation, formal dealing strategies against perpetrators, and the main issues arose during and before my data collection. The chapter clarifies for the reader the constraints and the logic I applied both in my methodological choices, which are discussed in Chapter 6, and in my discussion of the collected data, Chapter 10.

## 5.2 – The Research Settings: The National Perspective

Although the two research settings belong to two different EU healthcare systems, they share many similarities, both at the organisational and functional levels. The main reason for this is that, in 1978, with the law 833/1978, the Italian national healthcare (Servizio Sanitario Nazionale, henceforth SSN) was reorganised, heavily drawing upon the English experience and the, at that time, National Healthcare System (hereinafter NHS) (Comodo and Maciocco, 2005, p27). However, due to recent reforms of the public healthcare sector, the differences between the two systems increased; nevertheless, similarities are still evident, which allows for a study of the two systems.

Please note, Section 5.2.2 of the SSN is shorter than Section 5.2.1 of the NHS because, due to the strong similarities between the two systems, I have focused my attention on post-reform differences without replicating the same information twice.

### 5.2.1 – The NHS, an Overview

The NHS is universally recognised as the traditional universalistic system (Esping-Andersen, 1990) since it generally offers its services free at the point of delivery to all residents, who are eligible to receive medical support in terms of diagnosis or treatment of an illness without being asked to pay for it before, during, or after the provision of care. However, following the 2012 reform, the NHS underwent significant organisational and ethical changes, losing part of its democratic and public original nature. It became significantly market-oriented, changing its internal organisation from pyramidal and politically owned to more horizontal, fragmented, and localised, with medical experts and private, commercial entities playing a significant role (Reynold, 2013; Davis et al, 2015). The aim of this reform was to free the NHS from organisational redundancies, disservices, and ‘excessive bureaucratic and political control’ (Department of Health, 2010, p9) to improve the quality of the services provided. However, scholars and commenters remain critical of the reforms’ capability to reach the expected goals, claiming instead that it has led to a poorer quality of care provided (Appelby et al, 2014; Bojke et al, 2016; Robertson et al, 2019) and greater territorial disparities in terms of access to healthcare services (Withehead et al, 2010; NHS England, 2016). Although these claims are still debated, the reduction of hospitals and A&Es is indisputable (Boyle et al, 2017; Ewbank et al, 2017), as is the increase in pressure on the remaining ones (Baker, 2017). Moreover, the NHS suffered and still suffers from a reduced staff turn-over, resulting in a shortage of staff that has further increased waiting times while reducing patients’ satisfaction (Appelby et al, 2014; Bojke et al, 2016; Robertson et al, 2019).

In the NHS, as well as in the majority of today’s healthcare systems, patients’ first points of contact are general practitioners (GPs) and emergency departments (A&Es in this thesis). The GP is a physician operating within a defined community who treats patients with minor or chronic illnesses while referring those with serious conditions to a hospital or a specialist. The A&E, meanwhile, offers a similar diagnostic service, although it is more specialised and thus focused on major trauma and urgencies. Moreover, its services are not limited to the members of the community where they operate and are instead open to everyone, independent of their citizenship or residence. Patients can access an A&E without prior appointment, either by their own means or by ambulance. Due to the unexpected nature of patients’ conditions, an A&E is generally able to provide initial treatment for a broad spectrum of illnesses and injuries, some of which might be life-threatening and require immediate attention. According to the department equipment and actual capacity to intervene in complicate urgencies, A&Es are organised in three levels: from walk-in minor centres (level 3) to fully equipped one (level 1) (The King’s Fund, 2017). The last, to which both my cases of study belong, are major A&Es that can 24 hours per day, have a shock room for life-threatening conditions, and are able to treat patients with highly complex or acute conditions. They have a triage area (where priority of treatment is assigned), at least one waiting room, and different recovery areas.

The triage process is central to the A&E activity, and it regulates patient admission based on the complexity and urgency of their health conditions. First developed by Baron Jean Dominique Larrey, Napoleon’s chief surgeon, to prioritise health treatments to soldiers with higher chances of survival, it was further improved during the wars of Korea and Vietnam and, finally, adopted by the civilian sector during the 1980s (Blythin, 1988). Although a unique and internationally acknowledged definition of triage does not exist, it can be described as a dynamic process of selection implemented by specifically trained nurses. Its purpose is not to provide a diagnosis, nor to define the necessary treatments, but rather to prioritise patients’ access to the real department according to subjective and objective parameters (Gruppo Formazione Triage, 2010).

The NHS, which since its creation has been at the forefront of medical and organisational innovation, today uses the Manchester Triage System (Ganley & Gloster, 2011). This is based on a complex algorithm consisting of 52 flow charts related to the incoming patient’s condition, and it focuses on six key discriminators: life threatening, haemorrhage, pain, consciousness level, temperature, and acuteness, or time since onset of illness or injury (Ibid, p50). Clinical priority is assessed on a colour scale from one to five: red for highest priorities and then orange, yellow, green, and blue for the lowest ones. Each colour also indicates the expected waiting time as defined by national guidelines, and blue codes have a maximum waiting time of four hours (Wyatt, 2019). Triage nurses start their screening from health indicators related to the highest priority, assigning the lowest code as a result of an excluding process. However, the assigned level of priority might be reassessed according to changes in patients' health condition.

#### 5.2.1.1 Zero Tolerance Policy in the NHS

Drawing on Wilson and Kelling’s ‘broken window theory’ (1982), which suggested that ignoring or being too tolerant toward minor crimes results in the occurrence of major crimes, the locution ‘zero-tolerance policy’ indicates a set of strict punishments for those who infringe upon a defined rule. It is characteristic of zero-tolerance to avoid differentiating between minor or major infringements without offering justifications to misbehavers and while requiring those in positions of authority to always impose the pre-defined sanction. Although little evidence supports this approach (Paniagua et al, 2009 Dickerson, 2014, Skiba, 2014), zero-tolerance policies are today applied in different settings, including the NHS, and can be traced to the 1974 Health and Safety at Work Act, which was further integrated by the 1999 Health and Safety at Work Regulations. These two bills require employers to protect the health, safety, and welfare of staff members, assessing the risk of aggression and establishing procedures aimed at preventing serious danger, and they are meant to be followed in case such danger arises. Finally, employers are required to provide information and training on health and safety risks and the control measures in place (NHS England, 2012).

Following the large number of unacceptable behaviours against NHS workers, a zero-tolerance policy was first announced in 1998 (Department of Health, 1998), and it required NHS trusts that provided mental health services to prevent any incident of violence against staff, to properly report and record those that did take place, and to establish protocols of cooperation with the police and prosecution services to pursue cases of violence against staff. Following this, in October 1999, several initiatives to reduce violence were officially incorporated under the flag of ‘zero tolerance’, more precisely, the ‘zero-tolerance zone campaign’ (NHS Executive, 1999). However, according to Paterson and colleagues (2008), it was only in 2001 that discourses of zero tolerance become pervasive (Ibid, p28).

In September 2018, the Assaults on Emergency Workers (Offences) Act 2018 was approved. From one side, this act reinforces the application of zero-tolerance policies in the NHS, harshening the punishments and simplifying the legal recognition and punishment of acts of violence. However, it also implicitly acknowledges the failure of the zero-tolerance approach, admitting that its introduction in the early 2000 did not solve the problem of abuse against healthcare workers, which instead rose according to official figures (Cowper, 2018), although, as discussed in Chapter 2, the figures are often disputable. However, as discussed by Paterson and colleagues (2008), it is not possible to state whether these policies are effective because they are hindered by broader strategic problems that cannot be solved at the local level with more CCTVs. Rather, they require government actions at the national level, such as resolving the chronic shortage of nurses, reducing the waiting time, or improving the access to mental healthcare services (NICE, 2015).

From nurses’ perspectives, despite the government’s official commitment and large campaigns, the zero-tolerance policy did not reach the expected objectives. Summarising the literature on this topic, today, zero-tolerance policy mainly consist of passive defensive systems such as CCTV, panic alarms, security doors, and other physical or practical solutions (NAO, 2003; 2005; see also Section 2.4.1). Much of it is reported by nurses to be unfit for its purpose, while many, including those at high risk, complain that they did not receive any training at all, and that they do not feel safe at work or protected by the State. Moreover, nurses complain that only few collaboration protocols with the police and prosecution services have been set in place to pursue cases of violence against staff (NAO, 2003; Royal College of Nursing, 2018).

### 5.2.2 – The SSN, an Overview

Similarly to the NHS, the SSN is also considered an example of a universalistic healthcare system but, like the English one, it faced a similar process of de-centralisation and, more indirectly, privatisation aimed to reduce costs while improving the quality of services. Following the 1999 reform of the Fifth Title of the Italian Constitution, the legal competence for the provision of healthcare was delegated to the 20 Italian Regions. These can develop new policies and re-organise the forms of care offered, although they must ensure a minimum level of care defined by the Ministry of Health. As discussed by Tognetti Bordogna (2010, 209-11), this resulted in significant differences between regions in terms of the actual provision of care, the participation of private entities, closure, and the management of existing hospitals and in the dilatation of real waiting times, with Veneto steadily among those offering the best care. This caused a poorly regulated increase of requests for private, faster, and easy-to-access healthcare, which has led to a significant increase in out-of-pocket expenditures. In addition, noteworthy flows of internal healthcare migration from the southern regions to the northern ones have increased the pressure on A&E, which are seen by users as the best way to accelerate the process of admission to specialist consultation (HoNCAB, 2014). Therefore, like the NHS, the SSN also suffered a reduction of staff and of first points of contact, as well as an increase of pressure on the remaining structures, thus leading to lower patients’ satisfaction (Ministero della Salute, 2010; Evangelista, 2017).

Again, with first point of contact, I mean GPs (medici di base[[4]](#footnote-4)) and A&Es (Pronto Soccorso[[5]](#footnote-5)), whose institutional function does not differ between SSN and NHS. Nevertheless, Italian A&Es differ from English ones in four respects: the first contact, how priority is assessed, a second triage at discharge, and the request of a €25 co-payment for those triaged at discharge with low priority. Please note that since, as previously discussed, the SSN is regional, patients undergo different procedures and receive requests of payment according to the region of hospitalisation. In agreement with the aim of this thesis, the description here provided applies to the Veneto-region hospitals only.

The triage colour code applied in Veneto hospitals does not require an objective assessment of biometrics; thus, although it is nominally based on the Manchester Triage System, it focuses on life-threating conditions and diagnosis rather than on an analytical workflow. The red code, the highest priority, indicates an immediate, life-threatening condition such as inability to breathe, severe cardiovascular condition, severe neurological deficit, or failure of vital function; a yellow code indicates serious injuries that may affect vital functions if not promptly treated; a green code indicates no life-threatening and stable vital functions, such as fractures that do not involve vital organs; whereas the white code, lowest priority, is assigned to patients whose conditions do not justify their presence in the A&E. As for the NHS, the maximum expected waiting time is four hours.

#### 5.2.2.1 – Zero-Tolerance Policy in the SSN

The introduction of zero-tolerance policies in Italy is quite recent, and they were mentioned for the first time in 2007 (Ministero della Salute, 2007) with the aim, once again, of replicating the English experience. Although the reason for such late interest has not yet been fully explored, it may be related to the fact that the Italian legislature has always been primarily focused on process-related injuries or chemical/biological hazards. Only recently, following the 2007 industrial disaster at ThyssenKrupp in Turin, did the legislature conduct a broad, substantial review of the several pieces of regulations on health and safety. The revision was open to suggestions from the civil society and trade unions, resulting in the 2008 legislation on wellbeing, health, and safety on the workplace (D. Lgs 81/08). It is thanks to the introduction of the concept of wellbeing that situational improprieties from service users, co-workers, or managers were integrated, resulting in the adoption of a holistic perspective that also includes psychological damages from verbal abuses. However, as discussed by Brunetti and Bambi (2013), the SSN workers benefitted from an earlier intervention, which was not legally binding, with the 2007 ‘Recommendation to prevent acts of violence against healthcare operators’ issued by the Ministry of Health (Ministero della Salute, 2007) with clear reference to the NHS experience. This recommendation promoted a program of prevention based on five pillars: to enforce, promote and disseminate a zero-tolerance policy against physical and verbal aggression; to encourage workers to report every episode of violence; to enhance the relationship with police forces and other public bodies that can support the identification of new policies and procedures; to internally identify a group of workers who can contribute to the definition of specific policies and procedures; and finally, an invitation to the management to affirm its commitment to end violence against workers (Ibid). Finally, in 2009, physical aggressions against SSN workers were included among the ‘alarm indicators’ to identify unhealthy workplaces in need of assessment and restructuration.

As can be observed, the Italian zero-tolerance policies do not mention the punishment of perpetrators because the Ministry of Health guidelines have administrative value only. Nevertheless, they are reported to have reduced the aggressiveness of many, especially of those who have been repeatedly violent (Quaranta and Granieri, 2016). This success remains disjointed from the punctual enforcement of severe penalties, or from the increased use of passive defensive systems. Instead, a positive effect is recognised in the diffusion of dedicated training courses aimed at improving nurses’ interpersonal and soft skills, such as

‘availability, empathy, patience, competence, and knowledge of the social environment we are working in.’ (Granieri and Quaranta, 2016; Carrara, 2017)

In conclusion, although the Italian definition of zero-tolerance draws from the English one, due to a lack of State intervention, it evolved in a quite different direction. Despite the public political rhetoric in support of harsher penalties, these never came into force; instead, Italian healthcare providers focused on prevention through specific and dedicated training courses for their front-line staff.

## 5.3 – The Research Settings: Two European Hospitals

This thesis collects data from two research settings: the Essex hospital, enrolled by my first supervisor via personal contacts, and the Veneto hospital, enrolled by me due to the fact that I worked there as project manager at that time.

The process of gaining access to the research settings was similar: after a first introductory meeting to discuss the general aspects of the research and to meet and engage the gatekeepers (one meeting per structure, two gatekeepers per structure), both hospitals produced non-binding preliminary letters of acceptance. Their participation was subject to prior approval of the research protocol by the ARU Faculty of Medical Sciences Research Ethics Panel, and then by their own ethical committee. The Italian version of the research protocol was updated in accordance with the Italian legislation in terms of privacy, anonymity, and the disclosure of collected data (see Section 6.6.4 for additional information). This operation was performed in cooperation with the internal support service for non-profit research.

In terms of access and research methodology restrictions, both hospitals denied me permission to conduct any form of observation of nurse-user interactions. primarily because my simple presence as observer would have meant an additional person occupying the limited A&E working space, thus potentially disturbing or limiting nurses’ activities. Also, as the Italian ethical committee, as well by the ARU one, noted that observing a social interaction implies the observation of at least two actors, which implies the collection of both their informed consent (hereinafter IC). Drawing upon the literature discussed in Section 2.4.2, perpetrators often have mental health conditions, are in pain, or are severely distressed. Without mentioning the practical difficulties of convincing an agitated user to sign an informed consent, ethical doubts on the actual informed nature of their consent would remain (Schuster, 1996).

Following this restriction, I first felt that this would have prevented me from informally interacting with nurses, thus limiting my chances to win their trust and cooperation. Luckily, my gatekeepers have been extremely supportive, and they eased my access to the field, introducing me to their colleagues, inviting me to prolong my presence in the department and, for the Veneto hospital, granting for my reliability as researcher. As previously stated, in both settings I had two gatekeepers: the A&E manager, who acted as the liaison with the hospital management, and an A&E nurse, who acted as liaison with the nurses. As Pole and Lampard (2002) have stated,

‘[The] gatekeeper may occupy a powerful position within the setting, which may have potential implications for the researcher’s activities within the setting and on the research output.’ (Ibid, p.45)

This is particularly true for the Italian arm of the research. Whereas the access to the English setting did not raise any significant concern and I was welcomed as am external researcher, Italian nurses initially perceived me as an unwelcome observer from the management due to my position within the organisation. It was only thanks to the gatekeepers’ efforts that my identity as researcher was detached from that of project manager, significantly improving nurses’ attitude toward me and toward the research.

In both settings, my first formal meetings with the participants was organised by the gatekeepers. In addition, they distributed copies of the Participant Information Sheets (PIS), IC and the qualitative checklist reports (see Section 6.3.1.1) to those who were off-duty at the time of my visits. Last, they acted as a mediator between me and the staff, personally introducing me to those nurses who could have been more interested in my research and to those who experienced significant improprieties from users.

### 5.3.1 – The Essex Hospital

As the fictitious name suggests, the English hospital is located in the Essex County. It serves a large sub-urban and urban area on the East of London, and in it 2018/19 received around 150.000 attendances to the A&E department or other urgent and emergency care services, such as GPs services.

The department is accessed through the main entrance to the hospital premises, although ambulances have a separate entrance from the back of the premises leading directly to the ‘majors’ area. Other users must access from the front door through a short ramp that leads to the waiting area. Users have to walk straight to the reception, register themselves, and wait to be called by the triage nurse who sees them in a separate room next to the reception. The waiting room is furnished with lines of seats; some face the outside, and there are two vending machines (hot drinks, cold drinks, and snacks) and two monitors that show the expected waiting time and warnings against abuses, and a phone to call for a local taxi. According to the triage code, a nurse from ‘minors’ or ‘majors’ opens the related security door and calls in patients by surname. The doors on the right of the receptionists’ booth can only be opened from the inside or with a badge.

The receptionists sit in a security booth, raised around 20 centimetres above the floor and protected by a glass wall (due to previous knife attacks); they face the entrance door, the waiting room and, slightly to their left, the triage room. Between the receptionist booth and the triage room, a short corridor leads to the paediatrics waiting room – half the size of the main one and with no windows. Children draw, and a play area identifies it. Here, paediatric nurses sit behind an L- shaped desk with no protection.

The department is composed of four main sections: ‘minors’, ‘majors’, paediatrics, and resuscitation. Minors, on the left of the booth, has a small waiting room, a desk with a PC, and two visiting rooms. Majors is a large, square room organised like a star, and at the centre it has a squared counter with PCs and other office tools inside the space it delimitates. On one corner stands the nurse in charge, coordinating the work of the staff. Patients are hosted in the cubicles around this, with two to three per side, separated by curtains; usually, there is one bed per cubicle. The four corridors exiting the room lead to the back of the receptionist booth and the waiting area, where patients are admitted; to minors to resuscitation; and to the ambulance entrance. Two additional small rooms are used as an office and resting area, or, sometimes, as visiting rooms.

The resuscitation area is placed between the paediatrics and majors, and it consists of a pharmacy area (a high-to-the-ceiling L-shaped chest of drawers) and a desk area facing the two cubicles (larger than those in majors) separated by curtains. Two security doors and a corridor link it to the paediatrics area, which consists of four visiting rooms behind the aforementioned desk. All areas communicate between them and with other areas through security doors that can be opened only with a valid badge. The only exception is the door in ‘majors’ that leads to the ambulance bay to allow paramedics out without a badge. The staff area is located on the first floor and consists of the manager office, two classrooms, two changing rooms, and one kitchen that also works as a coffee and relaxation area. It is accessed through a stair from minors, at the top of which a security door prevents users from accessing it.

In terms of staffing, around 15 nurses and healthcare assistants, around seven doctors and a maximum of three receptionists operate during day shifts. Figures are lower at night shifts: around eight nurses and healthcare workers, around five doctors, and two receptionists who alternate between front-end and back-end administrative activities. Unfortunately, due to staff shortages, holidays, and sick leaves, figures vary each day and from shift to shift. What remains stable is the number of nurses performing triage: one. This is mostly because of the single triage room, but it is also because few are trained for it.

Staff members in Essex are of mixed cultural origin and nationality. Although the most represented group is that of Britons, many were immigrants from Spain, India, and Nigeria. Some of them were not fully proficient in English, and two of them refused to be interviewed because of language issues.

During the research, both gatekeepers were moved to other departments. The nurse one entered the hospital research centre, whereas the manager moved to a different hospital. Luckily, they both left after the first phase of data collection, when I was already well introduced to the staff. In addition, the new gatekeepers did not question the arrangements I had with the previous ones in terms of informal chats with nurses.

Concerning my presence there, I had to wear a badge at all times, which gave me access to every area. On my first day, I was personally introduced to every available nurse by the nurse gatekeeper, who was well respected and known for her availability and readiness to help. This positively impacted my interactions with the Essex staff, although my relationship with them always remained professional. Although I was not formally allowed to do any ethnographical work, I was often invited to do so during the time spent there. In one case, on my second day of data collection, I was warmly invited to come and observe a patient who was threatening to assault a nurse – which actually happened in front of my eyes. To avoid disappointing the nurses who invited me, and who also were quite in distress, despite not being formally allowed to do so, I followed them. I took note of what I saw, I interviewed the abused nurse who refused to complete the hospital form because of the perpetrator’s known mental health condition, and, due to the agreement limitation, I spoke about it with the manager. The second gatekeeper concluded that my behaviour did not violate the research protocol and agreed to let me keep my notes, provided that anonymity of both actors involved was ensured. I believe that that significantly consolidated my identity as a researcher among the nurses.

In terms of the zero-tolerance policy, the Essex Hospital abides by the policy of the Health and Safety Executive (HSE) to address

‘any incident in which an employee is abused, threatened or assaulted in circumstances relating to their work.’ (Hand, 2015)

The Essex hospital recommends that, in the event of the above-cited incidents, a senior member should issue the perpetrator an informal verbal warning. Should this be disregarded, the said person has to be removed from the premises, either by security staff or by the police. Several A2 posters in the three waiting rooms provided reminders of this, and the message was periodically shown on the two monitors. In addition, a team of three security guards was always ready to reach the department upon call and eventually remove the perpetrator from the department.

### 5.3.2 – The Veneto Hospital

Located in the Veneto Region, it is one of the largest hospitals in Italy. Divided in two campuses, one in the north and one in the south of the city, it has two A&Es. The one enrolled in my research was the north one, which is also the larger, and it is where the majority of cases, especially the more serious and complex ones, are referred. According to recent figures, it receives around 90,000 patients per year, but, due to severe staff shortage, there are only 11 doctors and 15 nurses to cover all the shifts. To these figures should be added a variable number of final-year students of medicine and nursing studies who complete their mandatory internship there. The number of staff members per shift can thus vary significantly according to staff and student availability.

Patients access the A&E from the same entrance, although it is divided in two adjacent doors. Urgent cases arriving with an ambulance enter from the right one, which leads directly to majors and can be opened only from the inside or from an external keypad. Other users, including not urgent cases arriving with an ambulance, must take the left one that opens on the main waiting room and leads to the triage booth. Regular and emergency entrances are separated by a white glass wall, which is transparent enough to allow those in the waiting room to see shadows moving behind it, and thus understand that an urgent case has arrived.

The triage booth is placed directly in front of the left entrance, with at least two nurses sitting there. The booth is completely closed, and communication happens through a microphone, while documents or other papers need to be placed into a drawer to be pulled in by the triage nurse. All seats look toward the three monitors, placed on the left of the booth, and that show the expected waiting time per colour. Three vending machines, placed under the monitors, provide hot drinks, cold drinks, and snacks. Users can also take a book from a shelf placed next to the vending machine that works as free library. Users are invited to contribute with new books.

The medical part of the department is composed of four areas: majors, minors, resuscitation, and orthopaedic. The triage security booth represents the centre of the department, with majors and resuscitation on the right, and minors and orthopaedic on the left. Behind is the triage room, and to access it, users must cross the security door that leads to majors, which can only be opened from the triage booth or from the inside. At the right of the triage area there are, in order of distance, the head nurse office and the staff kitchen, which also works as a social area, majors, and resuscitation. Majors has a main desk area at the centre with five operation rooms around it and a small waiting area. On the right and back is the resuscitation area, which consists of a pharmacy area (several closets) and a room divided into three large cubicles by curtains. A corridor behind the triage area links these areas with minors, orthopaedic, and the administration area. There are no security doors separating one section from another, only between the medical areas and the main waiting room.

Minors occupies the largest area and shares with orthopaedic a second waiting room and four rooms for users who need to lie on stretchers. These four rooms are opposite the ambulatory rooms, but in contrast to them, their size varies, hosting from two to a maximum of eight stretchers. This second waiting room is furnished with two vending machines, a desk with a PC, and a copy machine. Users access this area from a door on the left side of the main waiting room. It can be open only from the inside.

On the left side of minors, two parallel short corridors lead to the administration area. There are no doors preventing users to access this area, mostly because here they can find the counter where they will eventually pay their co-payment. The department director’s office and two meetings rooms are also located here; staff members use these to take short naps during night shifts. I first met and presented my research to the majority of the staff in the largest of these rooms in two rounds: first those soon to start their shift and, immediately after, those whose shift just ended.

Although the department environment is quite cold (white and pale-yellow walls and greenish linoleum), the hospital hosts the works and expositions of several local and national artists. Several paintings and prints decorate the department.

Regarding my access to the field, it was more complicated than expected. Although I entered the department with the full support of both gatekeepers, my presence was negatively perceived at first, especially by doctors. As previously introduced, at that time I had a double identity: that of researcher and that of project manager. I was thus seen as part of the hospital management, perceived as the closet cause of staff shortage and lack of funding. Actually, during the first meetings, where I presented the research aim and its methodology, doctors openly voiced their dissatisfaction with the situation, claiming that my research was useless because the real issue was the lack of staff; this suggested that my presence there was an attempt from the management to refute their requests. With the support of the two gatekeepers, I negotiated my presence there as mere researcher, suggesting that my study could offer some pragmatic solutions and that, in any case, I was not there to deny their request for additional staff. I also suggested that my thesis could cast light on the aggression problem, thus supporting the department director in developing new, effective guidelines and policies and thus providing additional material to support their claim of a staff shortage. Thanks to this and the gatekeepers’ endorsement, my identity as researcher was finally accepted.

With respect to my presence in the department, I was of course at an advantage compared to the Essex setting. Due to my professional position, I was fully entitled to roam, even though as a researcher, I was not allowed to do so. In order to both not appear invasive and to keep my data collections aligned, I avoided visiting the A&E during my office hours as much as possible and kept the number of visits to informally chat with staff members similar to what I did Essex. Moreover, I always asked the head nurse for permission to visit the department before going there. It was never denied, and at first it was perceived as unnecessary, but when the head nurse was transferred to another ward and I met my new nurse gatekeeper (the new head nurse), they expressed appreciation that I was respectful of their work and commitment. Regarding my dress code, in agreement with the hospital regulation, I was required to always wear my admin coat when there. This was to prevent patients’ companions from claiming that another user was free to walk around while they had to stay in the waiting room, or have limited time to visit their relatives or friends. However, the admin coat is distinct from the physicians’ only by blue stripes on the collar; thus, although coat differences are well advertised around the hospital, the majority of users were not able to spot the difference. This caused a few of them to ask me about a diagnosis, treatments, or other information, with one grabbing my sleeve and refusing to leave me until I had visited them. Although I did not feel threatened or harassed by this behaviour, this experience was a helpful indicator of the stress level in the department and of the need for additional staff.

Contrary to the Essex hospital, in Veneto, all nurses were Italian, with the large majority being locals, meaning that we spoke the same dialect. This facilitated my communication with them, which was helpful because ‘situational impropriety’ cannot be directly translated in Italian. In this case, drawing upon the Essex experience, I presented my research as focused on any behaviour from users deemed not acceptable in that context, ranging from physical aggression to lack of manners. This was initially taken with irony, claiming that they would have had to spend half of their shift writing about the other half.

Finally, regarding the implementation of zero-tolerance policies, the only sign of it were two A2-size posters warning that any form of physical or verbal violence against staff members would have been reported to the police. The posters were quite plain and formal. At the time of the research, the hospital did not provide any security service; thus, in case of emergency, nurses had to call the police. However, due to informal agreements between the hospital and the police, one or two police cars always patrolled near the hospital, ready to intervene.

## 5.4 – Chapter Conclusion

In this chapter, I have provided a short but exhaustive presentation of my cases of study, preceded by an introduction to the English and Italian healthcare systems. As discussed, despite the recent reforms, the two systems are quite similar in their organisation, which allowed for a joint exploration.

The two settings present similar characteristics, both in terms of the number of patients served and the internal organisation. However, several differences can be identified: from the institution of zero-tolerance policies to the nationality of the nurses; from the adoption of several security doors to the use of rooms instead of curtains to delimit cubicles.

In the next chapters, I often recall information provided here. For instance, in Chapter 8, I refer to the differences between the two departments to support my understanding of the data collected.

# Chapter 6 - Methodology

## 6.1 – Introduction

In Chapter 2, I offered a critical review of the most relevant studies on unacceptable behaviour in A&E from users against nurses, discussing and stressing the need for a qualitative approach to this issue. In Chapter 3, I then explored the concept of unacceptable behaviour in order to identify the most appropriate sociological term to explore behaviour deemed unacceptable from a constructionist perspective, a discussion that led me to Goffman’s concept of situational impropriety. In Chapter 4, I presented Goffman’s sociological theory and recent developments and discussed Ensink’s theoretical framework. In Chapter 5, I presented my two cases of study, discussing both similarities and differences at the national and local level in terms of how they function and how they officially define and address situational improprieties. Moreover, I have discussed my access to the field and the limitations imposed by the hospital management.

In this sixth chapter, I present and critically discuss my research methodology, based on the triangulation of methods suggested by Goffman: observation and interviews (Lofland, 1989, p.131). However, due the veto imposed by the hospital on ethnographic observation, I have instead pragmatically developed easy-to-use qualitative checklists to collect participants’ first impressions of the improprieties experienced or witnessed.

The chapter, which consists of six main sections, opens by presenting my research question drawing from Goffman’s ‘within-method triangulation’ (Denzin, 1978): perspective by incongruity to uncover tacit expectations in the nurses’ guiding frame; this is coupled with the exploration of frame-clearing strategies to gain a deeper understanding of the expected acceptable behaviour. As a result, my research question is informed by two sub-research questions.

Section 6.3 presents my research design, discussing the nature of a multi-case study and the methods employed to collect the participants’ viva voce: qualitative checklists and semi-structured interviews. The relevance of these methods for the two sub-research questions is discussed here. Moreover, I offer a discussion on the qualitative nature of my checklists.

Because of the bi-lingual data collection, in Section 6.4, I discuss my process of translation. Data was collected in local languages, thus requiring the translation of the Italian arm to create a unique body of data in a single language – English – to allow for their joint analysis. A practical example of the adopted performative translation is offered.

Section 6.5 offers a step-by-step, detailed description of the process of data analysis adopted. As previously introduced, I follow Ensink’s (2003) methodology, and I discuss it with the support of practical examples.

Section 6.6 discusses the main ethical considerations related to this research. Here, I discuss how participants’ rights were ensured in terms of full information, collection of informed consent, and anonymity.

Finally, in Section 6.7, I reflect upon the main criticalities and validity of my methodology and methods. This section describes the reflexive process adopted, the self-criticisms exercised on my own work, and the qualitative nature of my checklists.

## 6.2 – Research Question

Following Goffman (Lofland, 1989), I adopted a within-method triangulation to explore the A&E Frame from two different perspectives. Despite not being aware of any previous use of it in frame analysis, drawing upon the theoretical discussion offered in Chapter 4, I am convinced of the robustness of my approach, and I defend it in this chapter. As discussed, situational improprieties and frame-clearing strategies are connected and consequential, allowing for a holistic exploration of a social event. The former forces actors to reflect upon their tacit expectations, whereas, consequently, the latter requires actors to verbally clarify their expectations for the benefit of the perpetrator.

In terms of research question, this results in an overarching one investigated through two sub-research questions. The main research question is:

How do accident and emergency department nurses frame their professional interaction with users?

This is operationalised through two sub-research questions:

1) Under what conditions are users’ performances perceived as situationally improper?

2) What informal strategies are adopted to deal with situational improprieties?

These inform the overarching research question and explore the A&E Frame from two different perspectives. Following Burke’s perspective by incongruity (1965), the first sub-research question explores the frame through its ‘cracks’, through ‘what is wrong’ and what violates nurses’ tacit expectations. The second is informed by Goffman’s concepts of frame disputes and frame clearing. It has the twofold purpose of investigating the informal strategies implemented to promote the correct interpretation of the frame and, consequently, the discussion offered about the expected performances to which transgressors should be led.

Following Denzin (1978), I expect the two sub-research questions to produce converging and mutually supporting answers, with each confirming and completing each other. I believe this will expand the depth and breadth of my exploration while reinforcing the validity of my findings.

## 6.3 – Research Design

The research design draws on a qualitative multi-case study research approach to collect nurses’ original descriptions and narrations. As discussed by Punch (1998), the case study aims to explore a single case in detail, or a limited number of cases as per this thesis, within its real-world context using the most suited methodology to ‘develop as full an understanding as possible’ (Ibid, p.150). Moreover, as suggested by both Stake (2000) and Yin (2013), the case study methodology suits constructionist purposes by investigating reality as a human creation because it allows for a close observation of the process of creation and reproduction of institutional facts. The case study thus suits both my constructionist ontology and my theoretical framework.

In agreement with the definition of A&E offered in Section 5.2, my research settings are the Essex Hospital A&E (England) and the Veneto Hospital A&E (Italy), which fully represent ‘the circumstances and condition of an everyday or common place situation’ (Yin, 2009, p.48). Other criteria of selection were the pre-existence of good relations with the management, their availability to cooperate, and their accessibility.

The case study methodology has been criticised in the literature because it is considered unable to produce generalisable conclusions (Bryman, 1988, p.35; Gobo, 2008, pp.240-42; Silverman, 2014, pp.69-71), and because the findings are at risk of reproducing researchers’ preconceived notions (Flyvbjerg, 2006). However, as suggested by Alasuutari (1995), the inability to present generalizable conclusion is intrinsic to social sciences, independently of the methodological stance, due to the constant mutation of social reality. Examples of this are the quantitative studies discussed in Chapter 2 that, due to the different social contexts and the different definitions adopted, failed to produce generalizable conclusions. Moreover, as suggested by Yin (2009), qualitative researchers should not focus on generalisability as defined in hard sciences, but rather on general theory that can be applied in similar settings. According to Yin (Ibid), the aim of a case study is to

‘expand and generalise theory (analytic generalisation) and not enumerate frequencies (statistical generalisation).’ (Ibid, p.5)

In agreement with this statement, the purpose of this thesis is to explore nurses’ definitions and informal dealing strategies in depth in order to generalise about their guiding frame – not to indicate the frequency of certain situational improprieties or of certain dealing strategies. The focus is therefore on the organisation of performances (frame), defining generalisability as present in the existence of any case, even if it occurs only once, because each case belongs to the observed frame. Thus, this thesis cannot, and does not aim to, generalise about a specific dealing strategy and its use. Instead it aims to generalise about the frame that guides A&E nurses’ definition, evaluation, and judgment of users’ performance independent of the research context.

With reference to the second criticism, that case studies tend to confirm the researcher’s preconceived notions (Flyvbjerg, 2006, p.21), as already discussed in Chapter 2, this should rather be a concern for quantitative scholars and their pre-conceived data collection tools (Ferns, 2005a; Taylor and Rew, 2011). Instead, the case study methodology allows for a greater analysis of participants’ voices and definitions, marking a clear separation between the researcher and the participants’ voices (Flyvbjerg, 2006, p.21). Moreover, as discussed by Bloor (1978), qualitative studies allow researchers to verify their own interpretations through ‘respondent validation’ (Ibid, p548). This, according to Mays and Pope (2000), is defined as a technique

‘in which the investigator’s account is compared with those of the research subjects to establish the level of correspondence between the two sets.’ (Ibid, p.51)

With reference to my research, I validate my understanding of the information reported on qualitative checklists (see Section 6.5) by discussing it at the beginning of each interview. In doing so, I tried to minimise the influence of my preconceived understanding of nurses’ answers.

As discussed in the introductive chapter, my decision to use a multi-case study design with two different European hospitals relates both to the pre-defined topic of my studentship and my interest in investigating the trans-cultural validity of the A&E Frame. This expectation is based on my personal direct experience with different European hospitals and taken for granted by the scholars whose work is critically discussed in Chapter 2. A single case study would have therefore produced findings that were valid for that specific culture only, and would have been strongly influenced by the countless social and organisational external factors (see Section 2.4.2). In agreement with my ontological and epistemological stances, the use of a culturally different second case of study supports the minimisations of local influences on my analysis. Thus, it allows for the identification of commonalities between culturally different realities, and supported by further explorations, it leads to conclusions of wider transferability.

I believe that my research contributes to knowledge improvement and testing findings’ transferability, as it is the only qualitative research that collects data from culturally different settings; see Section 2.5. A gap in knowledge was identified by international bodies such as the ILO (Chappel and Di Martino, 2006, p.295, pp.300-01) and the EuroFound (2007, p.2), who have called for in-depth qualitative cross-cultural studies investigating workers’ perspective in order to improve the understanding of this phenomenon. Therefore, my study aims to verify the assumption, taken for granted by many scholars, that nurses share a similar understanding on situational improprieties, or that a cross-cultural A&E Frame guides their everyday interactions with users.

Finally, the decision to limit my study to two European cases is not based on theoretical or methodological assumptions. Instead, it reflects the pragmatic need to complete my part-time Ph.D. within the expected deadlines. In fact, as noted by Mason (2010), qualitative research is ‘very labour-intensive’, and ‘analysing a large sample can be time-consuming and often simply impractical’ (Ibid, p.1). The exploration of a third, or more, case of study would have not been feasible in terms of time.

Concerning the selection of the two countries, this hinges upon the studentship topic, my linguistic proficiency, and that of my supervisors, thus limiting the cases to Italian and English. Because of my focus on original expressions and taken-for-granted definitions, it would have not been possible to collect data in settings where these two languages are not currently used as a primary language. The choice of the research settings was thus limited.

### 6.3.1 – Data Collection

As Stake (2000) has noted, case studies combine different research methods according to their goals. Here, given the above-discussed research questions, my ontological and epistemological stances, and my theoretical perspective, I collect primary data through qualitative checklists (instead of ethnographical observation, as Goffman would suggest) and semi-structured interviews. In addition to this, informal conversations and my research diary supported the data collection. A detailed description of the methods used is offered in the next sections.

An eligible participant was any nurse employed in one of the two settings, independently of their duties or specialisation. Patients, companions, attendees, other un-specified non-members of the staff, and other staff members were not included. Therefore, no IC was provided to the excluded subjects since they had no research-related contact with me, nor a direct role in this research. With reference to users, despite exploring their situational improprieties, their descriptions were collected as nurses’ perceptions of their characteristics and not as users’ real data. In addition, their personal information was not collected, and it is not possible to identify them. In agreement with the literature (Zampieron et al, 2010; Pulsford et al, 2012; Koukia et al, 2013) and with the hospitals’ ethical committees’ indication, perpetrators and users’ IC was thus not necessary. This research is based on nurses' perceptions and definitions of users’ improprieties in A&E only.

The data collection was organised in two phases and lasted a total of 12 months, six per hospital, alternating my presence in the two settings. The first phase, four weeks per setting, consisted of the collection of participants’ original descriptions of situational improprieties they were victim of, or witnessed, through qualitative checklists. The second phase began once the checklist findings were analysed. Two groups of 10 nurses per setting, were interviewed to validate my interpretations of the information reported on checklists, to reinvestigate their definition of impropriety, and to further investigate nurses’ guiding frame through the exploration of their informal dealing strategies.

As discussed in Chapter 5, despite not being allowed to interact with on-duty nurses unless engaged by them, due to their interest in this research, while collecting complete checklists (three times per week), I was allowed to exchange informal chat with nurses. Such informal conversations were noted in my research diary and successively used during the interview phase as conversational stimulus (see Section 8.2). Initially, these conversations focused on the nature and structure of this research, or on differences between the two healthcare systems. However, after several encounters, they felt confident enough to discuss recent events they deemed unacceptable, thus providing useful insights into nurses’ perceptions, definitions, and dealing performances.

Concerning my research diary, updated after each visit and in use until the submission of this thesis, it includes field notes, methodological and theoretical notes, and personal reflections about my feelings and impressions. This mix of information and thoughts not only guided me through this long and exciting Ph.D. experience, but it also allowed my previous theoretical thinking to be applied in other studies and work-related occasions.

#### 6.3.1.1 – Sampling strategy

Sampling strategies primarily differ on the use of probabilistic and non-probabilistic sample (Ritchie, Lewis and Elam, 2003, p78). The former characterises quantitative research, whereas the latter qualitative one. Usually, in probability sample participants are chosen at random – although with a known probability of selection – to produce a statistically representative sample of the population in study in order to test a theory. In a non-probability sample, participants are selected to reflect particular features of the studied population, statistically representativeness it is not pursued, the chances of being selected are unknown and no theory is to be tested. The characteristics of the population, and not of its members as individual, guide the identification and selection of participants. In agreement with Goffman (1974) I was interested in the group perspective, rather than in sub groups’ ones. Although sub-groups exist in every group, and potentially every sub-groups down to dyads of actors, these are often influenced by the environment at different levels (cultural, political or simply by central or local policies). The identification of sub-groups would have increased the complexity of my analysis in a way which was not directly relevant to my main focus. As discussed in Chapter 2, scholars’ excessive focus on settings’ peculiarities can cause overly narrowed investigations at the expense of more broadly applicable and overarching findings. My aim is to contribute to fill this gap, improving the transferability of my findings and focusing on European nurses at large.

In agreement with the theoretical explanation provided above, my qualitative stance and the chosen methodology, drawing upon the work of Sala (2010) and Ritchie, Lewis and Elam (2003), I have adopted a non-probability sample. More precisely, a theoretical sample by convenience (Patton, 2002, Sala, 2010): participants were selected as representative units of the studied population, both to align the sampling strategies of the two data collection methods; and to comply with the restrictions imposed by the hospitals.

To define participants as representative units means that each of them carries aspects and knowledge of the research subject that allows for the in-depth exploration of the guiding frame (Cardano, 2007; Sala, 2010). Therefore, applying the same rationale adopted for the research settings, each nurse (participant) fully represent the ideal nurse (Yin, 2009, p.48). Despite in Section 7.3 I will identify and discuss different sub-categories of nurses, my goal is not to pre-classify nurses based on gender, age or experience. Rather my aim is to focus on nurses as group to explore the group guiding frame. Individual perspectives, or sub-group ones, do not inform my methodology, although they will be later analysed to fully disclose my findings and inform future research.

Despite a certain level of agreement was reached with the hospitals, data collection, data analysis and theoretical reflection moved almost together, expanding the sample size till the achievement of theoretical saturation (Glaser and Strauss, 1967, p.45). With reference to the first data collection method, qualitative check-lists granted absolute anonymity. Distinctions based on nurses’ socio-demographic or professional characteristic were thus impossible. Also, nurses were free to submit as much check-list as they felt necessary and it is for me impossible to identify groups or individuals who contributed more.

Regarding the interview method adopted, the number of participants was agreed upon with local gatekeepers following managements’ request. Based on previous studies on this topic (Luck et al, 2007a; 2007b; 2009; Kamchuchat et al, 2008; Person et al, 2013; Pich et al, 2013), the number of employed nurses, the time I was able to allocate to this activity, and in agreement with the literature on theoretical saturation (Glaser and Strauss, 1967; Warren, 2002; Cardano, 2011), a number between 10 to 15 interviews was agreed. As per the previous method, every nurse was eligible. I was not allowed to directly select who to interview, rather participants were self-selected by informing the gatekeepers of their willingness to participate.

Despite I was not fully able to select my interviewees due to the agreement in place with the hospitals, I did try to reflect the workforce distribution at national level. Both samples were mainly composed by females, with all Veneto nurses being Italian whereas the Essex group was of mixed cultural background. Regarding this last point I was able to interview only one Spanish nurse, others refused because they felt their English level was insufficient for this activity.

In terms of age, in agreement with healthcare workforce national statistics, Italian nurses were generally older and with more years of experience (not necessarily in A&E) due to the blocked turn-over in the SSN.

#### 6.3.1.2 – Qualitative Checklists

Since ethnographic observation was not allowed, as discussed in Section 5.3, drawing upon the work of Elliot (1997) and Cardano (2011), I have developed dedicated ‘observation documents required by the researcher’ (Ibid, p.243), or qualitative checklists, in order to collect nurses’ first-hand, unmediated, and original descriptions of what was going on. Although this method is poorly discussed in literature, and mostly in the form of diaries (Elliott, 1997; Meth, 2003, 2004; Milligan et al, 2005; Kenten, 2010), I applied it as immediate annotation of the most relevant information, a method I have previously adopted in different settings and whose validity I successfully defended in front of different audiences (Gangitano, 2012; 2013; 2016). As discussed in the literature (Elliott, 1997; Milligan, 2001; Kenten, 2010; Cardano, 2011), solicited written documents represent an excellent pragmatic solution to obtain rich, qualitative data when observation is not possible, thus allowing participants to be both observers and informants (Zimmerman and Weider, 1977).

Drawing upon the discussion offered in Chapter 2, checklists were conceived to collect information on the two most relevant characteristics of a situational impropriety: the perpetrator’s identity and the nature of the impropriety. They were provided in English or Italian based on the setting, printed on A6 size (105 x 148 millimetres) paper in order to be comfortably carried in coat pockets, and they were bound in groups of 10 so that nurses were always reasonably provided with checklists. Following nurses’ complaints of overly long accident reports reported in the literature (Crilly et al, 2004; Pawlin, 2008) the checklists were conceived to be completed in less than two minutes. As per the example in ‘Annex 1 – Checklists sample’, they collected information on the date and time of impropriety, the perpetrator’s role, perceived estimated age and gender, the perceived identity of the perpetrator, nature of the impropriety, and the intervention of hospital security, or police forces for the Italian setting. Compiling instructions were provided on the back of each checklist and on the dedicated Participant Information Sheet (hereafter, PIS), which was distributed to each nurse by gatekeepers prior to the data collection. Once they had been completed, checklists were to be dropped in sealed ballot boxes placed in the department, two in Essex and three in Veneto due to the different spatial organisation (see Section 5.3). These were emptied by me every two or three days, thus allowing for frequent, informal interactions with on-duty nurses to answer their questions about the research and to encourage their participation.

All nurses were invited to participate and to complete as many checklists as they felt necessary, one per each perceived impropriety, either suffered or witnessed. In terms of IC, as discussed by Schmidt (1997), due to their absolute anonymity, the previous induction meeting and the distribution to each nurse of a dedicated PIS, the act of returning a completed checklist was considered equivalent to the provision of a formal informed consent. Therefore, no IC was produced for this method. At the end of the data collection period, relatively for this method, a brief and mostly graphical report was offered to the two teams: both as restitution and in order to stimulate nurses’ interest in the second phase of data collection. The report, written in the local language, was sent to the two gatekeepers, who circulated it among their colleagues. A copy of the English report is offered in ‘Annex II – Qualitative Checklists Mid-Term Report’.

#### 6.3.1.2 – Semi-Structured Interview

According to Sala (2010), interviews are the perfect instrument to access someone’s perception, to understand how social situations are defined, ‘and to investigate how social actors construct the surrounding reality’ (Ibid, p.77). Interviews were here used to verify my understanding of what was reported on checklists, to further investigate the same improper events, and to answer my second sub-research question on dealing strategies and expected proper behaviour. In order to do so, I developed a shortlist of key topics to be investigated, whose use defines my method as semi-structured interviews (Corbetta, 1999). The decision to use semi-structured interviews pragmatically answered the requests from both hospitals to avoid diverting on-duty nurses from their tasks for more than 20 minutes and my need to ensure that the relevant topics were discussed.

The moderation guide was composed of six strands, investigated with the support of information collected through checklists and informal chats. Interviews began with the provision of some information about the method, a review of the PIS, the collection of the IC, and the validation of the translation table followed by the first question. This directly asked why A&E nurses seemed keen to accept, understand, forgive, or ignore behaviour that would instead be considered unacceptable in different contexts, thus informing the first sub-research question (see Section 6.2) and adopting the previously discussed perspective by incongruity. A stimulus taken from the checklist report was used to support each interview: interactions aimed at underplaying nurses’ professional skills (see Section 8.2). I was aware that my respondents might have perceived this question as too direct, thus affecting the interviewee’s predisposition toward the research. However, due to time constraints, I had to give priority to this topic. As a form of precaution, the question was always phrased in a way so as not to put pressure on the interviewee (Sarantakos, 2013, pp.294-95), showing my admiration for their patience and professionalism.

From a theoretical perspective, the second question was opposite and consequential to the first, exploring the informal dealing strategies adopted by the interviewee. Informed by the second sub-research question, it explored the process of frame clearing.

The third question re-investigated the first response (unacceptability), introducing the perpetrator’s identity to explore if this plays a key role, as discussed in the literature (Lanza and Carifo, 1991; Jones and Lyneham, 2000; Pawlin, 2008; Lau et al, 2012b; Pich et al., 2013). Moreover, this question has theoretical reasons behind it. As discussed in Section 4.4.1, social interactions are influenced by the Mutual Relational Frame, thus by actors’ tacit expectations based on the counterpart’s age, gender, class, and race. It is therefore logical to expect users’ social characteristics to be relevant for nurses’ distinctions between what is proper and what is not.

The fourth question investigated the perceived level of support, or criticisms, offered by co-workers when the interviewee applied his/her dealing strategies. Specifically, I asked if support was provided by co-workers and if they were ever congratulated, criticised, or invited to behave differently by one of their colleagues, or if they ever found themselves in the position to compliment or criticise a colleague. As discussed by Ensink (2003), the distinction between cognitive and social frames is the interactional nature of the latter, which implies a shared cognitive understanding. This means that social actors using the same frame should encourage other group members to apply it in order to reiterate its routines, thus preserving the expected normality (Goffman, 1963a, p. 11). Moreover, as discussed in the literature, nurses can be informally sanctioned, or are afraid of being so, should they fail to correctly deal with perpetrators (Hegney et al, 2003; Pich et al, 2010; 2011; Pinar and Ucmak, 2011). This indicates, in agreement with my theoretical framework, that group members have obligations toward the frame and that the A&E Frame has social validity. This question therefore contributes to my second sub-research question because it explores intra-group forms of frame re-construction (reiteration) and frame-clearing.

The fifth question aimed to investigate forms of peer teaching. As discussed in Section 3.4.1, and drawing upon Section 3.4.5, the social actor learns to use a frame through experience and through frame-clearing. Therefore, it is logical to expect that more experienced nurses would dedicate time to clear the frame for the new ones, thus confirming the social nature of the A&E Frame.

Finally, the sixth question investigated interviewees’ decision to work in an environment well known for its stress level and physical risks. As discussed in Chapter 2, nurses tend, under certain conditions, to show empathy toward users. However, the literature on aggression in A&E does not investigate this, often leaving the reasons for this tolerance unclear, although analysis of this can be found in the nursing studies literature (see Muller et al, 2008). This question contributes to the first sub-research question because it offers information on how improprieties are defined.

Nurse gatekeepers were in charge of distributing copies of PISs and ICs, thus ensuring that participants were aware of the possibility of leaving the interview should they be needed in the department or should they feel uncomfortable with the topic. The time and date of the interview were decided in agreement with the second gatekeeper.

Last, all interviews were digitally recorded, transcribed verbatim, and anonymised. Field notes were taken after each interview to record my impressions and thoughts.

#### 6.3.1.3 – Informal Conversations

Informal conversations are defined as informal dialogue between at least two subjects, one of which is the researcher (Guidicini, 1968). They are widely recognised by social scientists, especially ethnographers, as a way to access important information concerning the topic under study (Goodwin et al, 2003; Urinboyev and Svensson, 2014; Sundberg, 2015; Silverman, 2014). However, their use is often ethically controversial because they are not covered by informed consent.

Although I was not allowed to interact with nurses on duty outside the agreed-upon specific occasions, I was allowed to engage in informal conversations if approached by them. Despite not being allowed to record these conversations, in consideration of their potential relevance, I was allowed to take notes. This modus operandi was negotiated and reported in the research protocol approved by both the hospitals and ARU ethic committees.

Due to the limited amount of time available for interviews, their formal structure and the limited space on checklists to describe what happened, informal conversations resulted in a relevant source of information. Freed from the interview’s time constraint and the digital recorder, nurses offered longer and more structured answers, showing an interesting pattern of shared opinions when more nurses were involved in the informal talk. This additional information was used, and sometimes directly recalled, during the semi-structured interviews to help and support the discussion (see Section 6.2). Moreover, informal chats gave me the opportunity to build a positive relationship with participants, positively impacting both their participation and their willingness to share sensible information.

#### 6.3.1.4 – Research Diary

As stated above, I was not allowed to record informal conversations; however, I was free to report the information obtained in my research diary. The use of a research diary is recognised in literature as a powerful source of self-reflexivity, validity, a support of theoretical thinking, and moral self-support in case of demoralisation (Koch, 1994; Freshwater, 2005; Jasper, 2005; Mantzoukas, 2005; Clarke, 2009). Koch (1994) and Jasper (2005) have recommended its use to support rigour in qualitative research because writing down ideas, thoughts, feelings, and impressions helps researchers to keep their minds clear, stay focused on their research questions, and reflect upon their own research process and research findings. Research diaries are also useful as memory support when reporting the atmosphere of the interviews and the attitude of the interviewee. Last, the act of writing down impressions helps improve clarity in the researcher’s mind, thus developing their critical thinking (Jasper 2005).

On the other hand, the literature discusses (Mantzoukas, 2005) how research diaries might contain incorrect annotations that lead to an excessive focus on non-influential aspects or false paths. These are common mistakes that any researcher may experience during the processes of thinking and theorisation. Nevertheless, these do not necessarily represent an issue because the researchers’ acknowledgment of them supports reflexive thinking and improves the robustness of their theorisation (Ibid). Also, as Freshwater (2005) has noted, researchers’ mistakes can never be completely eliminated or acknowledged, as researchers can only acknowledge what they are conscious of.

Regarding my research diary, I started it at the beginning of my Ph.D. as a collection of to-do-lists, titles of books and articles, and scattered notes. Later, it became more detailed and organised. During the negotiations to access the research fields, I began to use it as a repository for reflection, especially when I was in need of some form of self-support. It was initially written in English, but during the interview phase, I realised that it was easier for me to write in the language of the interview. As discussed in Section 4.5, the act of translating feelings and impressions from one language to another is a complicated task that requires both time and thinking. Therefore, in order to prevent involuntary errors of translations, and to save time, from that point on, my diary was bilingual.

## 6.4 – Translation

Since my data collection was bilingual, I faced inevitable translation issues. As discussed by Schröer (2009), when dealing with different languages, researchers must be aware that vocabularies are never fully translatable due to their strong cultural dependence. The different cultural backgrounds, composed of unspoken concepts or social structures, are likely to cause a cultural misalignment between the source language and the target language. As a result, utterances and texts in the source language cannot be entirely re-built into the target language (Hatim and Munday, 2004). Therefore, according to Schröer, ‘the most that can be achieved between individuals is pragmatic understanding’ (2009, p.2).

Different types of translation are discussed in social sciences, and all are included on a continuum between what Scheffer has defined as ‘representative’ and ‘performative’ schemes of translation (Scheffer 2008, cited in Inhetveen, 2012). Both schemes lead to correct translations but differ in their purposes: the first translates words as literally as possible, whereas the latter translates by concepts. Taking my research goal into account, a performative translation represented the most effective solution to investigate nurses’ taken-for-granted and unspoken guiding frame and give meaning to their words. Moreover, doing so, I escaped the complicated task of translating concepts not directly or not properly translatable, thus avoiding complex linguistic issues that would not offer tangible benefits.

However, the main issue with performative translations is their evaluation in terms of quality. According to Birbli (2000), this hinges upon different factors which, when the researcher and the translator are the same person, consist of: the ability of the researcher, ‘the researcher’s knowledge of the language and the culture of the people under study’ (Vulliamy, 1990, p.166, cited in Birbli, 2000), and the researcher’s knowledge of the language in writing. I am a native Italian speaker, born and raised in Veneto and thus proficient in the local dialect, too, and proficient in English and with previous experience of translations of medical jargon from and to English; and considering that a native English speaker also proficient in Italian is part of the supervision team, excellent translation quality was ensured.

To resume, the performative translation I have produced was aimed at obtaining an English-based body of knowledge. In order to do so, I created a comparative table to translate the meaning of words and sentences from Italian to English. An example of this table and of the process of translation adopted is offered in Section 6.5 – Data Analysis.

## 6.5 – Data Analysis

In this section, I discuss and offer examples of the process of translation and data analysis of my findings. The first part is dedicated to the translation and analysis of my checklists’ findings, whereas the second part discusses the data analysis process of interviews. In both parts, I provide practical examples in order to guarantee the maximum transparency of my data analysis process.

### 6.5.1 – Qualitative Checklists

As discussed in Section 6.3.1.1, qualitative checklists collected nurses’ original descriptions of a perpetrator’s identity and of the nature of the impropriety, both in Italian and English. As previously discussed, in order to ensure the best quality of translation possible, I have adopted a performative translation but, due to the originality of my thesis, I was not able to find any suitable pre-existing validated translation tool. Drawing upon Chouikha’s thematic dictionary (2016, pp.93-7) and Miles and Huberman’s coding strategies for interviews (1994, pp.55-72), I created an original table of translation focused on overarching semantic codes rather than on single words. Instead of translating every single descriptor, I first coded (grouped) them by meaning and then semantically translated the overarching codification by drawing upon the relevant literature. An example of this process is presented in Table 6.1.

The table of translation I developed and used in this thesis is composed of seven columns: the first and the last ones contain the original words or expressions reported; the second and the sixth columns report the first codifications, from the original expression to a more formal and easy-to-translate concept; the third and fifth report the eventual second codification, which also represents the overarching semantic concept to be translated and used in my data analysis; finally, the fourth and central column reports the semantic meaning of the codification, allowing for the identification of semantic equivalents. This resulted in a unique set of participants’ descriptors semantically translated into English concepts. Based on this, I have run basic statistical analysis and graphically presented them in a short report. This was not done to drive my analysis of findings, but rather to produce a simple report I sent to gatekeepers and asked them to circulated among their colleagues, several weeks before my interviews, to raise interest in the research. The English version of the report is presented in ‘Annex II – Qualitative Checklists Mid-Term Report’. The report was useful because it both stimulated participants’ interest and resulted in valid support during the following conversations, both formal and informal.

Codification and data analysis were conducted using SPSS.20 because it allows for faster procedures of codification and data analysis. A detailed discussion of the final overarching codifications is offered in Chapter 8 – Findings: Definition of Situational Impropriety.

Table 6.1 – Example of performative translation

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Column 1 | Column 2 | Column 3 | Column 4 | Column 5 | Column 6 | Column 7 |
| **Original ENG** | **1st level codification ENG** | **2nd level codification ENG** | **Description** | **2nd level codification ITA** | **1st level codification ITA** | **Original ITA** |
| Drunk | Alcoholic | Intoxicated | A user whose normal capacity to act or reason is altered by alcohol or drugs. | Intossicato | Esotossicosi | Ubriaco |
| Known alcoholic patient | Alcoholic | Intoxicated | A user whose normal capacity to act or reason is altered by alcohol or drugs. | Intossicato | Esotossicosi | Etilista |
|  |  |  | A user whose normal capacity to act or reason is altered by alcohol or drugs. | Intossicato | Esotossicosi | Paziente con riferito introito alcolico incongruo |
| High | On drugs | Intoxicated | A user whose normal capacity to act or reason is altered by alcohol or drugs. | Intossicato | Drogato | Drogato |

Source: Collected data

### 6.5.2 – Semi-Structured Interviews

As discussed in Section 4.3.6, Goffman suggested that the analysis of actors’ footing makes it possible to explore their guiding frame. Following the sociolinguistic tradition rooted in Goffman’s work (Goffman, 1979; Tannen, 1993; Wortham, 1996, Ensink, 2003; Ensink and Sauer, 2003), footing strategies are mostly expressed through the use of deictics. These are linguistic resources used to create discursive structures and to transform relationships between categories, and between single actors and categories (Wortham, 1996, p.5). Three major categories of deictics are generally discussed in sociolinguistics: temporal, spatial, and personal (Fillmore, 1975). Temporal deictics position the narrated event on the timeline and consist of tenses and temporal adverbs such as ‘now’ or ‘later’; spatial deictics locate the narration in space through adverbs such as ‘here’ or ‘there’ and the demonstratives ‘this’ and ‘that’; finally, personal deictics, often in the form of personal pronouns, and verb forms for Italian, are used to define the footing of the narration and define who covers the roles of animator, principal, and author. Following Ensink (2003), I focus my attention on personal ones only, as the temporal and spatial nature of the interaction are also of minor interest for my analysis. In fact, I only deal with narrations of facts that happened in the past and in the A&E department.

#### 6.5.2.1 – Personal Deictics in Footing

Personal deictics have been extensively used in footing literature, especially to analyse political discourses where distinctions between categories are often explicit (Wilson, 1990; de Fina, 1995; Bramley, 2001; Ensink and Sauer, 2003). As discussed by Wortham (1996), personal pronouns suppose a relationship between the speaker and the subject of its discourse, organising the parties involved into categories or social groups.

‘Personal pronouns do index interactional alignments for the narrating event. These habitual presuppositions often serve as resources speakers use to organize their interactions.’ (Ibid, p.23)

Four types of personal deictics are relevant in Wortham’s data analysis methodology: *I, you, we,* and *they*. As discussed by Bramley (2001), although the personal pronoun ‘*I’* is mostly used by the speaker to indicate himself or herself, it also can refer to any of the speaker’s interactional and social identities. Therefore, a nurse might discern between his/her private identity and his/her working identity, demarcating the change of frame used to make sense of what is going on.

The definite *you* is used when the subject of a sentence is the ratified hearer(s) involved in the verbal communication. For instance, ‘*do* ***you*** *understand?*’. In contrast, the indefinite ‘*you’* can serve to either include or exclude the speaker in a social category. The indefinite *‘you’* is used inclusively when it replaces *I* or *we,* as shown in the following example, in which the speaker uses ‘*you’* to include herself among those who are married in London:

‘It always rather shook me, when **I** first got married in London, **you**’d be carrying away practically buckets of that every day.’ (Wales, 1996, p.79)

This specific use of indefinite ‘*you*’ can indicate that the respondent shares the roles of principal with other members of the category to which s/he belongs. Practical examples of this use are offered by Wilson (1990) and Pearce (2001), who have demonstrated how the indefinite ‘*you’* can be used to discuss conventional wisdom, something known to everyone but for which no one claims authority. It is often used to obtain empathy and agreement from the hearers. Finally, it can be used to indicate a category of actors that excludes the speaker but might include the hearers. It is often used to identify a specific category of social actors (Allen, 2007), as in the following example from my data collection:

ESS5: ‘**I** tell **you** what .. it is about attitude ... because **you** know what **you** are doing .. **I** am **here** working for **you** ... **I** am trying to help **you**’

In this case, the first ‘you’ clearly refers to me, the ratified hearer, whereas the following ones identify the perpetrator category, implicitly excluding both the speaker and me.

The pronoun *we* is, by definition, inclusive, and it is used to create a category inclusive of the speakers, although not necessarily of the hearer(s) (Karapetjana, 2011, p.3). Nevertheless, for the purposes of frame analysis, its most interesting use is the one often observed in political speeches (Allen, 2007), to share the author role with absent group members, such as absent members of the government. This technique is also often used when discussing topics that might not please the audience, such as racial discourses, in order to deflect a possible negative impression from the animator. In fact, by using *we,* the speakers create a defined category, making others co-responsible for possible negative consequences (van den Berg, 1996).

Finally, the pronoun *they* is used in opposition to *we,* and it indicates a third category not inclusive of the animator and of the audience. As discussed by Bramley (2001, p.182), it is often used, both consciously and unconsciously, to demarcate differences between categories.

#### 6.5.2.2 – Ensink’s Data Analysis Process

Following Ensink (2003), I use an amended version of Wortham’s technique to discover speakers’ footing (Wortham, 1996). Ensink’s version allows me to systematically analyse speakers’ utterances using a matrix composed of four columns: respondent sentence (or interview line), categories, deictic references, and implicit evaluations. Table 4.2 below presents an extract of my analyses of an interview held in Essex. Interviews were transcribed verbatim and manually analysed using Microsoft Excel 2013, which was preferred to NVivo because it empowers creative, intuitive, and qualitative discursive analysis.

The operational process suggested by Ensink is composed of four steps: first, identify the described categories; second, identify how these are placed and represented in the observed sentence through the speaker’s footing (deictic references); third, explore and interpret the implicit meaning of the sentence by drawing upon the previous two columns (Ensink, 2003, p. 171). Therefore, the first column reports the sentence analysed, whereas the second column presents the identified categories explicitly or implicitly cited by the speaker. Ensink uses the operative concept of ‘categories’ to graphically analyse how the speaker relates the subjects of his/her utterances both to him/herself and with respect to other subjects of the speech. Therefore, ‘category’ means a specific social group, different from other cited social groups, and that is differently discussed and conceptualised. In addition, a category can be further defined through the identification of subcategories, and Figure 6.1 (p.118) shows the graphical result of this process of subdivision based on the example provided in Table 6.2 at page 117.

The third column is the most important one because it reports the speaker’s use of deictics, indicating and making visible the specific function of each deictic as per the discussion offered in Section 6.5.2.1. However, although sociolinguistic frame analysis heavily relies on actors’ use of deictics, as discussed by Wortham (1996, p.23), strictly relying on grammatical rules might cause negative consequences at theoretical, ontological, and interpretivist levels. In fact, although grammatical rules are defined and reasonably stable in time, it also true that current languages are live social constructions in constant evolution and, further, are subject to speakers’ mistakes. Therefore, researchers should reflect on the original use of language referring to the whole narration offered by the speaker. This is why a final fourth column is included to allow the researcher to make explicit the contextual understanding of the discourse analysed. Moreover, this final column and its discursive reconstruction of the researcher’s analysis aims to improve the transparency and readability of the analysis itself, thus positively impacting its credibility (Lincoln and Guba, 1985).

In this short example, it is possible to observe how the respondent creates three different categories. The first category is represented by the respondent itself (repeated use of *I*), who then rapidly shifts to a *we* footing, thus creating a new category inclusive of the previous one: the category of nurses. In doing so, the respondent defines themselves as a member of the nurse group and, since they are part of it, talks on behalf of the entire group: ‘**we** take it in a professional manner’. A third category is further identified, perpetrators, through the use of the deictic *they*. The respondent thus demarcates a difference between nurses (us) and perpetrators (them).

Table 6.2 – Example of Ensink’s frame analysis technique

|  |  |  |  |
| --- | --- | --- | --- |
| **Sentence** | **Categories** | **Deictic references** | **Implicit evaluation** |
| **I** think ... as professional ... **we** take it in a professional manner whatever happen to **us** .. and if **we** are **outside** with strange people .. at that point … because **I** wouldn’t … although **I** wouldn’t be happy if **someone** yell at **me** … but **I**’m in my uniform .. **I** would be like **I**’m a nurse and **I** am supposed to take care of **them** .. **they** are not … **you** have this thinking and **you** know … there is a barrier like that .. there is a professional barrier … **I** don’t know … how to explain that .. maybe that stops **you** … although **you** know that what **they** are doing to **you** is not right … but these professional barriers … hem … **you** can’t do anything back … and … that’s all **I** think. | Nurse (Respondent); Nurse (any); User; Perpetrators (any) | I - herself; we - nurses; us - nurse; someone - perpetrator; they - perpetrators; you - nurses; that - professional barriers/obligation; that - nurses' behaviour; that - professional barriers/obligation | In terms of footing, this nurse is shifting in and out from the role of author, moving from ‘*I’* to ‘*we’* to stress that parts of their narration belong to the entire group of nurses.  Nurses do not tolerate abuse, although she defines abuse as yelling.  They clearly refer to professionalism as a lower-layer frame guiding nurses’ approach to situational improprieties. It is the first time that professionalism is openly cited in Essex. Professionalism seems to provide both formal and informal rules (frame?).  They are discussing themselves as a nurse; professionalism is limited to the role, and it does not affect their out-of-work identity.  Perpetrators are described as not justifiable but they have to be tolerated due to professionalism - ‘professional barriers’  Dealing strategies are limited by professionalism. Probably, this nurse would like to react differently, but this is not possible - ‘you can't do anything back’. Is this a connection with the legal issue? |

Source: Collected data, interview with an Essex nurses; Legend: see Table 6.3 at page 116.

Figure 6.1 – Categories identified in the example offered in Table 6.2

Respondent

Perpetrators

Nurses

Source: Collected data

The extracts presented in Table 6.2 (p.115) certainly look ‘plain’ to linguistic analysts because I did not use indicators of the length of pauses (i.e. [1.2]), changes in intonation (↑ or ↓), segment lengthening (:), inhalation (H), and exhalation (Hx). This was done for two reasons: first, Ensink’s methodology is not strictly focused on pauses or intonation. For instance, he applies it to official transcriptions of public political discourses released, and thus analysed, without phonetic markers (Ensink and Sauer, 2003). Second, four out of 10 interviewees in Essex were not native English speakers, and during the transcription phase, I was often unsure whether their intonations had a semantic value or were caused by their foreign accent. It was also difficult to assign a value to their pauses because many were due to the effort of finding the most appropriate word. Moreover, to stress the linguistic challenge faced, some refused to be interviewed because they were not confident with their English, and I had to delete one interview because we actually failed to achieve effective communication. Therefore, in agreement with Ensink (2003, pp. 175-76), reduced interest in the standard discourse annotation, his focus on Wortham’s uses of deictics (1996), and because of the above communicational and linguistic issues, I decided to adopt a pragmatic approach and focus on the deictics used. Table 6.3 below presents the symbols are used in my quotations:

Table 6.3 – Quotation Legend

|  |  |
| --- | --- |
| I | Interviewer |
| ESSx | Interviewer from Essex Hospital, ‘x’ is replaced by a number from 1 to 10. Numbers are assigned randomly and do not represent the original order of interviews. |
| VENx | Interviewer from Veneto Hospital, ‘x’ is replaced by a number from 1 to 10. Numbers are assigned randomly and do not represent the original order of interviews. |
| .. | Micropause, < 150 milliseconds |
| … | Long pause, 0.2 seconds or more |
| [TN] | Translation note |
| […] | Jump, part of the answer is missing because not relevant for the offered discussion |
| [words] | Used to indicate laughs or other non-linguistic verbal communications |
| “ “ | Quotations of previous conversations |
| Word | Underlined words were pronounced with emphasis |
| **Word** | Bold is used to indicate deictics |
| ? | Question |

## 6.6 – Ethical Considerations

This research was planned in accordance with the recommendations provided by the ‘Research Ethics and Governance for Human Research’ guidelines’ by ARU (Scott, 2012). The research received ethical approval by ARU, the Essex hospital, and the Veneto hospital ethical committees. Four key points were identified as sensible and are thus discussed below: participants’ information, informed consent, participant rights, and anonymity.

### 6.6.1 – Participants’ Information

As discussed by Scott (2012), it is ethically vital to provide participants with a detailed description of what the research foresaw, both in general terms and from each participant. Moreover, due to the participants’ specific occupation and the personal and emotional involvement that my qualitative methodology demands, it was important to ensure the participants’ informed consent and clear understanding of the research. For instance, due to the possible criminal relevance of the improprieties reported, it was essential to provide them with an exhaustive description of what would happen to the information they decided to disclose.

Since nurses were free to decide their level of involvement, I produced one PIS per method. They all described aspects such as information disclosure and data management, storage, and destruction in detail. Further, since the data collection took place during participants’ regular shifts, thus potentially impacting the service provided by the department, each PIS reported detailed information on the time necessary for data collection, thus allowing nurses to reflect upon the required commitment. Moreover, it was clearly stated that priority should be assigned to their work-related tasks, thus protecting me from possible issues related to participants’ temporary absence from their workplace. Last, each PIS included a brief summary of the entire research, allowing the participants to consider the entire research process in advance and to be aware of the upcoming data collection activities.

### 6.6.2 – Informed Consent

According to the ARU Research Ethic and Governance for Human Research (Scott, 2012), the achievement of informed consent is a process, and it does not end with the signing of a paper. Rather, it is an on-going interaction between the participants and the researcher. It reflects the delicate process of agreement on the research protocol, which involves the researcher, the ethical committees of the structures involved, and the gatekeepers, who have to deal with practical fieldwork issues. Moreover, the retention of a constant consent to participate is a fundamental requirement in research that investigates sensitive issues such as situational improprieties. This is especially the case when the data collection takes place through different activities (checklists and semi-structured interviews). Additionally, as Scott (Ibid, pp.12-15) has discussed, informed consent is based on a relationship of mutual trust between the researcher and the participants that is built over time. In my case, this relationship started with a face-to-face introduction led by one gatekeeper. Further on-going consent was achieved per each method, both verbally re-established at each formal interaction and though the interview dedicated PIS and IC.

### 6.6.3 – Participants’ Rights

Participants' rights were a matter of scrupulous attention and, along with the general right to anonymity, confidentiality was treated carefully. As discussed in Chapter 2, situational improprieties from users can cause severe stress, confrontation between co-workers, poor judgement of other co-workers, and loss of confidence (Luck et al, 2007b). Interviews were at risk of being used as an occasion for an outburst against other co-workers, and therefore, it was necessary to guarantee confidentiality in order to ensure the maximum freedom of speech. Names and direct references that might have led to the identification of a third person, of the speaker, or of the hospital were fully removed during the process of verbatim transcription.

The possibility of correcting previous statements was given serious consideration. Due to the strict confidentiality ensured by the methodology used, recorded interviews were transcribed as soon as possible and anonymised, and the original audio was then deleted. This process thus prevented the identification of the speaker and severely limited any second-though correction or amendment of the provided information. Nevertheless, participants were entitled to request a second interview to correct their statements, although their second interview would have to be treated as new material, while the previous one would still be part of the data collection. However, none asked for a second statement.

Last, by request of the hospitals’ managements, since interviews took place during working hours, participants were entitled to cease or interrupt their interview for any work-related matter. This was clearly stated in all the documents delivered and in every formal verbal interaction.

### 6.6.4 – Anonymity

Despite the use of pseudonyms to protect the identity of those involved, due to the description of very specific experiences, interviewees were still at risk of being identified by their co-workers. Consequently, I have decided to limit my use of direct quotation, also in terms of length. Moreover, any references to identifiable subjects were removed during the phase of transcription.

In addition, due to the different legal frameworks in which the research was conducted, different ethical indications on anonymity in data collection and data management were included in the research protocol. The Data Protection Act (1998), the Serious Crime Act (2007), and the Essex Hospital internal regulation were taken into consideration and integrated for the English arm of the research. Meanwhile, the Codice di Deontologia Medica (Italian Code of Conducts for Medical Staff, 2014), the law for personal data protection (D.LGS 196/2003), and the Veneto Hospital internal regulation were the legal references of the research protocol submitted to the Italian ethical committee.

## 6.7 – Methodological Concerns

I am fully aware that the methodology I used is open to criticism; thus, in the following sections I assess and describe my strategies to minimise the main criticism I was able to identify and reflect upon.

### 6.7.1 – Qualitative Checklists

As discussed in section 6.3.1.1, qualitative checklists pertains to a set of qualitative methods named ‘observation documents required by the researcher’ (Cardano, 2011). This method, like this thesis, does not aim to obtain generalisable results in quantitative terms, as the word ‘checklist’ might suggest, but rather to offer a deeper exploration of participants’ understanding, perception, and definition of ‘What is it that is going on here?’ (Goffman, 1974, p.25).

The main criticism of this method consists of the large amount of miscellaneous information that participants could write in their documents, thus creating confusion and potentially hindering the process of analysis (Elliott, 1997; Bell, 1998; Meth, 2003; Cardano 2011). Personally, I completely agree with this criticism because, as I discuss in Chapter 8, I actually had to remove several pieces of unrequired information from my data collection. However, in order reduce the chances of being overwhelmed with unnecessary information, I took three precautions: first, participants were required to compile their checklist immediately after the situational impropriety – in a way that was compatible with their workload – using few words in order to prevent a loss of spontaneity. Second, the checklists’ size was such that long answers could not be accommodated; open-ended questions allowed for a maximum three descriptors each. Third, to improve the collection of relevant information, I have pragmatically offered pre-coded descriptions of the perpetrators’ personal data in the form of closed-ended questions, raising legitimate concerns about the qualitative nature of this method.

Three main reasons led me to adopt this third precaution: first, drawing upon the work of Goffman (1983), van den Berg (1996), and my previous research experience (Gangitano, 2012; 2013), I was aware that participants would have focused the description of the perpetrators’ identity on their most relevant personal data in social terms: role (patient or companion), age, and gender. Therefore, to encourage nurses to focus on information that was more relevant to the aim of my study, such as being drunk or their ‘social class’, I have facilitated the provision of perpetrators’ personal data. Nurses were thus able to focus, in the first open-ended question, on more relevant information. Second, the provision of closed-ended questions minimised the completion time, since overly long forms are reported to discourage nurses from reporting improprieties; see below and in Section 2.3. Instead of writing the perpetrators’ age, gender, and role, nurses saved time and effort by simply checking one of the answers provided, which offered the full range of possible answers. Finally, the collection of the perpetrator’s age in pre-defined ranges ensured greater anonymity. The hospitals’ ethical committees welcomed this solution.

Regarding the concern that such closed-ended questions might nullify the qualitative nature of my checklist, I argue that these represent a mere pragmatic anticipation of an analytical process of data reduction that operates in the vast majority of qualitative research, mine included. It anticipates the subsequent process of codification and creation of meta-data from raw qualitative data. The answers provided fully addressed all the potential answers; therefore, no limitations or pre-conceptions were imposed. Specifically, the formally qualitative question about gender would only have produced either ‘male’ or ‘female’ as an answer. Options such as ‘unclear’ were addressed by leaving the answer blank. A user’s role can only be either ‘patient’ or ‘companion’, since attacks from externals or colleagues were not part of the study. Finally, concerning the perpetrators’ age, all the available options were covered, which, as mentioned above, also improved anonymity.

Although I agree with the fact the way answers were provided does not respect the standard of qualitative research, I believe that in this specific situation – given the impossibility of providing different answers – to claim a nullification of the qualitative nature of my checklist would be to claim that the use of semantic meta-data nullifies the validity of an established branch of qualitative studies (Koenig, 2004a; 2004b; 2006; Silverman, 2013; Keeny et al, 2015). Specifically, I did not limit nurses’ freedom of expression; rather, I have anticipated the adoption of meta-data that covered all the possible answers.

With regards to the two open-ended questions – the most salient characteristics of the perpetrator’s identity and of the nature of the impropriety – these represent the real core of nurses’ original contribution. However, they still follow the rationale of minimisation of the completion time. Nurses were in fact invited to answer with a maximum of three words, which also pushed them to focus on those impressions deemed most relevant. Upon hospitals’ request, an example of a valid answer was provided on the back of each checklist (see Annex I). Concerning the limited amount of space left for description, one could suggest that short answers might cause a loss of significant information. However, it should not to be forgotten that, as discussed in Section 2.3, one of the main causes of the so called ‘culture of silence’ is the structure of official reporting forms, which are often perceived as too long and complex (Crilly et al, 2004; Pawlin, 2008). Moreover, the use of a short document prevented unnecessary additional burdens for A&Es and their nurses already under significant work pressure, while allowing for an almost real-time data collection. Last, the eventual data loss was compensated, as expected, by the significant number of compiled checklists (also by virtue of the short compiling time), informal chats, and interviews.

A second criticism generally applied to this method, ‘observation documents required by the researcher’ (Cardano, 2011), is that it raises concerns of self-censorship and social desirability. Concerning the former, this criticism is proper to every method of data collection. However, the explicit instruction to compile a checklist immediately after an experienced or witnessed impropriety reduces the time to reflect and consciously decide what to exclude (Kenten, 2010). Regarding the latter, the influence of social desirability results was minimised by the absence of the researcher, while answers are provided and by the anonymity of the tool (van den Berg, 1996; Foglia and Vanzago, 2011; Silverman, 2014). In fact, as has been discussed in the literature (Luck et al, 2007b; Pinar and Ucmak, 2011), those claiming to have been harassed or offended by users are at risk of being negatively judged by their colleagues. Therefore, if they were aware of being observed, nurses might have decided to be more or less compliant than usual to avoid any potential judgement from me or from bystander colleagues aware of my presence. Furthermore, they might have adapted their vocabulary to either include or exclude me from the conversation, thus compromising the purpose of the activity. I believe that the ensured anonymity and my absence from the setting promoted more reliable access to nurses’ original perspectives.

As a last methodological concern, as observable in Annex I – Qualitative Checklist Example, I here define situational improprieties as aggressive behaviour, thus different from what is stated in Chapter 3 and reported in the PIS (see Annex IV). This was done because the Essex ethical committee was concerned that ‘situational impropriety’ would have been unclear to many, and thus I decided to use the concept of ‘aggressive behaviour’, which was also because of easier translation to Italian. When I finally met the Essex nurse gatekeeper and I explained the aim of my study, they suggested that ‘behaviour deemed unacceptable in the A&E’ would have been more appropriate; I will always be grateful to for this suggestion. Unfortunately, I had no time to apply for an amendment of my research protocol and tools but, luckily, as discussed in Section 5.3.1, I was introduced to the Essex nurses by the gatekeeper herself. In this situation, both the gatekeeper and I were extremely careful in stressing how ‘aggressive behaviour’ should have been interpreted. Moreover, during my following visits to the department, I paid great attention to repeating, clarifying, and stressing the aim of the research and my interest in any behaviour deemed unacceptable in that context.

Concerning the Italian hospital, I had to face a similar issue but, thanks to the previous experience, when presenting the research and the qualitative checklists, I paid great attention to stressing how ‘aggressive behaviour’ actually meant ‘behaviour deemed unacceptable in the A&E context’. Moreover, this message was reinforced during every visit, and I asked both gatekeepers to pass the message to those nurses I was not able to meet during my visits.

Reflecting upon this mis-alignment between my research aim and the terminology used on checklists, I was at first afraid that this might have negatively impacted on my data collection. I feared it may have restricted the spectrum of behaviour that nurses would have described in their checklists, with the risk of replicating previous research I have criticised in Chapter 2 for being too focused on physical aggressions. Although I am not in a position to know what the result would have been if the correct terminology was adopted since the very beginning, based on the checklist results presented in Section 7.2, I am confident in claiming that the effort spent in clarifying the real focus of my research led to a positive outcome: only a minor part of the reported improprieties were related to physically aggressive behaviour.

### 6.7.2 – Semi-Structured Interviews

The main issues with semi-structured interviews coincide with their strong point: their flexibility (Sala, 2010). Due to an interviewee’s relative freedom of speech, the answers provided often differ, and the information is thus often difficult to code, compare, and analyse (Ibid, p81). However, the semi-structured interviews adopted in this thesis are based on the checklists’ result, for which a summary report was circulated before the interview phase of my data collection, thus ensuring a shared and well-defined common ground between the two settings. Moreover, I was careful to provide the same stimulus and examples in both settings to minimise the risk of off-topic discussion. In fact, a second criticism is that, despite the guidance provided by the researcher, interviewees might focus their narration on aspects out of the interview’s scope. There was therefore the risk that interviewees’ answers could drift away, leaving the researcher empty-handed (Silverman, 2014, pp.198-203). Nevertheless, the flexibility of the moderation guide allowed me to return to those points not fully or erroneously explored.

Furthermore, as suggested by Statera (1982, p.142), in addition to carefully leading the conversations, it is important for the researcher to establish a positive relationship with the interviewee. In my case, such a relationship was built through the informal interactions described in Section 4.3.1.3, the diffusion of the checklist report and dedicated PIS, and the voluntary nature of well-informed participants. In fact, thanks to the voluntary self-selection of the interviewees, it is possible to assume that participants were already well informed and interested in discussing the interview topics.

### 6.7.3 – Validity

Because of the qualitative nature of this research, I reject the framework of validity commonly accepted by quantitative researchers in the social sciences. I therefore reject the truth or falsity of an observation compared to an external reality, which is the primary concern with validity in quantitative terms (Cho and Trent, 2006). Without denying the importance of quality in qualitative research, I embrace Lincoln and Guba’s (1985) suggestion that qualitative methods of inquiry do not have to use the same criteria used in quantitative research. Despite the fact that some efforts have been made to implement a qualitative evaluation that can respond to quantitative standards, such as LeCompte and Goertz (1982), Lincoln and Guba (1985) have developed a naturalistic approach that is still popular among qualitative researchers (Creswell, 2013). According to this approach, qualitative research should instead be evaluated on the basis of credibility, transferability, dependability, and confirmability. In the following sections, I address these four criteria in relation to my thesis.

#### 6.7.3.1 – Credibility

The credibility criterion involves establishing that the results of qualitative research are credible or believable from the perspective of the participant. This criterion is here satisfied through participants’ validation of my findings (Bloor, 1978; Mays and Pope, 2000; Barbour, 2001; Silverman, 2013), a data collection done in the local language, and my within-method triangulation through my two sub-research questions. Thanks to participants’ validation, my interpretation of the data collected has been constantly validated during each interview. Thanks to a data collection in the local language, the risk of misunderstanding was minimised, and this risk was further reduced using the comparative table of meaning, described in section 6.5.2.2, which was verbally validated by every interviewee. Finally, thanks to the within-method triangulation, each sub-research question supports and validates the findings of the other.

#### 6.7.3.2 – Transferability

Transferability refers to the degree to which the results of qualitative research can be transferred to other contexts or settings. I believe that, in this specific case, transferability is achieved through the analysis of two culturally different settings. As discussed in Section 6.2, this research aims to identify a guiding frame used in both the A&Es and thus, potentially, in other EU A&Es. However, Lincoln and Guba (1985) have argued that, when phenomena are described in detail, allowing external readers to have a clear idea of the subject, the evaluation of their transferability rests in those who will use that description deciding whether it can be transferred to other settings. Therefore, transferability can only be reached through detailed descriptions that allow the reader to reproduce the research in a different context. The detailed descriptions provided in the next chapters are thus my best tool to defend my methodology from the lack of a vast literature that supports Ensink’s (2003) frame analysis. This also means that the transferability of my analysis relies only on my ability to describe and justify the choices I made in agreement with the framework I use.

#### 6.7.3.3 – Dependability

The idea of dependability emphasises the need for the researcher to report any change that occurs in the research setting. Thus, as a researcher, I am responsible for describing the changes that occur in the setting and how these changes affected my approach to it. This discussion is in section 5.3.

#### 6.7.3.4 – Confirmability

Qualitative research tends to assume that each researcher brings a unique perspective to the study. Confirmability thus refers to the degree to which the results can be confirmed or corroborated by others. In my case, confirmability is achieved on six grounds: participants’ validation of findings; triangulation through sub-research questions, constant supervision of my supervisors; the Confirmation of Candidature, which has seen part of this thesis externally evaluated by two critical readers; the presentation of parts of my thesis to international conferences; and, lastly, through the final viva voce examination.

Moreover, the process of external evaluation is supported by the detailed description of my theoretical stance, my methodological choices, and all the decisions made during the analysis of my findings. Finally, thanks to my research diary, I also discuss the reflexive process that influenced this thesis, taking into account my own personal views and dispositions.

## 6.8 – Chapter Conclusion

Following the discussion on my theoretical framework offered in Chapter 4, this sixth Chapter details the multi-case study methodology and the methods I used to investigate the four gaps in the literature identified in Chapter 2 in accordance with the setting limitations discussed in Chapter 5.

The chapter opens with the definition of my research question, informed by two sub-research questions through a process of within-method triangulation (Denzin, 1978, pp.301-02). This process consists of exploring the A&E Frame through both a negative and a positive perspective, through a perspective by incongruity, and a perspective by expectation. Based on my review of the literature on qualitative frame analysis, I am the first scholar to adopt this methodology, thus making this an additional contribution to knowledge.

Drawing upon both my literature review and my theoretical framework, my investigation of the A&E Frame was obtained through two qualitative methods: qualitative checklists and semi-structured interviews. The former replaced the ethnographic observation suggested by Goffman (Lofland, 1989, p.131), whereas the latter verified and re-explored checklist findings and investigated the adopted clearing strategies.

Since one of the identified gaps in the literature pertains to the lack of studies exploring the transferability of the literature’s findings, this research took place in two European settings. This resulted in a bi-lingual data collection that raised several translation issues. Taking guidance from Chouikha (2016) and Miles and Huberman (1994), I have developed a performative translation by codification operationalised through the table of translation described in Section 6.5.2.2 and represented in Table 6.3 (p.117).

I am convinced that the methodology and the methods adopted are the most suitable in consideration of my literature review, my theoretical framework, and the specific characteristics of the settings investigated. Moreover, I believe that the methodology of investigation here discussed offers a contribution to knowledge per se. In particular, it introduces the use of within-method triangulation to frame analysis, and it suggests an innovative use of qualitative checklists as a pragmatic alternative to ethnographic observation.

In the following three chapters, I summarise and present the results of my data collection. In order to improve readability and clarity, in Chapter 7, I present what I call the background information: the analysis of the three background frames to provide validity for my findings; the identified categories active in the A&E Frame, and how these are perceived and acted upon by nurses; and the analysis of interviewees’ reasons to work in the A&E, thus, their answers to the sixth question of my semi-structured interviews. This chapter allows the reader to make sense of the findings presented in chapters 8 and 9, since connections between categories will be clearer as well as nurses’ self-perceptions of their role and mission.

In Chapters 8 and 9, I present those findings that allow me to answer my two sub-research questions, which, respectively, concerned nurses’ definitions of situational improprieties and dealing strategies and expected behaviour.

# Chapter 7 – Findings: Background Frames and Identified Categories

## 7.1 – Introduction

In the interest of transparency, I present my findings in three chapters and, following Ensink’s methodology (2003), this chapter presents background information to enhance the validity of the discussion and conclusion. In agreement with Goffman (1974), I expect the rim – the A&E Frame under investigation – to be rooted in lower frames that influence participant interactions toward users and toward me. Although I do not venture in a frame analysis of all the lower frames – an effort brilliantly presented by Goffman himself as endless and unrealistic (Goffman, 1974, pp 1-20), the three macro sections of this chapter discuss the most relevant background information. These include the research background frames (theory discussed in Section 4.4.1); nurses’ general perception of their workplace through the analysis of the identified categories of actors; and interviewees’ personal reasons to work in A&E despite the high level of stress and improprieties.

According to the research protocol shared with the hospitals’ ethical committees, two precautions were taken to ensure interviewee anonymity: first, peculiar narrated events were omitted to prevent identification by colleagues, unless the interviewee gave permission. Second, for the same reason, the genderless pronoun ‘they’ is adopted for male and female participants

## 7.2 – Background Frames

As discussed in Section 4.3.3, although social interactions are guided by the upper lamination, the rim, lower laminations work in the background influencing the ongoing interaction. Drawing upon the work of van den Berg (1996), Ensink (2003) suggests assessing the validity of the collected data before proceeding with its analysis through the investigation of the three background frames: interview frame, social research frame, and mutual relational frame.

### 7.2.1 – Interview Frame

The interview frame regulates and structures the specific social interaction that is known as the interview. It assigns precise roles and gives order to the conversation, which in semi-structured interviews can give results that are open to digression. Nevertheless, interactions never occur in a vacuum, but they are influenced by the surrounding environment. In this case, the interviews may have influenced participants’ answers. Precisely, as anticipated in Section 5.3, in Veneto, the interviews were conducted in a separate room, with a significant degree of privacy, whereas, in Essex, they were mostly conducted in an empty cubicle in the majors, where privacy was not fully ensured. Due to the number of incoming users during the nights on which data collection took place, most of the nurses requested to be interviewed in an empty cubicle to be closer in case they were needed, and only three interviews were conducted in the originally designated room on the first floor. Given the situation, interviews were therefore audible to passing-by colleagues and, I believe, some interviewees moderated their narration as a result. For instance, the Essex nurses made greater use of the indefinite *you*, suggesting that their statements were not personal but were shared by everyone in the team. Essex nurses thus took a more neutral stance, often avoiding personal considerations.

The second element of induced moderation is observable in the way in which the Essex nurses discussed the level of support offered by colleagues when dealing with situational improprieties. As discussed further in Section 9.3 and 9.4, the Veneto nurses reported different levels of support and identified sub-categories of helpful and less helpful colleagues, whereas most English nurses briefly replied that they feel generally supported. However, two of the three Essex nurses whose interviews were recorded in a separate room offered contradictory answers, although they both referred to specific episodes of physical assault.

These, of course, are personal reflections and do not necessarily indicate that the answers provided were adapted because of the possibility of someone overhearing. For instance, scholars of contemporary English report that the use of the impersonal *you* is increasing since the ‘60s (Haas, 2016). In addition, the lack of peer support was not unanimously claimed by those interviewed in a separate room, and it was always discussed with reference to violent events that might have alarmed the other nearby nurses. However, minor concerns regarding the Essex nurses’ answers remain.

In the case of the Italian arm of data collection, no significant issues are reported. The only deviation from what might be considered an interview interaction “by the book” was the exceeding of the interview time in nine out of ten cases. However, this might be interpreted as an interest in the research topic, it does not add relevant information for the purpose of this section.

### 7.2.2 – Social Research Frame

The social research frame is defined as cognitive awareness that the interview occasion is only one among several and that it pertains to a broader activity of social research. Within this frame, researchers can make use of previously collected information, either from the same participant or from others, whereas participants can recall situations described in previous parts of the research (for instance, a checklist) or, knowing that their answers might be read by others, they might feel intimidated by the research activity.

The recall of previous conversations or findings is the main source of influence of this frame over the ongoing interaction. The provision of different stimuli from one interview to another could unnaturally stir the conversation toward other topics or answers (van den Berg, 1996). Therefore, I offered the same two stimuli to every participant. The first was part of the first question on what should be considered improper, a question that required reflection upon widely accepted definitions of impropriety, which some interviewees struggled with. Based on the checklist findings and the possibility that implicit or explicit attempts to question a nurse’s skills may be negatively perceived, I asked each interviewee if and under what condition the question ‘May I see a doctor?’ can be perceived as improper.

The second stimulus was offered in question three, and it addressed the perpetrator’s identity. During the first interview, I realised that the concept of identity was understood as racial identity, thus limiting that nurse’s answer. However, based on the checklist findings, I became aware that the perpetrator’s perceived social identity was far more relevant than his/her race. Therefore, I asked whether the perpetrators’ age and dress code could influence the interviewee’s perception of the act. This stimulus, which was used in each interview, was introduced as follows: I first allowed the respondent to freely define ‘identity’ in their own words, then I asked about the role of age and dress – as sign of social status – to investigate other aspects of the perpetrator’s identity that emerged from checklists.

In conclusion, due to the thorough implementation of the interview protocol, both teams received the same stimuli and no significant difference was identified. The analysis of this frame does not suggest any undesired influence over participants’ answers; instead, it provides higher validity to my data collection because the nurses’ answers gave results that were consistent with the checklist findings and the informal conversations that occurred during the data collection period, which are discussed in the chapters that follow.

### 7.2.3 – Mutual Relational Frame

Both the researcher and the interviewee enter the interview social occasion with a complex and layered identity informed by the participant’s social characteristics (Goffman, 1983, p.14). Depending on the way in which the other’s identity is perceived, the predisposition toward the interview occasion can change significantly.

In this case, as discussed in Section 5.3, I entered the two settings “wearing” two different identities: in Essex I was a complete outsider, both professionally and culturally; whereas in Veneto I could reasonably be regarded as a colleague and I shared the cultural background, including the local dialect used by some in the most emotional parts of their interviews. I believe that this identity issue influenced my performance as a researcher and, thus, my data collection. For instance, despite the confidential and sensitive nature of the information offered by some of the Essex nurses during our informal conversations, those who were non-British like me provided more detailed information. On the contrary, despite the difficult start, my being both local and a sort-of-colleague granted me a higher level of closeness with the Italian nurses, with almost every interview lasting more than the expected 20 minutes. Although I cannot indicate any specific occasion that made me feel a stranger in the Essex A&E, with the exception of some, I failed to obtain the same level of confidence and to fully win their trust. I believe this can be identified in the different richness of details I have received from the two groups. The Essex nurses provided more information through the unmediated qualitative checklists, while the Veneto nurses offered more details in the face-to-face interview. Nevertheless, I am confident in defending the validity and depth of my analysis, since no question remained unanswered, although I believe that more details could have been collected in Essex.

However, even though I may not have reached the same depth of personal connection, I believe I did everything I could. For instance, the time spent in the Essex A&E building trustworthy connections to become a familiar face was greater than that spent in Veneto.

### 7.2.4 – Section Summary

Following the analysis of the background frames, some concerns might affect the Essex arm of data collection. Nevertheless, the discrepancies observed in the data collection are physiological, since every setting is unique and presents unique challenges and differences (Punch, 1998; Stake 2000; Yin, 2013), and they do not affect the validity of this thesis. In fact, as discussed in the next chapters, there are only minor misalignments between checklists and interview findings from the two settings, and these appear to be related to organisational differences rather than to interactions with me or with this research. Therefore, I contend that the Essex arm of data collection is reliable and as valid as the Italian one.

## 7.3 – Identified Categories

In agreement with Ensink (2003), this thesis defines categories as groups of actors sharing a specific characteristic differentiates them from other actors or categories of actors. As discussed in Section 4.3.1, the social actor covers a multiplicity of roles in her/his life because of affiliation to many categories. To indicate the category s/he wants to represent, the actor can use a range of verbal and non-verbal solutions (i.e. footing). When actors talk about themselves or about others, they position and define themselves in respect to others, in respect to their own category – either describing their category or introducing sub-categories – and differentiating between categories.

Schegloff (1996) states that an analysis of how categories are constructed helps the researcher to access the narrator’s ‘cultural inventory’ (Ibid, p.196), their universe of sense, their guiding frame. With regard to categories, actors organise their reality, thus providing information about the implicit interactional order suggested by their guiding frame.

Drawing upon the 126 valid qualitative checklists returned (82 in Essex and 44 in Veneto) and the 20 semi-structured interviews (10 per hospital), Figure 7.1 graphically presents nurses’ categorisation of actors in the A&E context, enriched with an overview of their moral evaluation.

Figure 7.1 – Categories of actors active in the A&E context. Distinctions and evaluation.

Elderly

Young user

Mental patient

Parent of young children

Experienced

Nurse in charge

Hot-tempered

Intoxicated

Demanding

Children

Disrespectful

*Companion*

*Patient*

**User**

**Security officer**

**Hospital management**

Unbalanced

Diplomat

Rookie

*Nurse*

*Doctor*

**A&E staff member**

Source: Collected data

Each rectangle represents a category or sub-category discussed by interviewees. The names of the four main categories are written in bold, first-level sub-categories in italics and second-level sub-categories in plain font. Colours are used to represent nurses’ positive or negative evaluation of the identified categories: blue indicates a positive evaluation, red a negative one, and black represents the absence of evaluation. Finally, some categories have a coloured dashed line because the evaluation was not unanimous or it was not fully defined.

As shown above, by drawing upon nurses’ narrations, I identified four main categories: ‘**A&E staff members’**, ‘**Users**’, ‘**Security officers**’ and ‘**Hospital management**’. The first two are the most discussed and were further organised into first-level and second-level sub-categories. However, the listed categories do not fully represent the complexity of the discussed reality. Rather, second-level sub-categories that were cited only once were incorporated in the semantically closest category.

### 7.3.1 – Staff Member

The category ‘**A&E** **Staff member**’ is composed of sub-categories ‘*Nurse*’ and ‘*Doctor*’, with the former further sub-divided into ‘Nurse in charge’, ‘Experienced’, ‘Diplomat’, ‘Rookie’, ‘Ill-tempered’ and ‘Unbalanced’. Interestingly the figure of ‘receptionist’ is not present in the nurses’ description despite their direct involvement with users and the high level of abuse they are exposed to, especially in Essex.

The category ‘*Doctor*’ was quite marginal in nurses’ descriptions, and they were depicted as almost immune from users’ situational improprieties and were mostly described as supportive.

ESS1: Yes … there is **always** support … **I** mean .. **you** can always count on the nurse in charge .. or even .. doctors … **I** mean .. if **you** notice that there is a patient **who** is very … and .. **they** are asking for … and **you** can try … “Hey doctor .. there is anything we can do for **this** patient?” .. Just to calm down the situation.

An important aspect of this example, in addition to its representativeness, is the stress on the word ‘always’, which indicates certainty, and the use of the referential pronoun ‘you’ in its indefinite generic form. As discussed in Section 6.5.2.1, the indefinite *you* serves different functions, one of which is ‘to include [the speaker] as a typical member of a category’ (Allen, 2007, p.4). In this case, ESS1 starts their discussion assigning to themselves the roles of animator, author, and principal (***I*** *mean*), but quickly abdicates that of principal adopting an impersonal *you* to speak for all the Essex nurses. With the exceptions of ESS2 and ESS7, who reported a lack of horizontal support, every nurse adopted the same position. This suggests a shared perception that the nurse in charge and the doctors are ready to offer help if needed. However, no participant presented doctors as proactive. For instance, ESS1 introduces the category of doctor after that of the nurse in charge and as a possibility: ‘or even’ and ‘you can try’. Therefore, due to the lack of an active role and the lack of agreement among nurses, the category is represented in black, thus neutral.

In terms of internal professional relations between ‘*Doctor*’ and ‘*Nurse*’, I believe that the perceived immunity of the former from users’ improprieties is caused by envy. This may be the case not because they are not involved in argumentations with users, as also demonstrated by Svensson (1996) and Allen (2001), but because nurses believe that doctors are regarded by users as the real medical professionals. A&E nurses perceive themselves as the best trained and the most competent in their profession. Because of their studies, only they can triage, a fact often ignored by most of the perpetrators.

VEN4: **I** mean ... it happened **yesterday** too … **I** am … **I** work in the red code area .. **I**’ve spent my life **here** .. there was a rigid bandage to remove .. it immobilises the knee .. ok? … who knows better than me how to do it? … if it was my father .. my mother or my brother or anyone … **I** would let it be done by someone like me … **this lady** wanted the doctor … the doctor did not know how to … how to remove it … **I** mean .. the perception is this … however **I** understand **I** should not get offended … because .. then I realise that users see doctors as … **they** picture **them** like the emergency department .. and it is correct .. **that** is the person who has to give **you** an answer … and it is correct .. do **you** understand? … but this is how it works in the collective imagination[[6]](#footnote-6)

In the ‘*Nurse*’ category, interviewees define themselves as active caring agents fulfilling a professional role that focuses on helping people in physical or mental distress.

I: Why are **you** willing to accept … **I** don’t know … someone yelling at **you** in **here**? Would **you** react differently **outside**?

ESS10: **I** think ... as professional ... **we** take it in a professional manner whatever happens to **us** .. and if **we** are **outside** with strange people .. at that point … because **I** wouldn’t … although **I** wouldn’t be happy if **someone** yells at **me** … but **I**’m in my uniform .. **I** would be like **I**’m a nurse and **I** am supposed to take care of **them** .. **they** are not … **you** have this thinking and **you** know … there is a barrier like that … there is a professional barrier … **I** don’t know … how to explain that … maybe that stops **you** … although **you** know that what **they** are doing to **you** is not right … but these professional barriers … hem … **you** can’t do anything back … and … that’s all **I** think.

VEN7: The point is that when **I** come **here** ... obviously **you** change personality somehow ... **I** mean .. **you** wear a uniform … **I**'m no longer [name, TN] in private life but **I**'m [name, TN] working ... Thus ... **I** distinguish ... meaning that .. **this** is not my life .. it's my job ... my life is **outside** … So **I** [laugh, TN] arrive **here** with a different personality.*[[7]](#footnote-7)*

Concerning the sub-categories, ‘Nurse in charge’ is positively described, especially in Essex. However, the Italian counterpart (*caposala*) has no formal responsibility for interactional support and is absent in Veneto narratives. However, due to the consistently positive descriptions from Essex nurses, I decided to represent it in blue.

Of the remaining five sub-categories – ‘Experienced’, ‘Diplomat’, ‘Rookie’, ‘Ill-tempered’ and ‘Unbalanced’ – the first one is positively discussed because it is perceived as competent and always ready to help and offer relevant informal peer-teaching (see Section 5.3.6).

ESS6: Ya .. ya … **they** come to me to solve **their** problem … if there is a problem .. **you** are the senior … **you** have to go and solve it … so **you** need to be diplomatic .. **you** need to help to handle the patient …

It is interesting how this (self-declared) experienced nurse defines peer support as a duty while externalising the occurrence of problematic situations: despite it being ‘their problem’, experienced nurses ‘have to go’ to support them. This sociolinguistic construction is adopted by the other self-declared experienced nurses and confirmed by less-experienced ones who reported examples of received support, as discussed in Chapter 9. Therefore, I believe that this category holds a positive moral value within the frame.

Diplomatic nurses are also positively perceived by their peers. Despite experienced nurses often defining themselves as ‘Diplomat’ too, the category deserves independence from the ‘Experienced’ because, as discussed by several nurses, some in the professions are naturally talented for conflict resolution. These are particularly welcome in the team.

VEN6: Yes .. yes ... let’**s** say that some try to be more diplomatic .. **I** don’t ... it is a form of art ... **I** mean **you** have to remain constantly calm ... sometime **I** can do it .. sometime not ... **I** mean maybe **I** ... tend to be slightly more aggressive .. let’**s** say ... but ... some colleagues are very good at this ... **I** mean **they** manage to make the person almost ashamed of what **he** did[[8]](#footnote-8)

‘Ill-tempered’ and ‘Unbalanced’ nurses are less appreciated. The former are too aggressive and often argue with users, contributing an unnecessary source of stress as they aggravate already complicated situations.

VEN9: **I** ... something **I** have the chance to notice is that when certain people [nurses, TN] are … in triage … and … regularly .. every day there is … an argument … this means that how **you** interact is important[[9]](#footnote-9)

While the latter are nurses who are not necessarily ill-tempered, they fail to use the recommended dealing techniques, which causes distress to their colleagues. Examples of these are nurses who undermine nurses’ authority by being too compliant or too strict.

VEN6: Hem ... **I** **often** saw strategies based on ... indulgence ... for instance .. a relative .. or a patient .. says “**I** want to be visited before the **others** because **I** feel sick and **you** don’t understand a thing” and **they** say “Ok” … in **my** opinion this is not good ... Or ... **I** saw the opposite .. **I** mean because **you** insulted me ... **I** say “let’**s** settle this **outside**” .. **I** mean ... come in so we discuss and then ... then maybe **they** threaten **him**[[10]](#footnote-10)

Finally, a neutral position is assigned to new nurses, or ‘Rookies’. These are inexperienced and thus often fail to use the recommended techniques properly. However, their ‘Rookies’ status prevents them from being negatively labelled as it is accepted that ‘… **they** will learn’ (VEN4) ‘in the process’ (ESS10).

### 7.3.2 – Users

The two teams discuss this category in an identical manner. In agreement with the literature (Section 2.4.2), participants acknowledge that users access the A&E in significant distress and therefore are generally treated with empathy.

ESS6: Yeah .. **I** mean … **somebody** is abusive .. it is because something happened … **you** need to find out what happened .. why **you** behave like that … that **somebody** accepts it .. that **somebody** told **him** .. that **somebody** even tries to .. ignore **him** … and **someone** treated **him** badly … if **you** find it out .. **you** can deal with **him** straight away

ESS10: […] **I** have had patients who told me “**I**’m really sorry .. **I** didn’t mean that … **I** was in pain and all the things” .. at the **end of the day** .. so ... there are reasons that … **you** know … **they** said bad things ... **You** know .. no one wants to be in a hospital and in that situation when you are really stressed and in pain .. and **you** don’t know what is happening to **you** ... And **you** go in that situation when you need to .. you know .. release **your** emotion and **you** say something .. negative … yeah .. it could be ... mostly does that .. but some … you know …

According to my sociolinguist analysis, nurses tend to discuss users as passive agents. This is particularly observable in the ESS1 justification of why some patients might be upset:

ESS1: Ah … well … **we** … **we** are here to feel that pressure from the … from the patients … **I** mean .. there is … **someone** waiting **outside** … just waiting **outside** without seeing **anyone** at all for three .. four hours … **I** mean … even more … so is not … not unusual … **we** bring **them** **in** … **they** have to wait in the cubicle for … **I** don’t know … one .. two hours more … before … yes … maybe **we** are just getting there … not fully explaining what is going on …

In this quote users are constructed as passive agents through the use of passive verbal construction such as “we bring them in” and “they have to wait”. The only active performance users do is to put pressure, which would be considered improper but is accepted considering the, often, long waiting time.

The ‘**Users**’ category is divided into ‘*Patient*’ and ‘*Companion*’ based on the reason leading them to the A&E. In terms of the perpetrators’ categorisation, nurses showed a minor tolerance toward companions.

ESS5: If it is the partner .. **they** don’t need **this** … the partner .. straight away **I**’ll get **them** removed ... straight away ... **you** can’t … **you** call the security to remove **them** … but if it is the patient .. then it is more complicated … **you** have to take into account “why **they** are abusive to **you**?” what … **you** have to try to … is … to try to calm **them** down as much as possible

However, despite being approached with less empathy, certain categories of companion are recognised as having a more active role. Whereas patients receive a triage code and they must follow a defined procedure, companions’ access to the medical area can be negotiated. With them nurses can use a wider range of techniques, disclosing more or less information about the relevant patient or bending the rules in terms of visiting time. These results are particularly true for elderly companions and agitated parents escorting their children.

The ‘**Users**’ category is further subdivided into the following categories: ‘Mental patient’, ‘Children’, ‘Intoxicated’, ‘Young user’, ‘Elderly’, ‘Demanding’ and ‘Disrespectful’. Patients with mental health conditions and children are seen as non-culpable and not responsible for their actions, as they are unable to understand what they are doing. Therefore, these categories are represented in blue.

ESS6: If it comes from a dementia patient … yes … **I** think dementia patients wouldn’t be blamed … just … give medication to **them** .. calm them down

VEN3: For children ... **you** always have ... a bit more consideration[[11]](#footnote-11)

In agreement with Pich and colleagues (Pich et al, 2011) both teams agree that an exceptional approach is reserved for intoxicated users. Although partially justified because unable to understand what they are doing, their presence in the A&E is perceived as an unnecessary burden. Therefore, despite the possible mitigation due to their temporary inability to control themselves the category is represented in red.

VEN6: Personally ... it depends ... from an elderly with Alzheimer **I** can accept it … **I** mean ... **I** contextualise it [the behaviour, TN] within the disease ... from the mental patient who maybe took some drug .. **I** don’t accept it ... even though **I** take it ... **I** have proof here ... by the way ... a girl who ripped my t-shirt with her teeth … this [she indicates the tear on her t-shirt, TN] … **she** was laying down ... **I** had to apply an IV [intravenous drip, TN] ... find the vein … so … **she** jumped up and tore my t-shirt ... yes ... luckily the cop was there and **he** stopped me ... because **I** ... **I** was going to react … **I** did not accept that behaviour … **you** see? also after a while **you** get a bit ... intoll ... irritable … do **you** understand?[[12]](#footnote-12) [Authorisation to present this episode granted, TN]

VEN4: So .. alcoholics bother me ... **to me** an alcoholic … if **I** could … never mind … because **they** really are … **I** mean .. to deal with **they** are ... extremely complicated ... **you** have to listen to **their** insults .. and **you** know ... **you** say “come on, **he** is drunk” and this is fine .. but meanwhile … **they** will come back .. **always** the same … and **they** are really … the worst to manage[[13]](#footnote-13)

Young and elderly patients are differently evaluated, with the latter enjoying more empathy whereas the formers are perceived, by some, as impatient and sometimes rude.

I: Is it possible that the perpetrator’s age, or dress style, might change **your** tolerance? … Let’**s** say … might affect **your** reaction to

ESS10: It really depends actually ... obviously with the elderly **we** might have a more … soft approach … toward **them** ... but if **they** are more young and **they** are still polite .. **we** might still be … having the things … kind of an elderly

VEN2: **I** think what is missing is ... manners .. and ... **I** notice it in the young **ones** .. really the basis .. **I** mean the respect for other people’s work … **I** believe is missing a minimum of patience .. to wait ... Hey .. is like this ... if you don’t like it [you can leave, TN]... oh ... many times .. **we** think everything is owed to **us** ... it is not[[14]](#footnote-14)

The ‘Demanding’ sub-category is the most negatively discussed one and every interviewee cites it. These users ask for procedures or treatments they are not entitled to.

VEN6: Let’s start from the premise that users are demanding from the **very begin** … the vast majority is demanding from the **very begin** … **they** … especially because this is a public hospital … **they** arrive **here** and demand ... **I** mean ... silly things ... “**I** pay taxes ... **you**” .. by the way .. “**you** are public servants” .. because [as public servants, TN] **we** don’t pay taxes .. “**you** work for the state so **I** am paying **you** .. therefore **I** demand **you** to do this … this and that” … many people come **here** stating what **they** want to do “**I** am here because **I** want the X-Ray, the ECG, a cardiologic examination …” well … everyday[[15]](#footnote-15)

Moreover, this category includes those users whose requests undermine nurses’ professional decisions questioning their medical skills.

ESS3 – […] **Some people** are ... ignorant of the fact that of … **your** training .. **your** experience … they believe that all the doctors are much qualified than what **we** are … in terms of qualification .. **they** are … in respect of … time of working .. the job **there** in … say not always … the doctors say .. **they** are upper us … but … the parents … **they** don’t know **this** … so **they** think doctors are upper than **us**

VEN1: Of course .. everyone must understand that **they** are talking with someone who has studied … but .. again .. if **I** go to the body shop mechanic .. it’s **his** job and **I** trust **him** … **I** am not going to discuss … unless it is so evident … though … the respect for other people’s [professional, TN] culture is missing ... if **we** are **here** it is because **we** studied .. **someone** evaluated **us** and established that **we** can do this job … is not up to **you** [who did not study, TN] to tell **me** what **I** have or do not have to do because **I** don’t come to **your** house to tell **you** what to do or not to do[[16]](#footnote-16)

Finally, the ‘Disrespectful’ sub-category includes all those users who are perceived to consciously lack respect for nurses, other users, or the frame. Several examples are provided of how disrespect can be shown against different categories and sub-categories, for instance, companions toward hospitalised family members.

ESS1: **I** mean … yes … **you** notice **they** are not taking care because … maybe … **he** or **she** is living alone at home and **you** know for sure … **this person** is not … eh … not suitable to live alone .. or **they** should take care of **him** … **you** know … the ageing … might not be the proper one .. or … or **you** notice **he** is not able to do … regular things … **I** mean .. eating or drinking … and **you** see … "oh, **he** is living alone … ok" … suddenly **you** appear from **nowhere** … asking **us** to solve **your** … I mean .. “**I** want **you** to solve it **now**” … “**I** want to go home”.

Other general users:

ESS4: They don’t care about anybody else … except their family member.

VEN8: Exactly ... “**You** stop [what you are doing, TN] for **me**” and above all “the **others** are nothing compared to **me**” .. because it happened **out there** [in the waiting room, TN] .. “**I** am more in pain than **that one**” … these kinds of discourses … and **they** say “**you** don’t understand because **I** am shouting because **I** am in pain .. **that one** stay silent because **he** is not in pain” … Instead he who stays silent perhaps has **his** reasons ... **he** is out of breath [for the pain, TN][[17]](#footnote-17)

The setting’s formal rules and aim:

ESS3: **I**’ve actually said to people before … "would **you** walk into a bank and start shouting … no … so why **you** are walking in **here** and start shouting?"

VEN5: Another one ... what was … **some time ago** … **he** was photocopying while waiting … yes .. yes .. yes **we** have a copy machine and **he** was photocopying **his** stuff and **we** asked “what are **you** doing?” ... “A photocopy because this is a public hospital and **I** pay my taxes” … just to say … therefore … people come **here** demanding … **you** laugh but it is true [laugh, TN][[18]](#footnote-18)

VEN1: Yes ... three days ago ... the ballot box was no longer **here** [the checklist data collection was over, TN] … **I** wasn’t directly involved .. because **I** avoided ... anyway ... **he** had a face .. not like a criminal .. worse … **my** colleague approached **him** .. **he** said “look .. **I** would like to tell **you** …” “No .. **I** .. let me speak with this .. let me speak with that .. let me speak with the other .. **I** don’t care .. call me the general manager” “But it is the law .. it’s valid for everyone” “**I** don’t care ...”[[19]](#footnote-19)

### 7.3.3 – Security Officer

The ‘**Security officer**’ category includes police officers, as private security was not regularly present in Veneto at the time of the research. These actors are seen as valuable support and last resort when nurses have to deal with the most difficult patients. The same discussion is valid for police officers, who often wait at the A&E either as form of crime prevention or while on duty escorting suspects and convicted criminals for medical checks.

I: Ok … how do **you** deal with … someone who is … misbehaving?

ESS2: Depending on what … to what level … **I**’ll tell **them** to stop ... if there is aggression .. **I** would call the security and tell **them** to remove **him**

ESS10: […] **I** think the security … if **someone** gets aggressive toward **us** ... **you** won’t do that because there are people allocated … certain job … **who** do that thing

The pronoun ‘them’ is used both for perpetrators and security officers demarking their distinction with the medical staff, a fact underlined by their absence from the setting – they have to be called. The function of security officers is clearly stated: they do not mediate or try to calm down the perpetrator; they remove him from the setting. This function of security officers and the positive perspective nurses have of them is consistent with the few studies on nurse-security officer professional interactions (Gillespie et al, 2012; Tan et al, 2015).

### 7.3.4 – Hospital Management

According to my findings, ‘**hospital management**’ includes several managerial figures, from the department manager to the hospital general manager and the hospital legal department. This category is depicted as negative in both settings, although for different reasons. In Essex, nurses perceived the involvement of the management as problematic rather than supportive, since in the case of litigation, the management would listen to the perpetrator and not to them. Nurses felt that, in this case, their job might be at risk, independently from the impropriety they suffered.

I: Is it because **you** have to accept it?

ESS2: yeah … because .. **you** can’t … **you** have to be careful of what **you** say … **they** might name **you** with … **I** don’t know … the manager ... it’s **your** job on the line

ESS4: […] but **you** have to do it in a way … if **you** shout **them**.. and **they** go to complain **you** … **you** get in trouble

Again, the use of the deictic ‘you’ suggests that this is not a personal opinion but a conviction shared among nurses.

On the contrary, as discussed in Section 6.3.2, Veneto nurses are less worried about disciplinary actions against them following user complaints. However, the perceived lack of interest from the management creates the unpleasant feeling of being left alone.

VEN1: [...] As I said .. I would press charges but I don’t want to .. because I don’t feel I am … protected from the very beginning .. I mean by the hospital .. at a legal level .. at police level [...][[20]](#footnote-20)

The VEN1 feeling seems to correspond to reality, according to another nurse who did press charges against two users for physical assault and was even supported by the deposition of the police officers who intervened.

VEN5: [...] Ok .. I filed a complaint but in the end they were ... under drugs and ... homeless .. psychiatric or similar ... and nothing happened [nervous laugh, TN] ... you can press charges ... but it is just reported [to the authorities, TN][[21]](#footnote-21)

According to these two testimonies, the lack of support seems to be structural and chronic in the Italian system. Nevertheless, with respect to the scope of this research, the nurses’ opinion of the hospital management remains negative and thus the category is marked in red.

## 7.4 – Reasons to Work in A&E

A background consideration, originated from my curiosity rather than drawn from the literature, is why someone would decide to work in such a stressful environment.

VEN5: **I** believe there is another thing to say ... **you** don’t last in an A&E ... [...] **I** think the main problem is that patients don’t know what will be … thus … **they** are way more tense and way more rude [...] when **you** are moved to a ward .. because **they** know the diagnosis .. **they** already know the prognosis .. **they** show up with pastries […] this is because **they** are calmer **there** … and … and **they** go through **their** procedure … **here** .. poor sods … **here** **they** face the initial panic […][[22]](#footnote-22)

Therefore, A&E nurses are among the professional categories most subject to episodes of burnout (Zampieron et al., 2010; Duxbury et al, 2013; Magnavita, 2013). For example, during my data collection, both the nurse gatekeepers requested to be transferred to other departments.

The purpose of this theme is, therefore, to investigate why participants decided to work in such an exhausting environment and what motivates and helps them to bear the work-related stress. Two questions were posed: ‘Why did you decide to work in the healthcare sector?’ and ‘Why in A&E?’

Concerning the first question, interviewees all followed different biographical trajectories; some did it because of family traumas whereas others followed their personal interest in medicine. However, all but one framed their decision as vocational, based on personal predisposition to care and help. The only exception is represented by ESS6, who replied

ESS6: Destiny? **I** can’t tell **you** why … my destiny was to do something’.

ESS5 was emblematic, representative, and comprehensive of colleagues’ answers:

ESS5: Oh .. **I**’ve got passion! .. **I**’ve got passion to do it … to care for people … it has **always** been in my heart to help people ... my father was not very well .. so **I** had to care for him ... so **I** said .. “Hang on a minute .. **I** could do **this** for **everyone**" .. So **I** decided to get some training and then become … whatever to help people to … **I** always had the passion .. when **I** come to work … **you** know sometimes **you** go to places and **you** feel it hard? … but **I** love this job .. **I** love to help people ... **I** just love it ... It is very rewarding

It is relevant that ESS5’s recognition that the job can be hard ‘but’ – adversative conjunction to introduce a sentence in contradiction with the previous (Tannen, 1993, p.27) – love, passion and the pleasure of helping other people reward nurses’ work-related stress and sufferance.

ESS5’s last sentence, ‘it is very rewarding’, is further explored by the second question: Why in A&E? Professional satisfaction is the common denominator for all interviewees. My findings indicate that working in A&E helps to improve nurses’ professional skills because, contrary to working in other wards, they face a wider range of conditions and are directly involved in the diagnostic process.

ESS5: **You** are the nurse, **you** have to investigate … do what **you** have to do ... this is what **I** love ... **I** love the problem-solving

In fact, A&E nurses believe that a significant difference exists between them and nurses working in other wards.

VEN10: **I** don’t like the figure of ward nurse ... **I** believe .. are two different things ... Yes .. **we** are colleagues ... if **someone** hears me saying **this** … **they** would probably nail me to the wall … but I believe there is a completely different training … Here you are much more autonomous although decisions ... are taken by doctors[[23]](#footnote-23)

ESS3: Because **I** don’t like to work in wards … no … **we** work through patients … and **you** see the same patients for **six days** ... at least in A&E there is a quick turnover … in wards **you** have very similar works … different people make the difference

Nevertheless, a significant difference is observable between Essex and Veneto. When asked about their decision to work in the healthcare sector, most referred to a vocation of active care for others. However, this motivation was not present in Essex nurses’ decision to work in A&E. Their decision resulted fully from their desire for professional improvement. On the contrary, Veneto nurses coupled it with moral satisfaction due to the impact their work can have on patients’ lives.

VEN1: **I** can say that ... as **I** was saying **some** [users] come to shake my hand before leaving … this could happen in other departments as well … also **I** can say .. working with urgencies is critical .. **I** can say that **I** saved **someone** .. at least **I**’ve contributed to give **him** an extra chance … then … the outcome is what it is .. but **I**’ve contributed to something[[24]](#footnote-24)

A moral pleasure is stressed both through the repetition of the concept and their vocal stress closing the sentence.

## 7.5 – Chapter Conclusion

This chapter aims to provide a background understanding of the findings discussed in the following two chapters and to ensure validity for the information discussed. First, I validate my findings by analysing the influence of background frames on my data collections. Then I present the categories of actors that emerged from the narrations collected, some perceived with hostility and some welcomed. In Chapter 8, Findings: Definition of Situational Impropriety, the role of the perpetrator’s identity is clarified, and the map presented in Figure 7.1 (p.134) will help the reader to understand the answers provided.

Although this section went above the aim of this thesis by discussing other professional categories formally excluded in this investigation, such as doctors and security or police officers, I believe it would have been too arbitrary to ignore them. In agreement with the qualitative purpose of this methodology, I believe it would be anti-ethical to pretend that nurse-user interactions happen abstracted from the surrounding complex reality, or that interactions are not affected by organisational factors and intra-staff formal interactions, as discussed in Section 9.2. Therefore, although some of my findings are not discussed in the next chapter, I hope that their representation in this thesis will stimulate other researchers’ interest.

Finally, I have presented nurses’ personal reasons for working in A&E and have identified a general desire to help and to make a difference in another person’s life, coupled with the professional development and satisfaction this department offers. I believe that the acknowledgment of this background, in combination with an analysis of the identified categories, will also support the understanding of the definition of impropriety and the dealing strategies developed.

# Chapter 8 – Findings: Definition of Situational Impropriety

## 8.1 – Introduction

As previously introduced, this chapter presents those findings relevant for the first sub-research question: under what conditions are users’ performances perceived as situationally improper?

This chapter comprises two main sections: the former presents the nurses’ original definition of impropriety provided in checklists, second open question, and in interviews, strand one. The latter presents the identity of the perpetrators as reported in qualitative checklists, closed-ended question and the first open question, and are discussed in semi-structured interviews, strand 3 - see Section 6.3.1.2 for an overview of the interview strands.

Before presenting my results, I believe that two clarifications are necessary: one addresses my refusal to run inferential statistics on my data; and one on my use of tables and graphs in this qualitative study. Concerning the former, despite legitimately suggested by many fellow students and more established researchers, I believe that statistical analysis would be both epistemologically contradictory and statistically weak. As discussed by Yin (2009, p5), qualitative research should focus on analytical, rather than statistical, generalisation. Thus, in accordance with my weak constructionist epistemology, the true value of my findings is not to be found in their quantitative nature but in their socially constructed and original meaning that informs my analysis and my discussion.

Moreover, from a statistical perspective, it would be difficult to sustain the statistical validity of my sample. First, it follows a convenience sampling method that, according to Gobo (2004) and Saumure and Given (2008), is not suitable for generalizability or transferability. Second, due to the anonymous nature of the checklists, I cannot assess the size of my sample and calculate its power since I am unable to know how many nurses reported at least one impropriety.

Nevertheless, in agreement with my aim for maximum transparency, ‘Annex III – Full qualitative checklist report’ presents a detailed descriptive statistical analysis of the checklist findings. These must be regarded only as a full disclosure of my findings and not as an attempt to build statistical generalisations.

The use of charts, percentages, and tables are merely to increase accessibility to the findings. Although this appears to contradict the above rejection of quantitative analysis, as discussed by several scholars (Downey and Koenig, 2004; Koenig, 2004a; 2004b; Silverman, 2013; Keeny et al, 2015), it is legitimate for qualitative researchers to reduce the complexities of the provided information through a codification process, which is also necessary when data are collected in two different languages. Such charts and tables are therefore used to increase the readability of my findings and to help the reader to better understand my process of analysis.

In addition, as previously discussed in Section 6.3, since this thesis aims to investigate similarities between the two teams, findings are presented as collected from a unique setting – a hypothetic and general European A&E. Although differences are identified, highlighted and closely examined in this and in the following chapters, in agreement with the aim of my thesis I will mostly focus on commonalities.

Finally, before proceeding, it is important to recall the conclusion drawn from the literature in Chapter 2 and to offer an overview of the achieved results: incidents of verbal abuse are more common than physical abuse, and the most commonly reported perpetrators are young male patients with low socioeconomic status or with mental health conditions (Cameron, 1998; Ferns, 2005b; James et al, 2006; Zampieron et al, 2010; Alameddine et al, 2011; Esmaeilpour et al, 2011; Pinar and Ucmak, 2011; Pich et al, 2013). Moreover, perpetrators are usually described as incapable of self-control due to substance abuse, pre-existing mental health conditions, or because they are upset by long waiting times (Crowley, 2000; May and Grubbs, 2002; Lau et al, 2004; Kansagra, et al, 2008). Finally, nurses are reported to be more likely to be abused between 15:00 to 23:00 (Ferns et al, 2005; Knott et al, 2005; Senuzun Ergün and Karadakovan, 2006; Pich et al, 2010) and during weekends (Knott et al, 2005; Sands, 2007; Gacki-Smith et al, 2009; El-Gilany et al, 2010; Esmaeilpour et al, 2011). As anticipated, these results are partially challenged by this study’s findings.

Table 8.1 – Answer distribution per close-ended question

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Day** | **N (%)** |  | **Age** | **N (%)** |  | **Gender** | **N (%)** |
| Monday | 17 (13,5) |  | <18 | 7 (5,6) |  | Female | 54 (42,9) |
| Tuesday | 20 (15,9) |  | 18 - 25 | 10 (7,9) |  | Male | 71 (56,3) |
| Wednesday | 16 (12,7) |  | 26 - 35 | 24 (19,0) |  | MISS | 1 (0,8) |
| Thursday | 18 (14,3) |  | 36 - 45 | 18 (14,3) |  | Total | 126 |
| Friday | 21 (16,7) |  | 46 - 55 | 29 (23,0) |  |  |  |
| Saturday | 21 (16,7) |  | 56 - 65 | 20 (15,9) |  |  |  |
| Sunday | 9 (7,1) |  | 66 - 75 | 8 (6,3) |  |  |  |
| MISS | 4 (3,2) |  | 75+ | 6 (4,8) |  |  |  |
| Total | 126 |  | MISS | 4 (3,2) |  |  |  |
|  |  |  | Total | 126 |  |  |  |
|  |  |  |  |  |  |  |  |
|  |  |  |  |  |  | **Security** |  |
| **Shift** | **N (%)** |  | **Role** | **N (%)** |  | **intervention** | **N (%)** |
| Night  (00:00 – 05:59) | 16 (12,7) |  | Companion | 56 (44,4) |  | No | 95 (75,4) |
| Morning  (06:00 - 11:59) | 37 (29,4) |  | Patient | 70 (55,6) |  | Yes | 23 (18,3) |
| Afternoon  (12:00 - 17:59) | 34 (27,0) |  | Total | 126 |  | MISS | 8 (6,3) |
| Evening  (18:00 - 23:59) | 35 (27,8) |  |  |  |  | Total | 126 |
| MISS | 4 (3,2) |  |  |  |  |  |  |
| Total | 126 |  |  |  |  |  |  |

Source: Collected data.

A&E nurses from Essex and Veneto reported the highest incidence of improprieties on Fridays and Saturdays (16.7% each), closely followed by Tuesday (14.3%), while Sunday (7.1%) is the quietest day of the week. My findings therefore partially confirm the results reported in the literature, identifying weekends as problematic days. However, this assumption is challenged by both the low number of improprieties reported on Sunday and the high number of improprieties reported on Tuesday. In fact, due to the definition of Sunday as a timeframe, according to the literature, Sunday night (00:00 – 05:59) and Sunday morning (06:00 – 11:59) should be peak times, with many users arriving intoxicated from their night out (Ferns et al, 2005). Therefore, Sunday morning should also have a high incidence of improprieties. The concentration of improprieties on Tuesday remains unclear.

In terms of shifts, it is reported that evening and night shifts (15:00 – 23:00) should record higher rates because intoxicated users are ‘more likely to present at the department following a long day’s or night's drinking.’ (Ferns et al, 2005, p.726) However, according to my findings, night shifts recorded the lowest number of improprieties (12.7%), while morning shifts recorded the highest rate (29.4%), closely followed by evening (27.8%) and afternoon shifts (27%).

Lastly, the significant level of checklist completeness – average response rate 97.2% -- is symptomatic of participants’ interest and concern for the investigated issue. Thus, confirming that dramatic diffusion of it and the relevance of this research in nurses’ life.

## 8.2 – Definition of Situational Impropriety

Definitions of situational improprieties were collected through the second open question of the qualitative checklist and the opening question of the semi-structured interview. A total of 126 checklists were correctly completed and returned during the four-week per hospital data collection, resulting in an average of 2.25 situational improprieties per day. In the four weeks of November 2015, Essex nurses returned 82 valid checklists (2.9 per day), while between January and February 2016, Veneto nurses returned a total of 44 checklists (1.6 per day). I decided not to collect data in December and early January to avoid extraordinary peaks of access due to Christmas and New Year’s Eve holidays.

Improprieties were to be reported with a maximum of three descriptors, although many used more words or wrote a full sentence. Extra information was not excluded and full sentences were deconstructed to extrapolate the relevant descriptors. For instance, ‘He came to me shouting and kicked the triage door’ was coded as ‘shouting’ and ‘kicking’, two single improprieties linked to the same unique event (checklist). Thus, from the 126 checklists, I identified 275 improprieties (2.2 per checklist; 2.3 per day) so divided: 177 in Essex (2.2 per checklist; 2.9 per day) and 98 in Veneto (2.2 per checklist; 1.6 per day).

In terms of the type of improprieties, these findings reported behaviour that escaped the usual verbal/physical dichotomy. Free to express themselves, nurses reported a more articulated conceptualisation of situational impropriety, introducing improprieties that I define as ‘Attitudinal’, ‘Emotional’ and ‘Interactional’ as represented in Chart 8.1 below. Despite previously identified – although not investigated - in literature by the few authors who explored nurses’ perspectives (Crilly et al, 2004; El-Gilany et al, 2010; Pich et al, 2013), these new categories are here considered in detail. In addition, my interpretations of these were discussed during informal chats and validated at the beginning of each interview.

Chart 8.1 – Distribution of identified types of situational impropriety

Source: Collected data

As observable, the three dimensions that escape the verbal/physical dichotomy are the majority of the reported descriptors. This suggests that the nurses’ definition of impropriety is different from that of the many authors whose work I critically reviewed in Chapter 2. In addition, anticipating the discussion below, that improprieties are not only defined by ‘what’ a perpetrator does, but also by ‘how’ s/he does it. A finding supported by Fernandes and colleagues (Fernandes et al. 1999) and other more recent studies (Crilly et al, 2004; Luck et al, 2007b; El-Gilany et al, 2010; Wilkes et al, 2010; Pich et al, 2013).

Please note that my interpretation of the collected information bears a certain amount of arbitrariness since an improper utterance could fit in two or more groups. For instance, I had the opportunity to observe a user shouting to a nurse, ‘bastard .. you don’t understand’. From my perspective, the sentence contains two improprieties: ‘bastard’, a verbal one, and ‘you don’t understand’, an interactional one, as explained in Section 8.2.3. Other researchers might code this as simply verbal, focusing their attention on the adjective.

In the following sub-sections, I discuss my findings per each form of impropriety, ordered by their “weight” as in Chart 8.1 above

### 8.2.1 – Attitudinal Improprieties

These resulted in the most reported ones (77; 28%) and they refer to Goffman’s definition of attitude (1961, p.45; 1956, p.493). According to the Canadian sociologist,

‘frame, however, organises more than meaning; it also organises involvement […] all frames involve expectations of a normative kind as to how deeply and fully the individual is to be carried into the activity organised by the frame.’ (Goffman, 1974, p.345)

As discussed by Goffman, each social encounter is guided by a frame that gives meaning to it, that defines which roles can be performed and defines which level of involvement is expected by actors (Ibid; Giddens, 1990, p.85). Therefore, actors have obligations in terms of face-work, engrossment, deference, and demeanour toward the frame and, consequently, toward the other involved actors. Examples reported in checklists are being arrogant, rude or being too loud (shouting).

In addition, to the more reported improprieties, attitudinal improprieties were discussed by every interviewee and the most cited one was that of selfishness, which is discussed in line with the discussion offered in section 7.2.2 about disrespectful users. According to all the interviewed nurses, the A&E is a context where everyone is equal and evaluations are made on objective medical conditions only. Selfish attitudes aimed at trying to ‘jump the line’ or that show a lack of consideration for other users cannot find space here, and thus are referred to as abusive and situationally improper.

ESS4: **They** don’t care about anybody else … except **their** family member.

VEN8: Exactly ... “**You** stop [what you are doing, TN] for **me**” and above all “the **others** are nothing compared to **me**” .. because it happened **out there** [in the waiting room, TN] .. “**I** am more in pain than **that one**” … these kinds of discourses … and **they** say “**you** don’t understand because **I** am shouting because **I** am in pain .. **that one** stays silent because **he** is not in pain” … Instead who stays silent .. perhaps has **his** own reasons ... **he** is out of breath [for the pain, TN][[25]](#footnote-25)

Other behaviours perceived as attitudinally improper include rudeness, arrogance or presumptuousness

ESS3: **I** believe … it is unacceptable to be abusive … hem … rude .. shouting … **I** cannot tolerate that and **I** always speak quieter … so …

VEN2: **I** believe the majority of behaviour that bothers **us** is due to the attitude **they** use to ask **you** things … or the presumption of saying “**I** am **here** .. it is **my** right to know …” It is fine per se ... but there are ways and ways [to approach us, TN][[26]](#footnote-26)

Finally, attitudinal improprieties also can be directed toward the setting itself, or the frame, as Goffman would say.

ESS3: **I**’ve actually said people before … "would **you** walk into a bank and start shouting … no … so why **you** are walking in **here** and start shouting?"

These results in partial contrast with the literature discussed in Chapter 2. In fact, as discussed by Luck and colleagues (2007b)

‘violence that was directed towards a nurse as a symbol of the ‘system’ did not impact negatively on the emotional well-being of the participants.’ (Ibid, p.1074)

In contrast, my interviewees reported that the system itself, although with its own defects and faults, still deserves respect and requires the proper attitude.

### 8.2.2 – Verbal Improprieties

The second most reported form of impropriety is “Verbal” (76; 28%), such as offensive utterances and words, as well as racist offences and verbal sexual harassment. However, despite being reported in the checklists often, according to my interviewees, verbal improprieties were not perceived as a major issue. In agreement with the first data collection, they were discussed as racist insults, sexual harassment, or specific insulting words.

Verbal improprieties were mostly discussed from a personal stance using singular personal deictics. From a sociolinguistic perspective, this indicates that the definition is personal and that other nurses might have their own perspective on this.

ESS5: […] if **they** be racist toward **me** for example … **I**’ll go to one of **my** colleagues and say “**he** has been racist toward me” for example .. **I** cannot stand racists … “Can **you** please go and take care of **him**?” … it is not being abusive to **me** .. is about being racist ... so in that case **I** just call me off .. that’s what **I** do

Finally, nurses praised themselves for being quite resilient to verbal improprieties, and this might explain the absence of this form from their interviews.

### 8.2.3 – Interactional Improprieties

Third, in terms of occurrences is the “Interactional” form of impropriety (74; 27%). Originally discussed by Crilly and colleagues’ (2004), who reported that verbal abuse and physical violence were often (44% of the cases) preceded by ‘demanding behaviour’ and unnecessary requests of attention (Ibid, p.5). These represent improper ways to approach or interact with nurses, such as being not-cooperative, to claim for treatments they are not entitled to and, in agreement with Crilly (Ibid), being excessively demanding.

Their significant presence in Chart 8.1 (p.158) and the fact that the topic was discussed and further detailed by every interviewee does not come as surprise from a frame analysis perspective. As discussed in Section 4.3.3, each frame indicates the accepted performances and how these should be performed, creating, in those familiar with the frame and behavioural expectations. These have the double nature of providing sufficient confidence to the performer that his/her interactions will not be rejected and s/he will be treated according to his/her expectations; as well as to the audience who knows what to expect from the performer. Should expectations not meet interactional improprieties happen and frame disputes arise (see Section 4.3.5).

Further investigating this impropriety, I have identified two subcategories: performances challenging nurses’ medical skills, and performance challenging the expected passive role of users.

#### 8.2.3.1 – Performances Challenging Nurses’ Medical Skills

These were mostly discussed as questioning the nurses’ expert role, medical knowledge, and professional skills.

VEN1: **I** believe it is not acceptable ... to jump assigned hierarchies ... **I** mean **sometimes** .. **they** go straight to a doctor .. when it is a problem **I** can easily solve … and **often** doctors don’t know … but because there is still this medical figure .. the doctor .. identified as … **who** at the end send **them** [patients, TN] to **you** [nurse, TN] ... so **you** say .. “and **now** **you** come back to **me”** … do **you** understand?[[27]](#footnote-27)

In this narration, VEN1 makes a strong claim for the recognition of nurses’ competence and independence of action and decision, which is often ignored by users. However, this lack of knowledge is contextualised in the popular culture that considers nurses as mere assistants without specific medical skills. For instance, the sentence ‘but because there is still this medical figure … the doctor …’ communicates frustration, stressed by the adversative conjunction ‘but’ (Tannen, 1993, p.44), the emphasis on ‘because’ and ‘the doctor’ and the use of the adverb ‘still’ – this last one presenting the issue as something that should have been solved long time ago. The same perspective is shared in Essex, although more pragmatically discussed.

I – Ok … going back to someone saying "**I** would like to speak with a doctor" … why do **you** perceive **this** sentence as offensive?

ESS3 – Hem … **I** wouldn’t … not necessarily ... if … that’s **their** choice .. if **they** say **they** want to see a doctor … **that**’s fine … **they** don’t want to take **my** advice and … as a professional … **some people** are ... ignorant of the fact that of … **your** training .. **your** experience … **they** believe that all the doctors are much qualified than what **we** are … in terms of qualification .. **they** are … in respect of … time of working .. the job **there** in … say not always … the doctors say .. **they** are upper us … but … the parents … **they** don’t know **this** … so **they** think doctors are upper than **us**

In this quote, ESS3 constructed three categories of actors using the plural personal deictic ‘*they*’ to create the ‘nurse’ category as residual from the two cited categories: ‘doctor’ and ‘user’. ESS3 initially adopted a personal stance (“*I*” and “*my*”) presenting themselves as “*professional*” but rapidly moved to a plural generic stance (‘your training .. your experience’). This shift in footing, as discussed in Section 6.5.2.1, suggests that ESS3 was talking of a common situation that interests every nurse, interpretation supported by the use of the plural inclusive deictic “*us*”. In line with VEN1, ESS3 represented doctors as experts, even though not in everything and still in need of support from nurses. Meanwhile users were described as ignorant of nurses' medical skills and, in this case, of the real labour division in the healthcare sector. This quote is also representative of two different narration styles, with Essex nurses often choosing a more pragmatic and impersonal stance.

As discussed in Section 7.3.1 interviewees suggested that the A&E Frame offers an unusually powerful position to nurses. Here, unlike in wards, nurses have several medical and diagnostic tasks usually reserved for doctors. It is therefore correct to claim that the A&E nurse has a social identity different from that of other nurses, both in formal and informal terms. Borrowing from Goffman’s frame terminology, A&E nurses are a keyed version of the regular ward nurse. Nevertheless, this higher specialisation is often not recognised by users, a fact generally perceived as an understandable consequence of users’ common lack of knowledge about professional relations within the medical professions and the A&E labour division.

VEN1: [...] nurses are still perceived as ... in **my** opinion ... as urinal and clean up … if a doctor says .. if says … the same things said by **me** … **mine** is worthless .. if a doctor says the same things **they** leave saying “thank **you**, have a nice day, etcetera” […]*[[28]](#footnote-28)*

As discussed in Section 4.3.3, a key can be removed through a process of ‘downkeying’ (Goffman, 1974, pp.359-66) using the immediately lower frame to make sense of what is going on. For instance, the A&E hospital department exists within the larger hospital context where inter-professional interactions and power distribution differ. Therefore, the A&E social interaction exists within the broader hospital interaction, and the A&E Frame is thus rooted in, or it is a key of, a lower frame that, for the sake of clarity, I define as ‘Hospital Frame’, which is beyond the scope of this research. In this lower frame, as discussed by Allen (2001, p.125-28), nurses are subordinate to doctors and, as also confirmed by the above VEN1 quote, are not expected to make diagnostic decisions.

A&E nurses are thus still perceived within a sort of broader and traditional medical frame where nurses are mere assistants covering non-diagnostic tasks. Based on my analysis I, therefore, believe that this specific type of Interactional impropriety can be defined as an attempt to re-frame the nurse-user encounter, or more precisely an attempted down-key of the guiding frame.

#### 8.2.3.2 - Performance Challenging the Expected Passive Role of Users

As discussed in Section 7.3.2, users are expected to be passive actors when accessing an A&E. However, this does not always happen and nurses perceive such deviation from the expected behaviour as improper. Behaviour here discussed refers to being too demanding and asking for personalised attention without any reasonable entitlement.

VEN5: Another one ... what was … **some time ago** … **he** was photocopying while waiting … yes .. yes .. yes **we** have a copy machine and **he** was photocopying **his** stuff and **we** asked “what are **you** doing?” ... “A photocopy because **this** is a public hospital and **I** pay my taxes” … just to say … therefore … people comes **here** demanding … **you** laugh but it is true [laughing][[29]](#footnote-29)

Another example, although limited to the Veneto narration, is the attempt to use role power to influence the triage process of priority assignment.

VEN6: Also many doctors who … don’t work **here** .. but maybe in other structures .. **they** demand to speak with **their** colleagues as soon as **they** arrive **here** ... but it doesn’t work like this … or **they** demand to be visited immediately … or **they** demand ... yes ... maybe even before telling **you** **their** symptoms .. **they** show **you** **their** badge … showing **they** are doctors … lawyers … maybe .. **they** think **they** can intimidate **you** … or that **you** will open **them** the doors … do **you** understand?[[30]](#footnote-30)

Moreover, I believe that this quote also stresses how off-duty doctors also do not recognise nurses’ medical skills since ’**they** demand to speak with **their** colleagues’ an impropriety within another impropriety.

Being excessively demanding or not cooperating differ from the previous impropriety because the impropriety is not clearly aimed at questioning the nurses’ skills. Rather, the A&E Frame’s interactional order is challenged and the passive role assigned to users. The concept of role power (meaning in this case what an actor with a certain role can do) was not clearly incorporated by Goffman in his social theory. Nevertheless, Rogers (1977; 1979) and, more recently, Jenkins (2008) explored it in detail within Goffman’s intellectual production. As stated by Jenkins,

‘power [in Goffman] is a matter of a taken-for-granted, ‘normal’ everyday order of interaction, which enables and constrains efficacy and capacity’ (Ibid, p.164)

Thus, power is a consequence of the different amount of natural and interactional resources differently provided to categories and actors by the guiding frame. Limiting my interest to socially provided resources, A&E nurses are empowered by society to fulfil a delicate role. However, for reasons I am not able to identify or discuss due to the unilateral perspective of my research, some users question the power distribution proper of the A&E Frame.

Drawing upon medical sociology, interactional improprieties in the healthcare setting have already been introduced by Parsons (1951). His analysis of the function covered by healthcare professionals in society suggested that healthcare professionals are active actors who take care of temporarily deviant actors. Whereas patients are passive actors in need of expert support to heal and thus re-gain their social identity endangered by the disease. As discussed by Elston and colleagues (2002), when users refuse this passive role, they commit an impropriety against healthcare professionals: an act of defiance against legitimised agents of social control. Based on my findings I believe this definition matches the A&E nurses’ self-understanding of their role and of that of users.

Following previous works in medical sociology, interactional improprieties can be seen as a consequence of two evolutions within the NHS: on the one hand, the reconstruction of patient identity to active consumer (Keaney, 1999; Conrad and Leiter, 2004; Callaghan and Wistow, 2006). This has resulted in new demands of accountability from patients and, on the other hand, the introduction of a capitalistic ideology in the healthcare system, which has led to

‘the dissolution of the autonomous acting subject to be replaced by conformity to bureaucratic processes based on abstract calculations.’ (Gabe and Elston, 2008, p.701)

Therefore, if patients feel entitled to ask for more, nurses are forced to be more rigid and to refer to standardised procedures, thus reducing the space for dialogue between the two roles. According to Gabe and Elston (2008), this has led to an increase in demanding patients/consumers

‘who are quick to emphasize their rights’ causing a growth in the pre-existing problem toward NHS staff.’ (Ibid, p.698)

In agreement with their analysis, these findings report that demanding users perceive themselves to be entitled to services and attention that are not foreseen by the A&E Frame as expressed by VEN5 above.

Based on this discussion, this type of impropriety will become increasingly frequent. In fact, while European societies are shifting from a definition of health as a right to that of a commodity (Directive 2011/24/EU), and thus overlapping the figure of patient with that of consumer, this is still not applicable in A&E departments. These, by virtue of their role, do not answer to economic or commercial rules, is instead based on the logic of objective life-threat emergencies – at least in the Western European context.

In conclusion, unlike the attempted downkeying discussed in Section 8.2.3.1, in this case, users reject their expected passive role and are becoming too demanding and uncooperative. Based on Gabe and Elston’s (2008) analysis, this form of interactional impropriety can be understood as an attempted re-framing of the interaction from “patient-medical expert” to “buyer-seller”.

### 8.2.4 – Physical Improprieties

Physical improprieties, defined as acts or attempts of physical aggression, such as kicking, are not often reported (28; 10%). These improprieties were only briefly mentioned in interviews and were cited by only six interviewees. These included episodes of physical aggression, acts toward department furniture, self-harm, and getting menacingly too close. Physical improprieties were always discussed adopting a footing aligning the triad animator-principal-author, as showed in the quotation below, suggesting that the discussed events were personal, which is why I limit the use of examples to the one below to protect the anonymity of the interviewees.

VEN4: Something that really bothers **me** .. that really … when **they** knock on the triage glass ... **somewhere else** it wouldn’t bother **me** … see? …there are things that **outside** would bother **me** more and others less[[31]](#footnote-31)

### 8.2.5 – Emotional Improprieties

Emotional improprieties are less reported (20; 7%) and were only briefly mentioned by one nurse. Introduced in literature by El-Gilany and colleagues (2010) and further developed by Pich and colleagues (2013) and Luck and colleagues (2007b), they indicate a manifested state of emotional distress perceived as excessive and improper based on nurses’ evaluation of the seriousness of the medical condition. Examples of this are frustration, apprehension, or anger perceived as unjustified by the contextual situation of the perpetrator.

Emotional improprieties are also difficult to evaluate because, while patient anxiety is a possible escalating factor, these are generally also viewed by nurses as a mitigating factor (Luck et al, 2007b, p.1075). Thus their presence in checklists is somewhat unclear since, while all interviewees validated them in the table of translation, none openly and directly discussed the topic. Nevertheless, it is my understanding that, as discussed by ESS3, some users tend to exaggerate their affliction (see Section 8.3.2). In addition, as discussed by ESS4 when explaining its dealing strategy, some parents appear excessively concerned about the condition of their children.

I: Ok … do **you** touch them … or do **you** try to avoid .. physical contact …

ESS4: **I** try to avoid physical contact … because again if **you** touch them might be wrong … but … all depends .. because if **you** got a parent who is really .. really … upset and **they** don’t let **you** go because **they** are upset … it could be the child … **they** are scared ... so maybe a pat on the shoulder … “ok love .. **we** will sort it out” … it really depends

In the quote above, ESS4 also includes in the perpetrator category the parents who are perceived to have exaggerated emotional reactions regarding their children’s health conditions. In fact, although being scared is an emotion usually accepted in the A&E context, the vocal stress on the second repetition of the adverb ‘really’ emphasises that sometimes such preoccupation may be perceived as excessive and thus improper. This interpretation supports Goffman’s stance since actors that exaggerate their display of emotion are may be defined as insane because they lack the self-control necessary to perform their role (Goffman, 1961, p.132).

In conclusion, I cannot further develop this topic since none of my interviewees directly discussed it as problematic and, because of its limited presence in the checklist findings, at that time I decided to focus the 20-minute interview on more discussed issues.

## 8.3 – Perpetrator Identity

Unlike the previous section, where findings from checklists and interviews are presented in combination, in order to make transparent the labelling process that led to the conclusion discussed in Section 10.3.1, findings from the two methods are discussed in chronological order of collection.

### 8.3.1 – Check-list Results

Concerning perpetrators’ perceived identity, my results confirmed that patients (55.6%) and males (56.3%) are more likely to commit situational improprieties, but a completely different age distribution was identified. Although the definition of ‘young’ in literature remains obscure, it does not indicate users aged between 46 and 55 years old (23% of all perpetrators). Despite the second-most reported cohort results, that of users between 26 and 35 years old (19%), the third one again refers to more mature users (56 – 65; 15.9%). Thus, middle-aged and senior users (between 46 and 65 years old) represent almost 40% of the identified abusers. Furthermore, in contrast with the literature, young users (<18 – 25) represent a minority of the identified abusers (13.5%), respectively 5.6% of those perceived as minors and 7.9% of those aged between 18 and 25 years old.

Chart 8.2 – Perpetrator age distribution

Source: Collected data

Lastly, probably due to the low presence of physical improprieties, the involvement of hospital security results was limited: only 18.3% of all the cases – see Table 8.1 (p.156).

In the analysis of the open-ended question on perpetrator identity, 125 descriptors were used to describe the perpetrators’ identities. However, not all the information reported was relevant or valid, lowering the number of valid descriptors to 82. In fact, with the term “descriptor”, I indicate a word providing information on the perpetrator’s identity, whereas “valid descriptors” indicates information relevant for the research question. A priori excluded information, or non-valid information, included the name and surname of the perpetrator, information about the perpetrators’ role or age already reported in the previous closed-ended questions and other non-required information (name of the involved nurse).

As discussed in Section 6.5.2, nurses’ original descriptions were coded twice: first to standardise the concept to plain English or Italian, and then to group them by meaning and thus reduce the complexity of the analysis. Although this process of codification was drawn from previous studies on nurses’ perspectives (Crilly et al, 2004; Luck et al, 2007a; Luck et al, 2007b; Wilkes et al, 2010; Pich et al, 2013), in line with the aim of this thesis – A&E nurses’ original descriptions and definition of reality – sufficient space was left for participants’ original contributions. Six dimensions of perpetrators’ perceivable characteristics were identified. Listed by number of occurrences (in brackets) these are: “Physical aspect” (43; 34%), “Socio-economic identity” (25; 20%), “Body language” (25; 20%), “Mitigating conditions” (13; 10%), “Intoxicated” (10; 8%) and “Ethnicity” (9; 7%).

The most represented one thus gathers descriptions of perpetrators’ physical aspects, such as hair colour, height, and body size. “Socio-economic identity” is informed by Goffman’s concept of social identity and comprises age, gender, class, and race (Goffman, 1983, p.14). However, details regarding the age and gender were already collected in closed-ended questions, whereas details of race were separately counted under the “Ethnicity dimension”. Therefore, this dimension only gathers descriptors that focus on perpetrator’s socio-economic identity, such as off-duty doctor or homeless. With equal weight, the dimension “Body language” is informed by the work of Luck and colleagues (2007a) and Wilkes and colleagues (2010), who identified a list of observable body signs that are generally perceived by A&E workers as indicators of users’ severe distress. According to Wilkes and colleagues, these include staring, tone and volume of voice, anxiety, mumbling, and pacing (Ibid, p.76). These were not perceived as situational improprieties per se, since they are reported in the identity question, and thus were recorded as part of the abuser’s identity. The dimension “Mitigating condition” indicates descriptors that highlight conditions that usually enhance nurses’ empathy, such as mental issues or being in severe pain (Pawlin, 2008; Lau et al, 2012b; Pich et al., 2013). The “Intoxicated” dimension indicates descriptors highlighting perpetrators’ intoxicated state, such as being drunk or on drugs. Users so identified are often reported to be the most problematic (Crowley, 2000; May and Grubbs, 2002; Lau et al, 2004; Kansagra, et al, 2008). Finally, “Ethnicity” gathers descriptors about perpetrators’ ethnicity. This category derives from my personal interest, based on my preliminary discussions with staff members of Veneto hospital, on an eventual role played by perpetrators’ ethnicity. The following chart visually presents the distribution of these categories.

Chart 8.3 – Dimensions of perpetrators’ identity – first analysis

Source: Collected data

Since information on the perpetrators’ physical aspects is not relevant nor significant for the aim of this thesis, I removed them. The adjusted distribution of the significant descriptors is presented in the following Chart 8.4.

Chart 8.4 – Dimensions of perpetrators’ identity – second analysis

Source: Collected data

The findings thus challenge the picture of perpetrators as being mostly intoxicated or mentally impaired. As shown above, intoxicated perpetrators represent a minority (12%). In contrast, nurses appear to be more aware of a perpetrator’s socio-economic identity (30%) and their body language (30%). On the other hand, my findings support Luck and colleagues’ (2007b) claim that higher levels of empathy are granted to patients in severe pain or who are clearly ill and who are therefore perceived as no longer responsible for their behaviour. In fact, the dimension “Mitigating condition” included 13 occurrences divided into three sub-dimensions: “Ill”, one occurrence; “In pain”, one occurrence; and “Mental health condition”, 11 occurrences – four of which refer to the same patient who caused significant disturbance while I was present in the department.

### 8.3.2 – Interview Results

This theme was investigated in strand 3 using two questions: one open question that allowed respondents to express their conceptualisation of identity and one that referred to a standard stimulus based on previous informal conversation and the unexpected checklist results regarding perpetrator identity (see Table 8.1 and Chart 8.2): ‘Do perpetrators’ dress code or age influence your perception of impropriety?’ Due to the colloquial nature of the interaction, the concept was phrased differently in each interview; nevertheless, I always referred to both the dress code – understood as perceived social status – and the perceived age, so to standardise the stimulus.

When asked about perpetrator identity in general terms, eighteen of the twenty interviewees denied that their perception might have been influenced by biological or physical characteristics. Interactions with users are professionally framed, always involving both empathy and understanding.

I: Ok ... thank you ... would **you** say that the identity of **that** person might affect **your** judgement?

ESS7: **You** can’t be judgmental

I: Mmm … but .. somehow … **we** all are...

ESS7: **We** all try not to be .. yes … But **you** can’t be judgmental … if **you** get something like … a chat with them bla bla bla **you** will notice it .. **they** want **you** to do **your** job **straight away** … and people come **here** …”how much longer? How much longer?” **They** won’t give up … But again .. **you** have to accept **them** and … do the best **you** can

I: So … is it something related to your profession?

ESS7: Yes … as **I** said … regardless of what **you** think of **that** person… **you** have to smile and greet … be patient … do **your** best…

VEN7: The point is when **I** come **here** ... obviously **you** change personality somehow ... **I** mean .. **you** wear a uniform … **I**'m no longer [name, TN] in private life but **I**'m [name, TN] working ... thus ... **I** distinguish ... meaning that .. **this** is not my life .. it's my job ... my life is **outside** … So **I** [laughs, TN] arrive **here** with a different personality*[[32]](#footnote-32)*

Of the remaining two nurses who admitted that pre-judgment can exist, the first, from Essex, identified travellers as a problematic social group, although adopting a footing suggesting that it was a general perspective (Tannen, 1993):

ESS3: Yes … sometimes **you** do … **you** pre-judge people … sometimes … **you** don’t even realize **you** have done it … **you** think … **we** have a lot of travellers here … much of the travellers are lovely … **I** have to say **they** are really nice people … but **they** all come together .. **I** get very .. very irate … **people** believe **they** are always moaning but **they**’re not … **they** are just worried for their child … and … **you** see this non-understanding that makes some people … so **that** people perceive **them** .. a travel mate … **they** are all loud when they come together …

ESS3 started presenting travellers as ‘lovely’ and then, through the adversative conjunction ‘but’, introduced the real issue: travellers are ‘always moaning’. ESS3 then corrected their statement using another ‘but’ to deny the previous sentence and remove themselves from the narration, changing their footing and becoming the mere narrator of what ‘people’ (other staff members) think. It is, therefore, possible that travellers are treated with limited empathy in Essex and that ESS3’s perspective is shared by other colleagues. Alternatively, based on the same linguistic analysis, it might be possible that, as often happens in discriminative narration, ESS3 adopted a position that aimed to present the discrimination as proposed and conceived by a third absent subject (van den Berg et al, 2003).

Concerning the second nurse who admitted to having a perception that was influenced by user identity, VEN1 presented a personal classification of ethnic groups per pain tolerance and aggressiveness based on personal experience – and adopted a personal standpoint based on the *I* pronoun. However, later in the interview, two other Veneto nurses conceded that migrants generally commit more situational improprieties, justifying this with migrants’ poor linguistic skills and that they may originate from a culture that is less respectful of women’s dignity.

Moreover, in agreement with Pich and colleagues (2010), these findings suggest that nurses have limited empathy toward intoxicated users, although this was discussed in terms of diagnosis rather than identity. It was made clear that to behave under the influence of substances does not necessarily lead to a perception of impropriety, but these users were considered more likely to cause extra work, which is not appreciated. As stated by VEN4, intoxicated users could be viewed with compassion because they are unable to understand what they are doing, but their aggressiveness and numerous admissions were negatively perceived.

VEN4: So .. alcoholics bother **me** ... to **me** an alcoholic … if **I** could … never mind … because **they** really are … **I** mean .. to deal with .. **they** are ... extremely complicated ... **you** have to listen to **their** insults .. and **you** know ... **you** say “come on, **he** is drunk” and this is fine .. but meanwhile … **they** will come back .. always the same … and **they** are really … the worst to manage[[33]](#footnote-33)

However, while the nurses generally denied that certain groups are more inclined to commit situational improprieties, this position became less neutral when the stimulus of age and dress code (understood as perceived social status) was provided. As discussed above, nurses do expect certain social groups to be more rude or aggressive – such as the intoxicated group. Similarly, they also expect other social groups to be polite (or less rude) and able to appreciate and understand nurses’ efforts to provide the best care possible. According to the findings of this research, this organisation of expectations appears to play a relevant role in nurses’ definition of perpetrator and, following the second question, nurses discussed how certain behaviours are accepted only if coming from certain categories. Respondents suggested that they create expectations based on a priori classification of user as problematic or not. See Figure 7.1 (p.134) for an overview of these categories. Therefore, if someone is perceived as drunk, nurses expect rowdy behaviour, including shouting and swearing, which is definitely not welcome behaviour but, since they are in line with nurses’ expectations, they are not perceived as improper. On the contrary, well-dressed users, or those who appear to have a powerful role in society, are not expected to act rowdy and their unexpected aggressive behaviour is perceived as improper.

ESS5: What **I** came across was a dementia patient who have been abusive … normal from **them** ... and sometimes drunky .. or under drugs ... **they** come **here** ... **they** don’t understand ... **they** wake up and **they** try to call **your** name ... That case **I** would not … [get offended, TN]

I: What about an act ... an accusation from a patient with Alzheimer's?

VEN7: No .. it’s fine ... **They** even physically attacked me but ... no .. **I** don’t mind .. it’s the disease .. **he** doesn’t understand ... It’s the disease[[34]](#footnote-34)

I: Is it possible that the perpetrator’s age .. or dress style .. might influence **your** tolerance? … Let’s say … might affect **your** reaction to …

ESS10: It really depends actually ... obviously with the elderly **we** might have a more … soft approach … toward **them** ... but if **they** are younger and **they** are still polite .. **we** might still be … having the things … kind of an elderly

VEN6: Yes .. **that**'s what **I** meant …. In the end it is a bit ... a bit ... **I** speak of myself .. my fault … because **I** expect ... **I** construct expectations about people ... and maybe **afterwards** **I** feel ... **I** feel a bit uncomfortable if **they** do not react as **I** expect ... however it is true ... especially family members … at triage .. family members that **you** see are classy .. **they** are the first to ... burst out and ... disrespect **you**[[35]](#footnote-35)

The expectations related to users’ social status appears to be a significant issue in Veneto. In this case, off-duty medical professionals who try to obtain some kind of facilitation by virtue of their profession are seen as the most disturbing.

VEN4: **I** believe .. **those** who are more arrogant are ... other medical professionals ... absolutely .. doctors and colleagues ... **these** are ... because if **someone** arrives and says “Hi .. **I** am a doctor” .. **I** reply .. because now **I** am ready .. “**I** am sorry... it’s a problem ... **I** am not sure **we**’ll manage to heal **you**” [...] **I** don’t treat **you** differently because **you** are a doctor … **I** don’t need **your** profession … but there are **people** … **I** believe it is **them** .. that demand more than **others**[[36]](#footnote-36)

User identity is thus significant in forming nurses’ perspectives, although, in agreement with the literature (Luck et al, 2007b), this result strongly is linked to the perceived user’s level of cognition. Thus, dementia patients, or those whose cognition is perceived as rightfully impaired by factors such as pain, emotional distress, fear, or age, enjoy a greater level of empathy. Similarly, migrants and working-class users are expected to lack politeness, whereas other categories of users are expected to act properly and any betrayal of such expectations is considered improper.

ESS5: **I** tell you what .. it is about attitude … because **you** know what **you** are doing .. **I** am **here** working for **you** ... **I** am trying to help **you** ... So in that case **I** can decline to look after **them**

VEN4: **I** understand a psychiatric patient .. **you** can do to **me** whatever **you** want .. but in the end it is not that ... a mentally ill who ... has Alzheimer's and is elderly .. **you** can do whatever **you** want … I mean .. so what? … it is not **his** fault ... an elderly who is able to understand but is taking advantage saying “**I** am elderly” .. that **I** don’t understand ... because **you** are still lucid[[37]](#footnote-37)

## 8.4 – Chapter Conclusion

This chapter presents those findings that are relevant for the first sub-research question: under what conditions are users’ performances perceived as situationally improper? Specifically, I have analysed those findings, both from checklists and interviews, about the definition of situational impropriety and the perpetrator identity and, as previously discussed, my findings gave a result quite in contrast with the picture presented by the analysed literature. See Chapter 2.

The definition of impropriety was more complex than the usual dichotomy verbal/physical, introducing new forms such as interactional – ways to interact that fail to appreciate nurses’ medical skills or the role distribution among medical staff; attitudinal – defined as selfish, rude, or presumptuous behaviour and attitudes; and emotional – unjustifiable demonstration of emotional distress. In addition, the occurrence of such unexplored improprieties was more significant than physical and verbal improprieties.

In terms of perpetrator identity, these findings strongly disagree with the image of the young, intoxicated and abusive male portrayed in literature – see Section 2.4.2. First, the majority of perpetrators were older, with those aged 46 to 65 being responsible for almost 40% of the reported improprieties. Moreover, nurses admitted that certain categories benefit from higher levels of empathy, whereas others are perceived as abusive because they do not behave as nurses would expect. This confirms Goffman’s suggestion that actors have expectations informed by the frame they are applying: situational improprieties occur when these expectations are betrayed. Moreover, based on my findings, rowdy behaviour is expected and thus tolerated from certain categories of users, whereas it is not from others. The latter, based on their social identity, are not expected to fail to apply the frame tacit regulation and thus to betray nurses’ expectations. See Figure 7.1 (p.134) for a brief summary of the main categories and their moral evaluation.

The following chapter presents my findings in terms of dealing strategies, and it completes the within-method triangulation process that will allow me to answer the main research question: how do accident and emergency department nurses frame their professional interaction with users?

# Chapter 9 – Findings: Dealing Strategies

## 9.1 – Introduction

This chapter presents the findings in relation to the second sub-research question: What informal strategies are adopted to deal with situational improprieties? This sub-research question aims to investigate nurses’ frame-clearing strategies, and thus to gain an understanding of the proper expected behaviour from users.

Due to the nature of the employed methods, only interview findings are discussed. The interviewees’ answers to questions investigating strands number two (employed dealing strategies), number four (dealing strategies common among the group of nurses), and number five (examples of peer teaching, if any) and included. Refer to Section 6.3.1.2 for the complete list of strands.

## 9.2 – Dealing Strategies

Due to the limited physical abuse in the investigated settings, interviewees’ informal dealing strategies were limited to non-physical improprieties. Interviewees reported a total of seven informal dealing strategies: to ignore the perpetrator, two strategies aimed at clearing the frame – from two different and opposite perspectives, three strategies to escalate the burden of dealing onto others – colleagues or the nurse in charge, and two purely interactional strategies.

### 9.2.1 – Ignore the Perpetrator

The most used strategy can be defined as ‘ignore the perpetrator’ and it consists of ignoring both the perpetrator and the impropriety: to pretend that nothing has happened while remaining polite and professional, without wasting time or emotional energy. Despite being the most used strategy, different justifications for its use were offered. They are presented in the order of occurrence, from most common to least common.

Improprieties are mostly ignored based on an empathic understanding of the perpetrator’s mental or physical condition.

ESS6: If comes from a dementia patient … yes … **I** think dementia patients wouldn’t be blamed [unclear, TN] give medication to **them** .. calm **them** down

ESS10: Ya .. it could be … there is a patient that ... are naturally abusive and aggressive … but there are **some people** who are in pain and … yes .. **I** have had patients who told **me** “**I**’m really sorry .. **I** didn’t mean that … **I** was in pain and all the things” .. at the end of the day .. so ... there are reasons that … you know … they said bad thing …

Many also justified their absence of reaction based on the lack of time to take care of every single impropriety.

VEN1: Surely **we** don’t have the time .. and if **I** should get upset .. with so many users .. after a day like that **I** need a liver transplant[[38]](#footnote-38)

Another largely discussed reason was the concern that a reply could cause further unnecessary escalations.

VEN7: **She** went completely mad … but **I** was new **here** … before **I** was in the intensive care unit and it was different … **I** did work a lot on these things when **I** was on ambulance service .. but **those** were my first years … **I** was new **here** ... but .. no .. **I** really felt the arrogance and ignorance of **her** ... my dad told me “when you deal with an ignorant .. ignore **him**” .. and **I** did so .. so in the end **she** was the one upset .. **she** even thanked me when **she** left … yes … eh … it works like **this** [laugh, TN][[39]](#footnote-39)

### 9.2.2 – Frame Clearing

The two frame-clearing strategies consist of engaging in a discussion to convince the perpetrators that their behaviour is improper and based on a misconception of how the A&E works. While these two strategies share the same aim, they strongly differ in their application.

#### 9.2.2.1 – Re-frame the Interaction

Preferred by 17 interviewees out of 20, it is based on the adoption of an understanding attitude aimed at mitigating the confrontation to reframe it as an ‘empathic conversation’. Respondents believe that perpetrators should not be confronted since this would feed their excitement and agitation. Instead, they should be approached with empathy and calmness. This strategy was discussed by interviewees as informed by studies at the nursing school, reinforced by positive experiences and grounded on the nurses’ assumption that perpetrators should be treated with empathy because they are scared and insecure (Pich et al, 2011), and on their understanding of their profession as a caring one (Muller et al, 2008) – see Section 7.3. In order to ‘cool down’ agitated users nurses lower their voice presenting themselves as non-confrontational while inviting the frantic user to move few steps aside so to create a new micro-environment where the interaction can be reframed.

ESS8: Usually **I** would take **them** to one side … take **them** **away** from the situation … and … **I** speak to **them** quietly .. **I** don’t raise my voice … because … if **I** raise **my** voice .. **they** raise **theirs** … so if **you** be quiet to the people … **they** are more likely to calm down because **they** realize **they**’re shouting and **you**’re not

VEN1: **My** strategy is to … with an aggressive user .. do not face **him** with the same voice tone … **I** don’t know … **I** look for a quiet spot … obviously not in **here** [separate and closed room where the interview is taking place, TN] because it would be my word against **her** ... but … **we** start talking …[[40]](#footnote-40)

Once the perpetrator has been moved to a symbolically different physical context, nurses can attempt to determine the reason for such discomfort, arranging an understanding performance. Then they try to look calm and empathic, showing their willingness to solve the issue or to explain why they cannot help. Nevertheless, the second step does not need to be immediate.

VEN1: ... **I** wait for the situation to cool down ... 10 minutes .. **I** calm down .. **you** calm down ... **after** this **I** kindly ask if **we** could discuss the issue again ... it might be me .. expressing myself improperly but **you** too … [**you**] come here and **we** discuss ... so .. doing so **I** obtained many positive results ...[[41]](#footnote-41)

#### 9.2.2.2 – Role Power

The second approach to frame clearing is antithetic to the first one and is based on the asymmetric distribution of power between nurses and users. As discussed in Section 7.3.2, users are perceived as mostly passive actors who are not expected to have any power to influence the situation. Moreover, nurses are the active actors, entrusted by society with the authority to assess the seriousness of the user’s health condition. Drawing upon this, the second frame clearing strategy consists of the nurses confronting the perpetrators to order them to change their behaviour immediately, demanding respect for the context, its caring mission, and the other users. However, this strategy was less preferred and mostly used when a previous strategy failed, or when perpetrators are known for their resistance to the first strategy – such as hypochondriacs who routinely access the department.

ESS10: **I**’m supposed to do that [to calm down the perpetrator, TN] but if **they** don’t listen at all and if there is no choice that … **I** tend to become strict to **them** … because … **sometimes** when **you** see a patient or when **you** ... **you** might understand that … **you** know .. if **you** are strict to them **they** will understand better than when **you** are being polite to **them** … so **that** time **you** tend to be strict … but most of the time **I** tend to be polite to my …

VEN7: [discussing dealing strategies, TN] … **you** must learn that in **our** job **you** must show authority … **I** mean … **you** must show **them** that **you** have the upper hand[[42]](#footnote-42)

ESS4: If **you** get pretty straight, **you** walk away … if **you** get too involved in the argument … **you** have to give extra explanation

VEN4: … **you** know that with **them** [hypochondriacs, NT] **you** have to use the stick instead of the carrot … but **you** know **them**[[43]](#footnote-43)

### 9.2.3 – Escalation Strategies

When the above presented dealing strategies fail, nurses tend to avoid further confrontation and to escalate to other professional figures. However, these strategies are no longer informal since they foresee the intervention of professionals officially appointed to deal with these situations. Although these escalations do not automatically lead to formal consequences, they are still formal and thus beyond the scope of this thesis. Nevertheless, in agreement with the aim of transparency, I discuss them in this section.

These three strategies consist of escalating the problem to the nurse in charge (Essex only), to the hospital security or police officers (both settings), or to the hospital management (Veneto only). Due to the organisational differences discussed in Section 5.3, these dealing strategies are similar in their intent but differ in their actual implementation. Precisely, Essex nurses enjoy substantial formal support and can escalate to the nurse in charge or to the hospital security officers, whereas Veneto nurses cannot rely on such support. For instance, in Veneto, the nurse in charge does not officially take care of improper users and none are cited this figure. Moreover, hospital security is not always present and was rarely cited in interviewees’ narrations, being instead replaced by police officers. However, this lack of formal support in the Veneto hospital is reported by an experienced to be creatively used to the nurses’ favour. Because users’ complaints are generally ignored – contrary to Essex where nurses reported to be concerned about users’ formal complaints (see Section 7.3.4) – Veneto nurses may dodge confrontations agreeing with users, showing sorrow and understanding while inviting agitated or aggressive users to file a formal complaint, thus shifting the blame onto the hospital.

VEN4: If someone comes to me saying "Look .. **I**’ve been **here** waiting for … five hours .. it's unacceptable .. **you** really have to ...” it is **you**r face on the line ... if **you** reply "Look .. **you**'re right ... it's true … **I** agree with **you** .. it's a real shame … Five hours? **This** is not acceptable .. **I** would suggest **you** to file a formal complaint and protest " .. here ... you disarm **him** .. you disarm **them** ...[[44]](#footnote-44)

Because this strategy was discussed by only one nurse and in the above-presented terms, it cannot be considered a common strategy it is probably implemented only when nurses are aware that the complaint is due to an organisation failure or irrational requests, not to nurse malpractice.

### 9.2.4 - Interactional Strategies

As discussed above, nurses in Veneto do not enjoy established strategies of formal support, with the exception of calling the police. Therefore, they have to invest more energy in dealing informally with perpetrators, so the hospital management organises courses on verbal de-escalation techniques, whereas Essex nurses receive a self-defence course. In this course, nurses learn two interactional strategies aimed at interruptingverbally agitated users: repetition and sudden interruption. The former consists of repeating the same information until the user, puzzled, stops talking.

VEN10: **I** repeat the same sentence over and over ... at first **he** would look at me puzzled asking himself what am **I** doing … at the third repetition .. although it isn’t easy to repeat the same sentence because ... it does not come spontaneously … **I** see that the person changes attitude and takes a step back[[45]](#footnote-45)

The latter, sudden interruption, consists of an abrupt interruption of users’ outbursts, blocking them at their first pause and calling for the respect of the basic conversational frame reminding that all participants should be allowed to talk.

VEN10: **I** wait in silence ... when **I** see that ... **he** goes on .. at his first pause **I** say .. "Done? May **I** speak too?”[[46]](#footnote-46)

## 9.3 – Common Dealing Strategies

The previous section addresses the dealing strategies adopted by interviewees. In this section, I further expand my investigation on dealing strategies in two directions: I first asked whether nurses felt supported by colleagues when using the above-discussed strategies and, second, whether respondents saw their colleagues using different strategies and if they approved of their behaviour.

My interest in peer support lies in the basic assumption of Goffman’s sociology that the frame’s expected interactional order needs to be reiterated and deviant actions (in Durkehimian terms) must be sanctioned to ensure the correct reproduction of the frame itself (Goffman, 1974, p.346). This means that, in clearing the frame for improper users, nurses should receive the support of co-workers, provided their dealing strategies are in line with the expected ones (Crilly et al, 2004; Pinar and Ucmak; 2011; Albashtawy, 2013, see Section 2.4.3). This investigation is fundamental to understand whether nurses’ cognition of the A&E Frame is shared, thus giving it a social and interactional value (see Section 4.4.1).

According to my findings in Essex, peer support is ensured by the nurse in charge. In addition, support seems to be offered by colleagues, especially by the more experienced and qualified ones.

ESS5: Yeah … yeah … it depends … all comes with the experience ... the more qualified nurses probably **they** might be … come to see if **you** are ok ... but … **I** for instance tend to be **around** and help everybody… if **someone** needs support **I** go and **I** support **them** ... maybe the less qualified are a bit … scared to … but if **you** call for help … obviously **they** will come ... it is quite a help ..

ESS4: So if **someone** needs help … **next time** it might be **me** … so … again … **we** help each other […] so if **you** see one of your colleagues getting very stressed so … if **you** see that someone gets anxious … **you** back **them**

Two different attitudes and two different narrations are offered in the above examples. The first nurse, ESS5, used footing to shift from the average nurse to a personal stance. This shift is marked by the adversative conjunction ‘but’, used to balance the auxiliary ‘might’ in the previous sentence, and the ‘it depends’ used at the very begin of their answer. Their narration started presenting peer support as possible, then as certain – although presented from a personal footing – and ended with a reinforcement of such certainty adopting an impersonal footing – although this time referring to less qualified nurses. The discussion seems more directed to convince me about the granted support, rather than an actual claim of certain support. On the contrary ESS4 showed a conviction that someone will support you if necessary because mutuality guarantees everyone’s safety. I have selected these examples because they are representative of what resulted from Essex, where responses swung from granitic certainty to the perception that support should not be taken for granted. For instance, two nurses reported that peer support is missing when improper interactions become physical. Therefore, while support is generally provided, it is unclear whether it is offered or if it has to be requested. This could be a consequence of the presence of a colleague formally indicated to provide support, lifting this responsibility from the other nurses.

Concerning the Veneto hospital, no significantly contrasting perspectives are reported. Peer support could be taken for granted, maybe as simple co-presence. However, this is not always welcomed. Anticipating the following discussion on the strategies used by colleagues, seven interviewees reported that some nurses are not able to properly use the previously discussed techniques because too stressed, naturally quick-tempered or because inexperienced (see Section 7.2.1 for a detailed discussion on these sub-categories). This is considered a serious issue by half of the Veneto interviewees, since these colleagues seriously endanger the wellbeing of everyone, exacerbating confrontations and creating a stressful work environment, for both users and colleagues who then have to offer their support.

VEN7: Well ... **I** did accept it from **some** .. from **others** .. **I** didn’t ... **I** mean .. if the **one** who comes to mediate does the right thing and … at **that moment** **he** has a better dialectic than mine .. and **he** manages to solve the problem before **me** .. this is welcome ... But if **I** see **he** is hindering my positive effort ... no ... it upsets **me** .. it upsets **me** [laughs, TN][[47]](#footnote-47)

Concerning the second part of this strand, strategies used by other nurses, my interest lies again in Ensink’s (2003) distinction between schemata and frame. As discussed in Section 4.4.1 a cognitive schemata – the personal understanding of what is going on – becomes a social frame once it is shared and implemented by the other involved actors, thus to guide real social interactions. My purpose was, therefore, to verify that the previously discussed dealing (interactional) strategies are shared among nurses, investigating their social nature and, consequently, the social nature of the A&E Frame. This was briefly introduced, recalling the dealing strategies that the interviewees previously discussed and then asking if they have seen these used by co-workers.

Both teams reported that the previously discussed dealing strategies are used by everyone, although individual temper and individual communicational skills affect colleagues’ preference for one of the two frame-clearing strategies: empathic strategies for the more patient and skilled ones, use of authority for the more hot-tempered ones. This opened the conversation to the above-cited colleagues’ skills topic. Both groups acknowledged that not everyone is able to informally deal with agitated users, suggesting that some in the profession are even likely to exacerbate simple misunderstandings.

VEN6: Ehm ... **I** **often** saw strategies based on ... indulgence ... for instance .. a relative .. or a patient .. says “**I** want to be visited before the **others** because **I** feel sick and **you** don’t understand a thing” and **they** say “Ok” … In **my** opinion this is not good ... Or ... **I** saw the opposite .. **I** mean because **you** insulted me ... **I** say “Let’**s** settle this **outside**” .. **I** mean ... “come in so **we** discuss” and **then** ... **then** maybe **they** [colleagues, TN] threaten **him** [perpetrator, TN][[48]](#footnote-48)

Six interviewees, two in Essex and four in Veneto, admitted that calming agitated users is not among their talents. However, all the interviewed nurses reported admiration for those colleagues who are more talented in this.

ESS1: **I** mean … **I**’ve seen some of my colleagues just … standing **there** … yes … receiving … “no no .. **this** is not going to happen .. **I** don’t mind if **you** … start shouting” … hem … “**this** is the way **we** work and **this** is how everything is gonna be” … **I** like that

VEN6: **I** mean maybe ... **I** tend to be a bit more aggressive .. yes ... but ... there are colleagues **who** are very good at this [to verbally calm down agitated users, TN] ... **I** mean .. **they** manage to make **him** feel almost ashamed … of what **he** did [...][[49]](#footnote-49)

## 9.4 – Informal Peer-Teaching

As discussed in Section 4.3.1 and drawing upon Section 4.3.5 the social actor learns how to use a frame through experience and through frame clearing. In accordance with the scope of this thesis, I explore if informal peer-teaching is used to promote the implementation of the expected dealing strategies. As noted above the concept of situational improprieties is not limited to users, nurses too can be considered responsible for occurred situational improprieties – see the discussion offered in Section 2.4.3.

As discussed above certain nurses are naturally talented in conflict solving, nevertheless, they all need to learn the right techniques on the job.

I: Ok … so this type of [dealing, TN] strategy … **you** learnt it **here** or is …

ESS8: **We** have had like courses and stuff like that on aggression …

I – Good … hem … although .. **I** think .. **I** heard that they [formal training, TN] are more … more like on self-defence

ESS8: Yes

I – **They** are not about dealing with … extremely … complaining patients

ESS8: Oh no … **I** think **you** get used to it … **you** learnt it … in the process.”

In terms of peer-teaching in Essex, because of the more structured organisation of the department, nurses do not often spend time informally training, sanctioning or praising their colleagues. These tasks belong to the nurse in charge or the department manager. Instead, more experienced nurses offer practical examples and, according to one nurse, verbal suggestions during informal chats about improprieties that happened that day. However, it remains unclear if this is a common practice or if it is done only by those who reported such activity.

Regarding the Veneto hospital, it is reported that experienced nurses informally assume a guiding role. This informal peer-teaching is recognised by inexperienced nurses who do not seem to feel patronised. Instead, suggestions seem to be welcomed and appreciated if they come from someone who is recognised as more experienced or more skilled.

VEN10: It depends on the colleague and ... **some** have so much to teach **me** .. **I** have been **here** for two years and **I** have been doing triage for eight months ... **Some** have so much to teach me .. about communication and **they** really have a way to approach users that … **they** rarely argue ... others ... **they** argue with the first patient[[50]](#footnote-50)

Informal peer-teaching is often practical and pertains to a specific aspect of the user-nurse interaction.

VEN10: **I** have an example ... a colleague that .. when **I** was next to **him** .. but it was the last apprenticeship in triage so we were in three instead of two … and .. **I** was sitting in between them and ... **I** couldn’t hear ... because three nurses speaking ... **you** can’t hear a thing ... and ... **I** stand up and got closer to the microphone and **I** heard **him** saying "sit down" … this was one of the corrections that came spontaneously to me … and **I** wanted to smile because unfortunately **I** did not think about it … to me it was a way to hear better … [but, TN] users see it as an aggression[[51]](#footnote-51)

However, offering peer-support and suggestions is perceived as a burden because it implies additional responsibilities.

VEN7: To me .. to me [name, TN] it depends on who is working with me … it really depends on that … if there are colleagues with a certain personality .. with whom **I** feel safe .. and so .. **anyone** can come here and **I** am not afraid … On the contrary if **I** know **I** am the strongest .. sometimes this concerns me[[52]](#footnote-52)

Being the expert one who provides suggestions also implies the provision of negative feedback. These, as discussed in Section 4.3.1, might result in adverse consequences such as the dis-alignment of the triad social actor–self–role. Therefore, peer-teaching must happen backstage, where the safety of the social representation, and the other nurse’s face, is not put at risk of public shame.

VEN4: **I** wait for [the inexperienced nurse, TN] to finish ... not to give to the person on the other side [user, TN] the perception that **this** [nurse, TN] is new .. an incompetent noob .. so ... **you** cannot do it in front of the person [user, TN] … and maybe **later** **I** tell **him** [new nurse, TN] .. **I** say “maybe it's ... it's better to adopt this technique and **you**'ll see that **he** [user, TN] gets more relaxed [[53]](#footnote-53)

Nevertheless, understanding is granted to new nurses who, according to the experienced nurses, will soon learn to use the right techniques properly or they will burn out.

VEN8: […] young nurses may be less but ... **they** will realize it ... **we** .. the older .. **we** arrive **here** and … clearly **you** have your problems from home .. family … and **you** come here ... Maybe that day **you** are happy and **you** can take it … more than what **you** usually usual … Other days no … So **you** lose your temper .. with a bit of experience .. **we** learn … **we** internalise something […][[54]](#footnote-54)

VEN9: **I** saw some younger colleagues arriving already nervous and … maybe when **you** see a waiting list … enormous … **you** start your shift arguing ... **I** mean ... "mate, it’s two o’clock ... it’s 2PM ... **your** shift ends at 9PM ... how will **you** get there?" ... it’s, it's ... but if **you** want to do it that way … [assumes a position to indicate ‘your problem’, TN][[55]](#footnote-55)

## 9.5 – Chapter Conclusions

Drawing upon three of the six strands explored in my semi-structured interviews, this chapter explores the dealing strategies adopted by A&E nurses in Essex and Veneto in order to answer the second sub-research question: what informal strategies are adopted to deal with situational improprieties? This supports my within-method triangulation to access the accepted guiding frame.

In terms of dealing strategies, nurses in both settings indicated that expected interactions should not involve unnecessary or unreasonable aggression or improper attitudes, in line with the expected nurses’ professionalism. This is evident based on the fact that both reported dealing strategies aim to restore such expectations. The first aims to reframe the interactions, from conflictual to empathic, physically shifting, even if just a few feet, to a different space where specific communicative techniques (talking quietly, looking empathic and cooperative) can be employed to clear the frame for the benefit of the perpetrator and restore the expected professional and respectful interaction. An opposite approach, the second frame-clearing strategy, was described as the objectification of the uneven distribution of power between actors to ask perpetrators to abide by the expected behavioural conduct.

However, due to the lack of time and energy to be dedicated to conflict management, the most common strategy is to, literally, ignore both the perpetrator and the impropriety. Finally, due to organisational differences, the remaining dealing techniques were not practised by both teams. Essex nurses reported frequent use of escalation strategies, especially to the nurse in charge. Whereas Veneto nurses, devoid of such formal support, adopt interactional strategies such as the sudden interruption and repetition. Quite singular and in between the escalation and the interactional strategy there is, although only in Veneto, the invitation to file a formal report – being fully aware that it will never lead to disciplinary consequences, thus to take advantage of the bureaucratic process while shifting the blame to an entity that is not there and it is difficult to reach (the hospital management).

These strategies result shared among team members, although with differences based on individual predispositions and temper. Nevertheless, both teams expressed admiration for those able to properly implement the empathic frame clearing strategy.

Support from colleagues could be taken for granted in both settings. Although in Essex the presence of professional figures formally designated to this activity seems to reduce individual spontaneity. Support can also come as informal peer-teaching to socialise new nurses to the A&E Frame. Again, formal organisational differences resulted in dissimilar strategies although a primary educational and supportive role is recognised to experienced nurses in both teams.

In the next chapter, I bring together my findings to answer my two sub-research questions, linking them and openly discussing the process of within-method triangulation to finally answer my overarching research question.

# Chapter 10 – Discussion and Conclusion

## 10.1 – Introduction

Following the presentation of findings offered in the previous chapter, I discuss them together to answer my research questions. The chapter is organised in six main sections. Section 10.2 reintroduces the research problem, providing a brief review of the journey that led me to this chapter.

In Section 10.3, I draw upon my findings to answer the two sub-research questions and the overarching question, offering a visual presentation of both the decisional process of nurses (what is improper and what is not) and how the frame is organised.

In section 10.4, I discuss the seven contributions that I believe my research brings to knowledge on the subject; more precisely, my answers to the four gaps identified in Chapter 2, and three additional contributions related to my theoretical and methodological approach. Section 10.5 discusses their implications to policy and practice, thus reflecting on the potential impact of this work.

In Section 10.6, I critically reflect on the eight main limitations of my study, reflecting on how this thesis could have been improved if I had more time, a larger data collection or if I had used a different theoretical approach or methodology.

Finally, in Section 10.7, I explore and discuss potential further research that might arise from my work.

## 10.2 – The Research Problem Identified

In June 2013, when my Ph.D. officially started, my research activity aimed to explore how A&E staff define certain behaviour as unacceptable, and what informal intra-group methods are used to deal with the situation. Following my first exploratory investigations, both from bibliographical sources and – thanks to my role in Veneto hospital – through informal chat with A&E staff members across Europe, I decided to reduce the complexity of my study and focus on the nurses’ perspective only (see Section 2.2).

As I read on the subject, I identified four interrelated main gaps in literature: lack of understanding of nurses’ perspective; lack of a clear working definition of unacceptable behaviour; absence of investigations of nurses’ informal dealing strategies; and absence of cross-cultural qualitative study. Concerning the first, as discussed in Chapter 2, scholars often impose personal definitions of unacceptability that best suite their methodology or research question. Moreover, such definitions are mostly drawn from the legal framework, resulting in the exclusion of deviant-but-not-illegal behaviour such as attitudinal, emotional or interactional situational improprieties. As previously argued, this perspective caused a significant discrepancy between the researchers and the nurses’ definition of what is unacceptable, fostering the so-called ‘culture of silence’. Drawing upon this, the second identified gap is the lack of a clear working definition of unacceptable behaviour. As indicated, authors failed to produce or identify a unique umbrella definition, providing instead several non-compatible definitions that mostly focused on verbal and physical interactions that were liable to be legally defined as aggressions. Furthermore, it directed scholars’ attention toward formal dealing strategies, leaving overlooked the informal ones – the third gap

Lastly, due to the peculiarity and the high standardisation of the research setting (A&E) at an international level, scholars often improperly assumed that their findings hold high transferability – this despite significant differences being identified both within the same country and between Western and non-Western countries. The fourth gap thus consists of the lack of qualitative cross-cultural studies, validating the supposed transferability of findings.

As a result of these four main gaps, I turned my attention to my previous research experience on the cultural consumption of alcohol and how this was differently defined by different social groups. Thus, I identified Goffman’s social theory as the aptest to support an investigation of the above-identified limitations in literature. Precisely, I adopted the concept of frame to explore the research context and its characteristics, both explicit and implicit, and to appraise the different, and potentially conflictual, definitions and perceptions. However, due to the lack of original methodological guidance on frame analysis, I felt the need to integrate Goffman’s theory with Ensink’s (2003) sociolinguistic development.

The definition of the theoretical and methodological approach to my research problem was therefore reframed: how do accident and emergency department nurses frame their professional interaction with users?

I carried out my research through a qualitative multi-case study research design, adopting a perspective idealist ontology and a weak social constructionist epistemology. Since it was not possible to develop an ethnographic methodology as suggested by Goffman (Lofland, 1989) I instead developed specific qualitative checklists capable of collecting the participants’ viva voce in almost real-time. Information so collected was integrated with that obtained through semi-structured interviews, informal chat, and my research diary. In practice, my data collection consisted of 126 checklists, twenty semi-structured interviews and a large number of informal chats that occurred during my visits to collect filled-in checklists. Results from qualitative checklists were codified and analysed using SPSS, whereas interviews were manually analysed following Wortham’s methodology (1996) on Microsoft Excel 2013. Data collected in the Italian setting was translated into English adopting a performative translation focused on the meaning of the information provided, rather than on the literal translation of the used words. The process was assisted by an original table of translation based on the work of Chouikha (2016) and Miles and Huberman (1994). The core aim of the research was to explore nurses’ cognitive perspective over the frame ruling the nurse-user interaction and to investigate its social and interactional nature, verifying its shared value among team members (Ensink, 2003).

## 10.3 – Answering the Research Question

In this section, I discuss my findings regarding the two sub-research questions and, finally, I complete the triangulation, discussing them against my overarching research question. Lacking proper theoretical and methodological guidance on how to qualitatively investigate a frame, I drew my approach to the phenomenon from Denzin’s (1978, pp.301-02) within-method triangulation, thus developing two sub-research questions to inform an overarching one. The first sub-research question, discussed in Section 10.3.1, in agreement with Goffman’s approach to social research (Manning, 1992), was inspired by Burke’s perspective by incongruity (Burke, 1965), exploring the frame through its violations, or situational improprieties.

An opposite approach, the second sub-research question, discussed in Section 10.3.2, investigates the frame from a perspective by expectation: the informal strategies adopted by A&E nurses to deal with situational improprieties. Following Goffman’s (1974) discussion on frame dispute and frame clearing, it is common that actors covering different roles hold different perspectives and expectations on how to frame a social interaction and how a frame should be interpreted (Ibid, p.339). This leads to performances of frame clearing that consist of the clarification of nurses’ own understanding of the A&E Frame in favour of the misbehaviour. Through these nurses offer detailed descriptions of their implicit expectations, discussing the broader organisation of expectations also defined as frame.

Finally, this section ends with the triangulation of findings. Drawing upon the previous Sections, I here bring together my findings to discuss and graphically represent the structure of the A&E Frame and how it guides nurses’ interactions with users. This last section closes the triangulation, validates my findings, and demonstrates the coherence and reliability of the research.

### 10.3.1 Under What Conditions Are Users’ Performances Perceived as Situationally Improper?

Drawing upon my findings, nurses presented improprieties as performances that betray their expectations based on the guiding A&E Frame. While these can be attitudinal, interactional, emotional, verbal, or physical, they all are behaviour not expected from users. As discussed by Goffman, frames create roles and ‘role-expectations’ (1963a, p.245), meaning that roles allow others to build expectations on what is taking place, on what that the actor is doing and, possibly, on what the actor will do. Thus, as discussed in Section 3.5, by reinforcing and satisfying each other’s expectations, actors make the surrounding world predictable and acceptable. When actors’ performances do not fulfil such expectations, situational improprieties occur (Ibid, p.194).

#### 10.3.1.1 – Nurses’ Definition of Situational Impropriety

Nurses defined situational improprieties in five forms: attitudinal, emotional, interactional, physical, and verbal. The first three results are poorly, if not at all, discussed in literature, although they cover a major role in the findings of this thesis: 62% of the reported improprieties.

In terms of verbal and physical improprieties, in agreement with the literature on unacceptable behaviour in A&E, verbal improprieties outnumber the physical ones, which are rarer and often in the form of threats rather than actual assault. However, contrary to the other three, the ill-suited nature of these improprieties is formal. According to the definition provided by the interviewees, these indicate acts that surpass the threshold of rudeness and could be reported to the competent authority, whether this is the hospital manager or the police. While the exact distinction between rudeness and offense is debatable and mostly a personal decision, it is also true that, whether the behaviour actually oversteps the above-cited threshold is defined by a lower frame not explored in this thesis. In agreement with my theoretical framework, verbal and physical improprieties thus pertain to the juridical frame and, therefore, cannot be investigated from the A&E Frame perspective. In agreement with Goffman (1963a), situational improprieties proper of a specific frame should not be confused with the violation of:

‘other moral codes regulating other aspects of life (even if these sometimes apply at the same time as the situational code): for example, codes of honor, regulating relationships; codes of law, regulating economic and political matters; and codes of ethics, regulating professional life.’ (Ibid, p.24)

Based on this I end here my investigation of these improprieties. Rather, I focus on the motivation behind A&E nurses’ tolerance and adoption of informal strategies toward verbal or physical improprieties – instead of reporting them to the competent authorities.

Returning to improprieties relevant for the A&E Frame, Attitudinal improprieties were discussed in relation to users’ improper engrossment, deference, and demeanour, such as being selfish, presumptuous, rude, or unnecessarily loud, either within direct nurse-user interactions, toward other users, or the A&E Frame itself. These can be defined as deviant-but-not-illegal behaviour, role violations that do not fit nurses’ expectations of how things should go. As discussed in Sections 5.3.4 and 5.3.7.1, expectations in terms of facework, engrossment, deference, and demeanour are also extended to nurses, who can be perceived by colleagues as guilty of attitudinal improprieties. This result is in line with Goffman who suggested that conformity to role expectations is a duty every involved actor must oblige, independently from the role they cover (1974, p.346). With reference to my analysis of identified social categories, see Section 7.3, I am confident in saying that these improprieties are associated with ‘Disrespectful’ users and “Hot-tempered” and “Unbalanced” nurses.

Emotional improprieties are the most difficult to explore. Defined in literature as excessive emotional distress (Luck et al, 2007b), they also find their position within Goffman’s social theory. In fact, actors that exaggerate displaying their emotions are potentially liable to be defined as insane because they lack the self-control necessary to perform their role (Goffman, 1961, p.132). However, despite being acknowledged by every interviewee during their validation of the table of translation, these were openly cited in checklists only – see Section 8.2.5. This is probably due to the mitigating effect that emotional distress operates on nurses’ definition of impropriety (see Section 7.4.2). Nevertheless, due to the lack of relevant data, I am not in the position to further develop this topic since none of my interviewees directly discussed it as problematic. In virtue of its scarce relevance in checklist findings, at that time I decided to focus my 20 minutes of interview on more discussed topics.

Concerning interactional improprieties, based on my findings I believe that these are examples of frame disputes since they represent improprieties toward nurses’ expectations in terms of roles’ activities. These are discussed in two main forms: performances challenging nurses’ medical skills; and performances challenging the expected passive role of users. Concerning the former, the impropriety consists in the attempt to downkey the encounter: from an A&E to a hospital one. As discussed in Section 8.2.3.1, perpetrators attempt to reframe the interaction defining the role of A&E nurses as regular ward nurses – less trained and with no triage or diagnostic tasks. Doing so they deny nurses’ authority to take decision concerning admission priority, lacking them of the expected respect. Nevertheless, this type of impropriety is often ignored or approached with empathy since nurses are aware of users’ ignorance. Moreover, as Goffman (1974) wrote, tension around operations of keying is to be expected since:

‘disputes over frame occur in connection with claims regarding keying, claims that although the events at hand may look like untransformed activity, they are really keyed, or at least were meant to be.’ (Ibid, p.331)

However, such empathy is not reserved for off-duty doctors who, due to their professional role, should be aware of such A&E nurse peculiarities and entitlement to complete diagnostic tasks.

Regarding the second form of interactional impropriety – performances challenging the expected passive role of users such as being excessively demanding or not cooperative – these reflect the discussed nurses’ perception of the user role in Section 7.3.2.

As previously noted in Section 8.2.3.2, users are perceived as laypersons in need of medical help, whereas nurses self-perceive themselves as caring expert socially qualified to take care of users’ medical issues. This role contraposition, as well as these improprieties, have already been introduced in the healthcare sector by Talcott Parsons, in his analysis of the function covered by physicians in society (Parsons, 1951). My findings strongly resonate in his work, where medical professionals are defined as experts who validate the claim of sickness of patients, allowing for patients’ ‘exemption from normal social role responsibilities’ (Ibid, p.294). Their authority lies in the

‘fact that modern medical practice is organized about the application of scientific knowledge by technically competent, trained personnel’ (Ibid, p.305).

Despite the link between nurses’ definition of situational impropriety from user and Parsons’ analysis of the medical encounter become observable only with this second form of interactional impropriety, drawing upon my findings, it can be stated, as previously anticipated, that all improprieties are a violation of the expected passive role of users, as well as a denial or challenge of the expert role of nurses. More precisely, nurses consider it improper for users to abandon their passive role or to attempt a downkeying of the interaction (Interactional improprieties), or to actively protest their passive position through lack the expected demeanour, deference and emotional self-control (Attitudinal, Emotional, Verbal and Physical improprieties).

Finally, although improprieties are here represented as unrelated to each other, it has to be clear that they can either co-exist or appear in sequence in real user-nurse interaction. For instance, an interactional impropriety can precede a physical one, just as an attitudinal one can co-exist with an interactional. However, an analysis of how these improprieties relate to and affect each other has not been developed in this thesis. In writing this discussion section, I felt that my data collection was not sufficiently detailed to support it. Moreover, such exploration would lead my Ph.D. to explore intellectual areas not strictly relevant to my research question. Further investigations with larger samples and dedicated research methods are therefore recommended.

#### 10.3.1.2 – Betrayed Expectations and the Key Role of Users’ Social Identity

As discussed in the section above improprieties consist of performances betraying nurses’ expectations. As presented in Section 8.3, nurses’ expectations are influenced by users’ identities. This topic is partially discussed in literature where scholars reported that nurses tend to categorise users as more or less deserving of their empathy based on three unilateral evaluations of users’ identity: (i) their mental/physical condition (Pawlin, 2008; Lau et al, 2012b; Pich et al., 2013); (ii) the perceived intentionality behind their unacceptable behaviour (Luck et al, 2007b); (iii) their (perceived) entitlement to access the A&E (Jeffrey, 1979; Lyneham, 2000; Pich et al, 2010; Lau et al, 2012b). These three evaluation results summarised in my findings as entitlement to deviate from the passive Parsonian patient role, which, according to my findings, also applies to companions too since they can also be in severe distress.

As discussed above, users are expected to accept their passive role as actors in need of expert support, acknowledging the active and leading role of nurses. Those who fail to meet this expectation are perceived as perpetrators. However, my findings suggest that the nurses’ evaluations are informed by an a priori categorisation of users: those expected to be unable to comply with their Parsonian role in virtue of defined mitigating factors, and those expected to fully acknowledge their role and to behave accordingly. The first group is further divided into those exhibiting positive mitigating factors that prevent them from fully adhering to nurses’ expectations, such as the elderly, mentally impaired users and children; and users exhibiting negative mitigating factors, such as young users, users on drugs and poorly dressed users (perceived as indication of low social capital). This second sub-group, in virtue of the stigma attached, is expected to misbehave. Thus, their ill-mannered behaviour is in line with nurses’ expectation, meaning that no unexpected, and thus unacceptable, behaviour occurs and no impropriety is perceived – allowing for the aggressive attitude of a drunk patient to become acceptable. Nevertheless, it is correct to say that negative mitigating factors do not offer the same level of tolerance granted by the positive ones. Examples of this are alcoholics or users on drugs who, although not significantly reported in checklists, are described as not welcome and were often cited in relation to physical improprieties during interviews. Following the application of such mitigating factors, those on which these mitigations cannot be applied are subject to the full range of nurses’ expectations: they are more likely to betray nurses’ expectations.

Figure 10.1 (following page) visually represents the nurses’ process of definition of impropriety here discussed, thus answering my first sub-research question. First nurses identify a behaviour that might be considered improper – please bear in mind that not-improper does not mean acceptable. As a second step nurses evaluate the identity of the subject who is committing it deciding whether to apply the above discussed positive and negative mitigating factors. Based on this, nurses evaluate the interaction as improper or not. In accordance with this, the major presence of middle age perpetrators can be related to the inapplicability of both positive mitigating factors (not too old, not mentally impaired, not children) and negative mitigating factors – not belong to traditionally stigmatised groups such as young or intoxicated users. The same perspective can be extended to well-dressed users who are perceived as within the limits of normality, and thus are expected to be fully able to cover their role of user. Of even greater value is its application to off-duty doctors, whose behaviour is often perceived as unacceptable. Not only these users do not fall in any of the justifiable categories but also are expected to be fully aware of how nurse-user interaction is structured. It is a betrayal from a group member.

Figure 10.1 – Nurses’ definition of impropriety based on users’ identity

Behaviour not complying with the expected passive role of patients

User identity

Acceptable behaviour

Situational impropriety

Legend: green indicates nurses’ highest level of tolerance and empathy, yellow indicates a medium level of tolerance and empathy, and red indicates no tolerance. Full-body lines indicate direct connections, whereas dashed lines possible connections.

The identified distinction between justifiable and unjustifiable users finds support in other pieces of literature on the healthcare professionals-abusive uses interaction. For instance, Elston and colleagues (2002), reported that GPs generally tolerate improper behaviours from their patients when they have known mental or drug issues. Whereas they do not tolerate improprieties from those

‘whose social situation and lack of health-related problems provided no mitigating circumstances’ (Ibid, p.593).

Based on what reported in Section 7.2.1 about “Rookie” nurses, I believe that this organisation of expectations is both self-developed as well as passed down by more experienced nurses during the first years in the A&E. This protects nurses from having their expectations betrayed even when dealing with users already expected – by experience – to be unable to cope with the Parsonian role. Thus, preventing the delusional state that follows (see VEN6 quote on p.177). This interpretation finds theoretical support in Goffman’s concept of stigma (Goffman, 1963b) and in its application in the healthcare setting (Phelan et al, 2008; Parker, 2012). As discussed by Jo and colleagues (2008) in their extensive review of the literature on stigma and prejudice, one of the functions of stigmatisation is to reintroduce deviant actors in society. Stigmatisation not only promotes strategies of exclusion but also allows for the re-inclusion of the deviants with a new role. Offering a plausible justification for their reintegration within the society as subject that needs to be justified or treated with more empathy (Phelan et al, 2008, p.7).

### 10.3.2 – What Informal Strategies Are Adopted to Deal With Situational Improprieties?

My second sub-research question investigated, from a perspective by expectation, the informal dealing strategies adopted by A&E nurses to deal with situational improprieties. This is based on Goffman’s (1974) concepts of frame dispute and frame clearing. As discussed by the Canadian sociologist it is common that actors covering different roles hold different perspectives and expectations on how to frame a social interaction and how a frame should be interpreted (Ibid, p.339). Discussing expected users’ proper behaviour nurses offer detailed descriptions of their implicit expectations, discussing the broader organisation of expectations also defined as frame.

#### 10.3.2.1 – Identified Dealing Strategies

Drawing upon my findings presented in Chapter 9, I have identified four groups of dealing strategies: ’Ignore the perpetrator’, ‘Frame clearing’, ‘Escalation strategies’ and ‘Interactional strategies’.

The most diffuse one was “Ignore the perpetrator”. In agreement with the literature interviewees reported that they tend to ignore improprieties of any type if performed by users perceived as unable to cope with their expected Parsonian role. However, this strategy is also adopted toward other less justifiable categories of users both because they do not have time or energy to confront every impropriety they come across during their shift, but also because they believe that no formal sanction will be applied to perpetrators. As discussed in Section 7.3.4 nurses feel abandoned by their hospital management and by the justice system. This lack of support is well discussed in the literature and it is considered one of the main causes of the so-called culture of silence (see Section 2.4.3). It emerges from my findings that this lack of protection does not encourage nurses to become too involved in discussions with users. Most of the time to simply ignore the perpetrator can be the best strategy.

Of major relevance for my Thesis are the actual frame-clearing strategies. As discussed by Goffman

‘In all personal‑service organizations customers or clients sometimes make complaints. A customer may feel that he has been given service in a way that is unacceptable to him – a way that he interprets as an offense to the conception he has of who and what he is’ (Goffman, 1952, p.457).

It is, therefore, necessary for someone in the organisation to deal with such deluded users and to explain how things actually work. This operation is defined by Goffman as ‘cooling the mark out’ (Ibid) and represents the emphatic strategy of frame clearing discussed in Section 9.2.2.1. This results in the reframing of the interaction, symbolically and physically moving the perpetrator from a conflictual situation to a less confrontational and more empathic one - adopting a calm and understanding stance, lowering the voice tone while offering an image of nurses as understanding and empathic. This strategy has the twofold aim of reinforcing the definition of the A&E as a context from which no one is rejected, as well as of reinforcing the role distinction between the involved actors. In fact, doing so nurses reinforce their role of active and empathic agent of social control whilst stressing the user’s passive role (Parsons, 1951).

As discussed by Goffman (1952), the main aim of this strategy is to convince the ‘mark’ to accept its new position while renouncing his desire for a different interaction or revenge. It allows the perpetrator to understand and realise its mistake, or its misinterpretation of the user role. Moreover, based on my findings, I believe that being successful in this strategy increases both colleagues’ appreciation, as discussed in my analysis of the nurse category in section 5.3.7.2, and self-appreciation and resilience. In fact, as discussed by Gillespie et al (2007), being successful at work increases A&E workers’ resilience to stress.

The second frame-clearing strategy foresees a more confrontational, but still polite, approach. As discussed by participants this technique is used when the empathic one fails and it aims to stress that the user is evading the expected situational proprieties, that the situation will not change as s/he expects and that further complaints will not produce any effort. Based on my findings this strategy has the triple aim of (1) sanctioning the perpetrator, (2) reinforcing nurses’ perspective of the A&E as a context that deserves respect, and (3) reinforcing the Parsonian image of the nurse as gatekeeper (Parsons, 1951). Concerning the first effect, sanctioning the perpetrator, in agreement with my theoretical framework situational improprieties leads to social sanctions. Despite this, as specified by my interviewees, it does not imply a reduction of the services provided, nevertheless it causes a sudden intromission of reality in the perpetrators’ comprehension of what is going on. In fact, perpetrators are suddenly, openly and, if the interaction takes place in the waiting room, publicly made aware of their misframing (Goffman, 1974, pp.302-324).

In regard to the second effect, reinforcing the nurses’ perspective of the A&E Frame, as suggested by Goffman:

‘to say that a frame is clear is not only to say that each participant has a workably correct view of what is going on, but also, usually, a tolerably correct view of the others’ view, which includes their view of his view’ (Ibid, p.338).

Third, it is my understanding that adopting this technique nurses reinforce their self-perceived identity of Parsonian gatekeepers. As discussed in my analysis of the described social categories (Section 7.3), nurses present themselves as active subjects, expert repositories of knowledge. On the contrary, users are perceived as passive agents in need of the support of an expert and they should not try to advocate a more active role, and doing so nurses aim to “put them in their place”.

However, I am not suggesting that Parsons’ theorisation should be uncritically used to understand the patient-nurse relationship identified from my findings. First because, as he admitted, his study refers to the figures of American physicists and surgeons (Ibid, pp.318-19), which does not imply any transferability to Western European public healthcare systems, nor to A&E nurses. Second because I am fully aware of the criticisms moved toward Parsons’ functionalist theory from different grounds, such as his heroic representation of doctors ignoring their utilitarian gain in terms of social power and social control (Waitzkin and Waterman, 1974), his omission of the capitalistic exploitations of healthcare workers (Varul, 2010), or his reduction of patients to mere passive agents (Hafferty and Salloway, 1994). All criticisms I share but, nevertheless, my findings suggest that nurses’ understanding of their role, and of that of users, strongly resonates in Parsons’ one – moreover, without causing any conflict with my goffmanesque theoretical framework. In fact, although Goffman focused his interest on mental illness, his presentation of the role of healthcare workers is that of experts dedicated to the identification of abnormal characteristics in social actors. Actors, thus, who need to be treated differently when involved in social occasion (Goffman, 1961).

In terms of with whom these strategies are adopted, it is quite difficult to identify a specific category among those discussed in Section 7.3. Nevertheless, based on my findings, I believe that the first strategy is generally performed toward those users who seem to be able to understand it, thus those who do not enjoy any mitigating factor. Whereas the second one seems to be preferred for those users who are known for being resilient to the empathic strategy – for instance known hypochondriacs or intoxicated users.

Concerning the interactional strategies, as discussed in section 9.2.4, only Veneto nurses reported them as techniques of repetition and sudden interruption. The former is the repetition of the same sentence until the perpetrator realises that s/he is not allowing the nurse to speak. The latter the sudden interruption of the perpetrator in order to block his/her outburst. However, neither of the strategies belong to the informal repertoire of dealing strategies, since these are taught in specific courses organised by the Veneto hospital. Therefore, these two strategies do not provide significant information for my exploration of nurses’ perception of the A&E Frame since, it is my understanding, they reflect the perception of the management of how complex nurse-user interaction should be dealt with. In addition, despite the fact that both these strategies could be used as opening of the above-described clearing strategies, their use in a single context and their lack of theoretical connection with my framework force me to terminate here my analysis. In fact, as specified since the very beginning, my aim is not to discuss differences between the two settings, but rather to discuss commonalities. As previously discussed in Section 9.2, differences in dealing strategies are driven by the different labour division in the two research settings. Further comment would thus be pure speculation supported and would not be supported by the literature review or the theoretical framework. Therefore, I conclude here my discussion on the identified interactional dealing strategies.

The same reasoning can be applied to ‘Escalation strategies’ which, as previously discussed, are not relevant for the purpose of this thesis and are thus no longer commented on.

In conclusion, drawing upon Chapter 9, interviewees presented informal dealing strategies that lead me to two interrelated conclusions: first, despite the discussed organisational differences nurses from both settings showed preference for the empathic frame-clearing strategies over the confrontational one; second, the implementation of informal dealing strategies is in line with nurses’ interpretation of their role and informs nurses’ perception of the limits of their caring role. Concerning the first conclusion, it is no surprise that organisational differences, especially the presence of a professional figure dedicated to dealing with perpetrators in Essex, would affect the development of informal dealing strategies. However, this did not cause Essex nurses to fully dismiss the adoption of the informal dealing strategy, with Essex participants suggesting that they aim and value a perfect mastering of the empathic frame-clearing strategy. Moreover, I believe that the limited focus on the caring nature of the nurse role showed in Essex (see Section 7.3) is due to the presence of formal policies and internal escalation procedures. Nevertheless, it is my understanding that the reduced need to care for the perpetrator – who is seen as someone else’s responsibility – might justify Essex nurses’ major interest in the expert nature of their role. On the contrary, Veneto nurses, who cannot delegate this task to other professional figures, must find additional personal gratification to cope with perpetrators. One of which might be the major focus on the caring nature of their job (see Section 7.4).

Concerning the second consideration – that the implemented informal dealing strategies are in line with the nurse role and informs nurses’ perception of the limits of their caring role – I believe it confirms the necessity to understand the socially constructed value and function of A&E to make sense of nurses’ definition of what constitutes a situational impropriety. Or, in agreement with Goffman’s social theory (1974), it confirms that human life is constantly framed and that social interactions cannot be studied isolated from their guiding frame. As discussed in Section 9.2.2.1, the empathic frame-clearing strategy aims to protect the nurses’ definition of the A&E context, quenching conflictual interactions unsuitable with the A&E social definition – also in line with the caring nature of the nurse role. I believe, as discussed in this chapter, that the identified dealing strategies aim to protect and restore the expected nurse-user interaction. Either refusing a confrontation – ignoring the perpetrator and refusing to accept any claim of reframing, or clearing the frame in order to reinforce the image of nurses as Parsonian gatekeepers – done either empathically or abruptly. In support of this claim I would like to stress again how nurses too can be defined as perpetrators and that, like users, can be informally sanctioned. New nurses are, in fact, socialised by their experienced peers to the proper interpretation of the A&E Frame, and to their obligations in terms of demeanour and respect toward users and colleagues. In fact, nurses reported to be fully aware of their role and their own personal limitations at the interactional level, nevertheless they all expressed admiration of those who master the empathic frame-clearing strategy.

#### 10.3.2.2 – From Individual Strategies to Group Strategies

As discussed in Section 4.4.1, to verify whether a cognitive frame is shared, thus whether it has social and interactional nature, it is necessary for it to be shared among the group members adopting the frame to orient their interaction (Ensink, 2003). Drawing upon my findings in Section 9.3 I am confident in confirming the social nature of this frame. In fact, not only is its cognition shared among nurses of the same setting, but also between teams from two different settings, despite all the identified and discussed organisational differences.

With reference to peer-teaching, or peer-socialisation to the frame, as discussed in Chapter 4, frames need to be internalised, especially for what concerns nurses’ reactions to users’ situational improprieties. New nurses need to learn how to deal with improprieties, since, as discussed in the literature and reported in these findings, if they fail to do so they will be perceived as poor co-workers and, thus, informally sanctioned by their peers (Crilly et al, 2004; Pinar and Ucmak; 2011; Albashtawy, 2013; Wolf et al, 2014). According to my findings, all participants are convinced that the empathic frame-clearing strategy is often the aptest dealing strategy. Moreover, most interviewees would like to work with “Diplomatic” and “Naturally talented” nurses, whereas ‘Hot-tempered’ and ‘Unbalanced’ nurses are generally disliked, especially in the Veneto hospital. See Section 9.3. I can thus claim that the effort experienced nurses put in offering their help to the less experienced ones, both in the form of support and of peer-teaching, confirms the existence and the structuration of the A&E Frame. I believe these specific intra-group social interactions work as socialisation activities of newcomers to the frame. Following Goffman’s (1956) discussion on teamwork, this is done because a

‘performance serves mainly to express the characteristics of the task that is performed and not the characteristics of the performer’ (Ibid, p.47).

Peer-teaching efforts thus ensure that new nurses’ performance will not contradict the team’s performance (Ibid), thus supporting the proposed representation in agreement with the guiding frame.

### 10.3.3 – How Do Accident and Emergency Department Nurses Frame Their Professional Interaction with Users?

Drawing upon the discussion offered in the previous sections, Figure 10.2 visually represents the answer to the main research question.

Central to nurses’ framing of their interactions with users is the social definition of A&E: a social structure dedicated to the identification of biological causes of “deviancy”, and to help “deviants” to re-gain their social identity and role in society (Goffman, 1961). As previously discussed, this understanding of the A&E defines roles that resonate in Parsons’ (1951) physician-patient dichotomy, where physicians cover an expert role aimed at helping passive laypeople (users) to heal from their sick condition. This resonates in participants’ narrations, presenting themselves as active caring medical experts while describing patients as laypersons frightened and stressed by the uncertainty of their health condition (see Section 7.3.1). This relation between the context definition and the available roles is represented with a bi-directional arrow, indicating that, in agreement with Goffman’s social theory (Section 4.4.5), the definition of the situation is possible only if accepted and reiterated by those performing the available roles.

Figure 10.2 – Graphical representation of the A&E Frame

**Social definition of the A&E context**

Nurse role

User role

Informal dealing strategies

Situational impropriety

Actor’s identity

Legend: arrows indicate the direction of the represented relation. Black lines indicate direct influences. Blue lines indicate expectations. Red lines indicate betrayed expectations. Green lines indicate actions toward.

Moreover, role definitions create expectations regarding user behaviour, as indicated in Figure 10.2 with a unidirectional blue arrow. As suggested in Section 4.3.2 expectations are mutual, thus the arrow should be bi-directions. However, while it is likely that users have expectations too, their perspective is not considered in this research. Moreover, it is merely acknowledged by nurses and it is thus not represented.

As previously discussed in Section 7.2.2, nurses have expectations about themselves represented with a semi-circular blue arrow. In agreement with Goffman (1963a, p.24), the role’s obligation applies to everyone and, as discussed in Chapter 2, nurses too can be perceived as perpetrators. ‘Hot-tempered’ and ‘Unbalanced’ nurses are perceived as poor co-workers unable to correctly perform their role of caring experts, thus committing a situational impropriety. This finds support in interviewees’ descriptions of their motivation to work as nurses in an A&E. As discussed in Section 7.4, the active, caring and expert nature of the nursing role was reported to be the main personal motivations at the base of their decision to work in such a stressful and challenging environment. Behaviours that contradict this role expectation are thus perceived as situationally improper – perhaps as horizontal situational improprieties.

When expectations are not met, behaviours are perceived as situationally improper, represented with red unidirectional arrows starting from the blue expectation lines and leading to the ‘situational impropriety’ dimension. However, the actual definition of behaviour as improper is influenced, or filtered, by nurses’ perception of perpetrators’ identity. The more a user is perceived as victim of his/her condition, the more empathic the nurses’ approach will be. Furthermore, in contrast with the literature discussed in Chapter 2, nurses seem to include forms of social stigma in their consideration, resulting in a more tolerant attitude toward users whose adverse medical conditions are self-inflicted (drunk and on drugs) and those whose social skills are expected to not be fully developed (young users) or accustomed (migrants and travellers). This “filter” is represented by the red lines crossing the ‘actor’s identity’ dimension. The same is true for nurses’ situational improprieties since, as discussed, those new in the department are differently treated. In agreement with this a black line links ‘actors’ identity’ with ‘Informal dealing strategies’, since these are adopted in accordance with the identity of the perpetrator.

Finally, a black line links the ‘Nurse role’ with ‘Informal dealing strategies’, indicating how these are primarily influenced by nurses’ self-understanding of their role. Whereas a green unidirectional line links the ‘Informal dealing strategies’ with ‘Situational impropriety’.

As discussed and demonstrated, my sociolinguistic frame analysis of nurses’ narrations identified a convergence of perspective between nurses employed in settings that differ both on organisational and cultural grounds. Very similar definitions of both improprieties and dealing strategies have been reported, thus confirming a shared cognitive perspective between teams. Moreover, since the cognitive perspective is informally adopted by all the interviewees, who also actively cooperate to reproduce it through informal sanctions to misbehaving nurses and specific strategies of peer socialisation to the frame, I am confident in concluding that the A&E Frame has a social and interactional nature. I can, therefore, affirm that a new and specific frame has been identified and described in this thesis.

## 10.4 – Contributions to Knowledge

In my review of the selected literature, I have identified four interrelated main gaps: lack of understanding of nurses’ perspective; lack of a clear working definition of unacceptable behaviour; absence of explorations of nurses’ informal dealing strategies; absence of cross-cultural qualitative study able to confirm the transferability of findings collected in different settings. I believe that in my thesis I have provided significant contributions to these four gaps and that, in addition to these, three additional contributions at theoretical and methodological levels have also been provided.

My first contribution to knowledge consists of my exploration of nurses’ perspectives and definition of behaviour deemed unacceptable. Contrary to the majority of existing studies that imposed external definitions and perspectives, I have adopted a social constructionist approach that allowed me to explore the phenomenon from nurses’ perspective. Thanks to this I have provided a more detailed organisation of situational improprieties from users. The usefulness of this contribution, I believe, is both theoretical and practical; theoretical because, following the work on rudeness of Philips and Smith (2003; 2004; 2006), I was able to identify, describe, and explore types of performance that had previously been overlooked in literature (Luck et al, 2007a; Luck et al, 2007b; Lau et al, 2012b). It is practical because, as explained in the following Section 10.5, it allows for the development of more tailored and effective policies.

I believe that pivotal to my first contribution was the introduction of Goffman’s concept of situational impropriety (Goffman, 1963a, pp.23-4) in this research context – which also constitutes my second contribution to knowledge, especially to the literature on violence and aggression – see Chapter 3. Through the adoption of this concept, I offer a suitable alternative to the plethora of definitions identified in literature, which led to distorted, confusing, partial and not comparable findings. Precisely, as discussed in Chapter 2, the imposition of external definitions caused a proliferation of incompatible concepts, also promoting an excessive focus on physical improprieties. As discussed in Chapter 3 the use of ‘situational improprieties’ allows researchers to adopt the participants’ perspectives, to make sense of the specificity of their research context and to provide enough flexibility to include any form of impropriety, without implying or inadvertently suggesting the predominance of one form over the others. Finally, according to my most recent review of the literature on unacceptable behaviour in A&E, and the last published systematic literature review, none have discussed A&E users’ unacceptable behaviour from a Goffman perspective, with only Lau and colleagues (2012a, 2012b) exploring the phenomenon from a constructionist ethnographic perspective (Ramacciati et al, 2018)

My use of ‘situational impropriety’ as a working concept led to the third contribution to knowledge: the identification of three new forms of impropriety, overcoming the traditional verbal-physical dichotomy. It is my firm belief that it is thanks to the flexible, context-based and constructionist nature of this concept that deviant-but-not-illegal interactions in the workplace were included in my study. This allowed me to identify three additional forms of situational improprieties: Attitudinal, Emotional and Interactional. Although their existence was more or less directly suggested by other authors, without Goffman’s focus on demeanour, engrossment and, more generally, attitude I would have not been able to systematise and describe their nature. As I will discuss in the next section, I believe that the identification of these additional forms of improprieties could be of great value for new policies aimed at improving A&E nurses’ working conditions. Moreover, these new categories can be adopted to study interactions in other contexts, allowing for a better understanding of the root causes of many interactional conflicts in society. Indicative of this is, for instance, the relevance of attitudinal improprieties in my data collection, covering 28% of all the impropriety reported through checklists (see Chart 8.1, p158).

My fourth contribution is the analysis of nurses’ informal dealing strategies. As discussed in Chapter 2, with specific reference to the concept of ‘culture of silence’ (Pich et al, 2010), formal dealing strategies and protocols are not fully effective and very little is known in terms of what A&E nurses can do at informal level. In my thesis I have identified seven types of informal dealing strategies, two of which – the frame-clearing ones – are of particular interest for my research. These two are relevant on both practical and theoretical grounds, with potential practical implications. Anticipating the discussion offered in the next Section 10.5, these two strategies suggest that nurses would consider beneficial both a spatial organisation of the department so as to provide physical space to cool down agitated users, as well as the provision of professional training to improve nurses’ interactional skills. Evidence of the benefit of such training can be found, I believe, in the minor number of improprieties reported in Veneto. Here nurses receive dedicated training courses and can resort to a larger variety of informal dealing strategies. It could, therefore, be, although additional research is necessary, that informal strategies are more effective than formal ones in reducing situational improprieties in A&E. According to Tan and colleagues (2015),

‘Current evidence points to the need to further explore nurses’ perspectives of how best to care for people exhibiting aggressive behaviour, which could contribute to efforts in reducing the adverse effect on nurses and identify the impediments for the required changes by organizations or individual healthcare professionals’ (Tan et al, 2015, p.308).

My fifth contribution, partially in reply to the last identified main gap, consists of the cross-cultural nature of this qualitative study. As discussed in Chapter 2 I was not able to identify similar approaches in the literature on unacceptable behaviour in A&E, with comparative studies being based on quantitative data – often secondary ones whose transferability was only assumed. I, therefore, claim that this is the first study verifying the standard nature of the A&E context, identifying similarities that overcome significant organisational and cultural differences between A&E departments. Moreover, I have operated the first bi-lingual qualitative frame analysis in the healthcare context – or at least the first published in English. As my data collection is bilingual, in agreement with Schröer (2009), I focused on the cognitive meaning assigned to similar concepts in the two investigated languages creating a table of translation. However, the originality of my contributions is not to be found in this table, rather in its dynamic nature. As discussed by Wortham (1996, p.23) today languages are live social constructions that evolve in time, diversely applied and used by different social groups. Thanks to the obtained participants’ validation of my understanding I managed to overcome this issue, reducing this invisible and intangible cultural dynamism in sufficiently stable concepts to allow cross-cultural comparisons and joint analysis. I, therefore, combined linguistic (Schröer, 2009), sociological (Goffman, 1974), sociolinguistic (Ensink, 2003) and methodological (Respondent validation technique, Silverman, 2013, p.288) elements in an original way, which application could allow other research to qualitatively explore culturally different settings.

The above discussion leads to my sixth contribution to knowledge, which also contributes to filling the last identified main gap, being the validation of transferability of findings collected in culturally different A&E – depending upon compatible data collection methodologies and similar cultural environment. As discussed in Chapter 2, scholars often used data collected in other settings without investigating their transferability, an assumption that leads to reduced clarity. In addition, especially with reference to studies included in the first two sets of my literature review – Practical Solution (Section 2.4.1) and Profiling of the Perpetrator (Section 2.4.2) – scholars often focused on differences between the set of their intervention/study and findings from other settings. In response to this, I conceived a radical approach to the analysis of data collected from different settings, focusing instead on similarities. As far as I am aware, this is the first and only research aimed to verify data transferability, demonstrating that the uniqueness of this context can overcome organisational and cultural differences. However, I would not dare to suggest that data collected from non-Western EU countries can be compared since the available studies seem to portray a different cultural organisation of social values.

Finally, my seventh and last contribution consists of the theoretical architecture of this thesis. Precisely, in this thesis I have developed a new approach to Goffman’s frame analysis, both at theoretical and methodological level. The former consists of my within-method triangulation of frame-clearing strategies observing the same frame both from Burke’s (1965) perspective by incongruity and strategies of frame clearing. Whereas the methodological one consists of my adoption of qualitative checklists to support and provide additional validity to the sociolinguistic work of Ensink (2003). I believe this new approach could help to overcome the main limitation of frame analysis methodologies that, as discussed by Koenig (2004a), often provides results that are unclear about the rationale of their analysis, leaving ‘the reader in the dark about the actual process of empirical frame detection’ (Ibid, p.3). Finally, Ensink (2003), like any other author using Goffman’s frame analysis as far as I am aware, did not apply Denzin’s (1978, pp.301-02) within-method triangulation to frame analysis. Despite Goffman suggesting triangulation of data, no one has ever proposed combining a perspective by incongruity with an analysis of the frame-clearing strategies (perspective by expectation). I believe this contribution could result in capital importance for future developments of qualitative frame analysis research. I believe that it allows for better and more detailed descriptions of the framing process. It offers theoretically robust guidance, preventing scholars from relying too heavily on their creativity (Maher, 2001, p.84), which has led to allegations that frames are merely constructed through ‘researcher fiat’ (Tankard 2001, p.98).

## 10.5 – Implications for Policy in Practice

Drawing upon the contribution discussed in the above section, I see my research findings as being useful to four groups of stakeholders: academics, policymakers and hospital managers, and nurses and other professionals involved in emergency or primary services.

I believe academics might be interested in my research on three grounds: theoretical, conceptual and methodological. The first one consists in my theoretical development of Goffman’s frame analysis, including in it the within-method triangulation of perspective by incongruity and perspective by expectation, and the reliable and robust qualitative sociolinguistic analysis introduced by Ensink (2003). As suggested above, I believe my approach could help to overcome the main limitation of many frame analysis methodologies (Koenig, 2004a), primarily the accusation that frames are merely constructed through ‘researcher fiat’ (Tankard 2001, p.98). At a conceptual level, the use of situational improprieties could be relevant for those scholars interested in deviant-but-not-illegal behaviour who, like me, found contemporary literature unsatisfactory. Flexibility, validity, identification of the limits and constructionist nature are only a few of the advantages of this concept, qualities that I personally struggle to find in other concepts. Finally, at a methodological level, I believe that many researchers in the field of unacceptable behaviour found themselves unable to collect ethnographic data and, as discussed in Section 4.3.1.1, the use of qualitative checklists, especially if integrated by other qualitative methods such as interviews, can be a suitable qualitative and pragmatic solution. For instance, this method ensures anonymity and protection to participants, also granting privacy to non-participants involuntarily or necessarily involved in the research.

Policymakers and hospital managers may find my research of practical interest since it offers a detailed description of what is considered not acceptable by A&E nurses and shows what dealing strategies can be successfully implemented. Moreover, my findings concur with that part of the literature on unacceptable behaviour in the workplace that suggests investing more in training courses aimed at improve workers’ interactional skills (Kamchuchat et al, 2008, Gates et al, 2011; Henderson and Colen-Himes, 2013), suggesting that the key to reducing physical aggression is to reduce verbal abuse - reported to be the gateway impropriety (Elston et al, 2002). In addition, the identification of the three additional forms of improprieties can help both healthcare workers and managers to develop protocols and environments that reduce the effect of Attitudinal and Interactional improprieties – for instance visually highlighting the medical diagnostic skills of those nurses working in triage, or creating spaces that favour the implementation of the empathic dealing strategy.

With regard to professionals, I believe that my research could be relevant to those who, like A&E nurses, might find it ethically and professionally challenging to refuse to provide their services to perpetrators. Examples of these social groups are paramedics, police officers, social workers, and all those other professionals that offer services that must be provided as necessary to the smooth functioning of our society. To these subjects the relevance of my research is twofold: first, I brought the focus back on professionals’ own self-perception of both their job and of themselves as experts. This means that solutions cannot be imposed from externals, but rather must be negotiated, identified and built with them in order to prevent identification conflicts. If such negotiation is ignored the implemented solutions will fail, leading to higher dissatisfaction, risk of burnout and a culture of silence. Second, I have suggested that informal and non-coercive dealing strategies could give effective results if sustained by the context and by a certain predisposition for interpersonal relations. Predisposition that could be replaced by formal and informal training aimed at improving professionals’ interpersonal skills.

Finally, nurses may find my research useful on different grounds. First, due to the chosen perspective, this research offers support to those who are contesting the value of traditional reporting forms. Second, it offers theoretical support to those in the profession who are fighting the culture of silence, helping them to analyse the causes and promoting bottom-up solutions and policies. Third, it helps nurses to reflect on the importance of their role, enforcing self-respect for their profession and supporting further studies to mitigate the impact of hot-tempered and unbalanced nurses in the workplace. Finally, drawing upon the analysis of users provided, it might be useful for nurses to acknowledge the decline of the Parsonian user role, reflecting upon the ongoing marketization of the healthcare system which, as the problem itself evolves, calls for new solutions and new role definitions.

## 10.6 – Limitations and Further Considerations

Following a reflexive process of critical review enriched by colleagues and more established researchers’ suggestions and indications, I have identified eight aspects of my thesis that would require additional reflection or exploration. Foremost my theoretical approach: Frame Analysis. As discussed in Chapter 4 this approach captures the social momentum, like a detailed picture, and allows for its thorough exploration. However, frame analysis overlooks what is behind that interaction – such as lower frames structuring it – and what led to it – such as actors’ biographical trajectories (Loyal and Quilley, 2004, p.4). Goffman’s frame analysis thus focuses on the upper layer only, leaving to what could be defined as common sense – or personal knowledge – what remains under the surface. Regarding the structuring lower frames, Strong (1988) claimed that Goffman was short in providing a ‘clear understanding of the interactional structure of the participants’ of a studied interaction’ (p.158). A criticism I agree with, although this has been partially resolved by van den Berg (1996) through the analysis of the involved categories - see Figure 7.1 (p.134) – and of the lower frames. Applying Ensink’s methodology, that incorporates van den Berg’s work, I was able to reflect upon relations guided by lower frames, although much of these remain unexplored.

In terms of actors’ biographical trajectories, frame analysis does not allow us to investigate how these influence actors’ performances. For instance, it would not allow for an understanding of the role of nurse as vocational, as a mission to care despite the significant level of improprieties. Despite my investigation of the provided example (see Section 7.4), I believe that the adoption of phenomenological or interactional (in the median conception of it) approach would have provided deeper insight into the nurse-user interaction. However, these approaches would have not allowed me to answer the pre-given research question. My aim was in fact that to explore the informal organisation of nurses’ reality when dealing with situational improprieties from users, not to explore the social construction of the role of nurse or of that of user. A final result I believe I have reached, although the adoption of Ensink’s methodology and the integration of my sixth question allowed for a more complete understanding.

Concluding this first reflection on my thesis, I believe that, due to my theoretical approach, I omitted almost everything that was not relevant in terms of interactional rules. Although I believe this is not a limitation – since it could only be defined so against the research question and mine was focused on informal interactional rules – I believe that integrations were needed, such as Parsons’ work on physician and the analysis of nurses’ non-utilitarian interest in their work. The former allowed me to make sense of the identified interactions while improving the validity of my study incorporating it within a broader and coherent sociological theory; whereas the latter allowed for a better understanding of nurses’ reluctance for zero tolerance responses and their preference for constructive informal dealing strategies.

The second point of reflection is my research design. Despite I have collected data from two settings with similar characteristics (see Chapter 5) checklists returned sometimes diverging results – see Annex II and Annex III – raising awareness on the transferability of my findings and my exploration of them as unique body. Although I am aware of the fictitious nature of such incorporation, from an orthodox qualitative perspective any comparison or combination would be impossible and this would represent an insurmountable limitation. Nevertheless, adopting a weak social constructionist epistemology, and rejecting the quantitative aim of statistical generalisation, following Yin (2009) I consider the identified discrepancies between settings not as a limitation, but rather as the reflection of the unavoidable micro and macro-organisational differences – as well as of the different social characteristics of the served population. Aiming thus for analytic generalisation, minor differences do not erode the validity of my findings, instead supported and corroborated by participants’ direct validation of them and by the general convergence of them.

Following this, a third topic that calls for additional reflection is the process of simplification and semantic grouping I have operated on raw data so to allow for a more systematic analysis of the same. Fully aware of the potential data loss, my decision was supported by the strong similarities between the two contexts under the broader organisational aspect – see Chapter 5. Also supported by a transparent and punctual acknowledgment, consideration and description of local differences. Moreover, the process of reduction was carried out with the support of a native English speaker fluent in Italian. Finally, in agreement with Goffman, I am convinced that despite the two settings are not completely equal, they share “to an intense degree many items” (Goffman, 1961a, p.5) that allow for their inclusion in a hypothetical group of West European A&Es.

Linked to the above, the fourth area of reflection interests the socio-linguistic analysis approach adopted. I believe that the main limitation of this approach rests on the performative nature of my translation since the shared meaning of a concept is contextually created and thus lacks a linguistic benchmark provided by, for instance, a dictionary – as per the literal translation. This implies that the social and semantic value of a word, or a sentence, rests in my understanding of what communicated to me, being potentially different from what another researcher might understand. Furthermore, in case of incorrect understanding during the first phase of data collection, this would have had implications on the second phase. As suggested by Inhetveen (2012), the involvement of a second professional translator is a recommended practice to reduce the risk of improper translation while improving the validity of the whole process. However, due to practical and economic reasons this solution was not possible. Instead, validity was provided through participants’ validation – since none of them suggested different translations or understanding of the proposed concepts. I believe this is indicative of the reliability of my translation and, consequently, ensure validity to my socio-linguistic analysis of the following interviews – since discussed concepts were directly drawn upon the table of translation.

Alternatively, as discussed in Section 4.4, I could have adopted a recursive methodology in data analysis (Recursive Frame Analysis) and identify metanarratives and semantic maps (Koenig, 2004a). Using a qualitative data analysis software on the verbatim transcription of interviews and original descriptions reported in checklists I could have developed a robust content analysis, not a qualitative frame analysis. Moreover, in agreement with Koenig (2004a, 2004b and 2006) the validity of such results would have been disputable on two grounds: first, it would have caused significant data loss instead achieved thanks to the sociolinguistic analysis – i.e. deictic analysis and voice stress. Second, it would have directly applied a strict linguistic logic and rules on non-native English speaker interviewees from the Essex hospital. Although this criticism could be valid on my approach too – the use of a certain deictic might hold a different value in the language of origin as well as the use of paraverbal resources – Wortham’s (1996) methodology forced me to explicit every step of my analysis and reflect upon it – see Section 6.5.2.2.

A final remark on this linguistic issue: In consideration of my interest in a western European perspective, it would have been interesting to include a third language to test the univocal value of, for example, the concept of Interactional impropriety in A&E. However, this would have implied the introduction of a third hospital but, as discussed in Section 6.3, this was not feasible.

A fifth aspect of my thesis that would require additional reflections is the research methods employed. As discussed in Section 4.3.1.1, I was not allowed to take the ethnographic ‘ﬂy-on-the-wall observational stance’ recommended by Goffman (Smith, 2006, p.115). Although I am confident in defending the robustness of my data collection methods, especially in consideration of the imposed limitations, participant observation would have improved my understanding of nurses’ perspective. My conclusions would be more solid and transparent if supported by ethnographic notes that, for ethical issues, will instead remain in my research diary.

Still, regarding the research method employed, a sixth reflection is to be dedicated to the limited time I was able to agree for interviews. I believe that 20 minutes were not enough, especially in consideration of the time I had to dedicate to brief the participant, discuss and evaluate the matrix of translation, collect the informed consent, and offer a de-briefing. Due to these activities, I was not able to discuss in-depth arguments such as emotional improprieties and perceived status differences between waiting and admitted patients. In addition, I was not able to discuss in further detail nurses’ dealing strategies and peer-teaching activities – or at least as I wanted to. On the same topic, interviews could have been organised differently. Perhaps I should have refused to collect interviews in Essex majors, but time constraints and the desire of nurses not to leave the department convinced me to do so.

Finally, the seventh point of attention consists of the different level of reliability offered by the two sets of interviews. As previously discussed in Section 5.3.1, the interview setting in Essex did not guarantee the necessary privacy, which might have influenced their answers – see 7.2.1. Moreover, as discussed in Section 7.2.3, I believe that I did not manage to establish the same level of interpersonal connection with the Essex participants, resulting in shorter and less descriptive interviews. Although I believe that the level of insight achieved still vouches for my clam of validity, this remains my biggest bitterness.

## 10.7 – Further Research

Based on my review of the literature on unacceptable behaviour in A&E, on the conceptualisation of violence in social studies, and on Goffman’s social theory, as well as my interaction with A&E healthcare professionals and with other academics, I am convinced that my thesis is innovative within several perspectives. This means that it can be improved on different grounds but also that several further pieces of research might be conducted to both dissipate the above-discussed limitations and expand the several new questions that arise from it.

I believe that new research can use my thesis as a starting point to further deepen the understanding of my topic in two main directions: expanding the pool of perspectives to achieve a more holistic perspective and to focus on specific aspects of my work. Among the former are those studies based on one of the other relevant categories represented in Figure 7.1 (p.134). It would be of great interest to determine how different professional groups of healthcare workers frame the same interactions. In fact, solutions adopted based on the analysis of nurses’ perception might give counterproductive results to others, due to potentially divergent and conflictual perspectives within the same setting. It would also be useful to explore how the concept of situational impropriety is negotiated among healthcare professionals, especially between front line staff and managers. It is possible that due to different conceptualisations of the nurse role asymmetric implicit expectations gravitate around the figure of nurses. Finally, it would be of extreme interest if further research could explore the users’ perspectives, allowing for a more holistic understanding of the nurse-user interaction, also verifying the impact of healthcare policies of marketization on it.

With regard to the second pool of researches, those focusing on particular aspects of my findings, following the discussion offered in Section 10.4 more extensive data collections would allow for a better understanding of how different types of situational improprieties interrelate. Furthermore, it could be interesting to explore the relevance of such improprieties in affecting actors’ perceived level of insecurity and general distrust toward society. Another interesting research could be on nurses’ impropriety, a relevant topic only marginally touched on by my research. Finally, linked to this last suggested further research, it would be important and relevant to apply the concept of situational improprieties in studies on horizontal improprieties – meaning improprieties committed by staff members toward other staff members – so to uncover a vast range of overlooked unacceptable behaviour.

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# 

# ANNEX I – Qualitative Checklists examples

Example from the Essex data collection

Check-list for aggressive behaviour research,

compiling information on the back side.

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Time: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Role: Patient O Companion O

Perceived estimated age:

<*18 O 18 – 25 O 26 – 35 O 36 – 45 O*

*46 – 55 O 56 – 65 O 66 – 75 O 75+ O*

Gender: Male O Female O

Description of the perpetrator:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What happened:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Security staff intervention: Yes O No O

Please fill the open question with few words (3 - 4),

those that first come to your mind. Do not think, be

impulsive.

As example:

Description of the perpetrator: mother, worried

What happened: verbal abuse, shouting,

racial offense

Please remember:

- It is not necessary to compile this check-list immediately after the perceived impropriety. Take your time. You can compile it at the end of your shift or during a break.

- Is not necessary to compile this check-list in all its parts. You are free to compile only those parts that **you** consider significant

- Should a question cause you stress or emotional distress please ignore it.

- If the act of reporting results stressing, please do not compile this checklist and contact the internal support line.

- Additional information are reported in the Checklist PIS

Example from the Veneto data collection

Si prega di compilare le domande aperte con

poche parole (3 – 4), le prime che le vengono in

mente. Non pensi, sia impulsiva/o

Ad esempio:

Descrizione del trasgressore: **madre, preoccupata**

Cos’é successo: **abusi verbali, urla, offesa**

**sessista**

Attenzione:

- Non é necessario compilare questa check-list subito dopo che l’incivilitá percepita ha avuto luogo. Puó compilarla al termine del suo turno o durante una pausa.

- Non é necessario compilare questa check-list in ogni sua parte. Compili solo le parti che ritiene significative.

- Se una domanda dovesse causarle stress la salti.

- Se il riportare l’inciviltá dovesse risultarle stressante non compili la check-list e si rivolga al servizio di supporto interno.

- Ulteriori informazioni sono riportate nel foglio informativo dedicato alle check-list

Check-list per comportamenti incivili contro

membri staff. Istruzioni sul retro.

Data: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ora: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ruolo: Paziente O Accompagnatore O

Stima etá percepita:

<*18 O 18 – 25 O 26 – 35 O 36 – 45 O*

*46 – 55 O 56 – 65 O 66 – 75 O 75+ O*

Genere: Maschio O Femmina O

Descrizione del trasgressore:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Descrizione del comportamento incivile:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Intervento della sicurezza: Si O No O

# ANNEX II – Qualitative Checklists Mid-Term Report

**Research on situational improprieties (incivility) in ED**

**Step 1 - Checklist activity: analysis of collected information**

Author: Lorenzo Gangitano, Anglia Ruskin University

This report graphically presents few statistical analysis of those users’ behaviour that you and your colleagues deemed as improper (not suited for the Emergency Department context) and reported on the provided checklists. This presentation is mostly graphical and comments are kept to the minimum. This because this research aims to understand your original perceptions and definition of unacceptable behaviour without imposing academic terms, theories or concepts. The real and final data analysis will be produced together with those staff members who will participate to the next research activity: semi-structured interviews. As stated in the Information Sheet you received at the end of the checklist activity, interviews will be based on these information you kindly produced. For further information or additional copies please contact either Ms Natasha Christmas or me at [lorenzo.gangitano@student.anglia.ac.uk](mailto:lorenzo.gangitano@student.anglia.ac.uk)

The report is organised in two sections: the first presents the aggregate result, so data from both hospitals; the second section presents disaggregated data, allowing for data comparisons and reflections on your specific experience.

**1 - General results**

A total of 126 checklist were collected during the 12 weeks (84 days) period of data collection, meaning 3 checklists every 2 days or 3 interactions deemed as unacceptable every 2 days. Giving as granted the high rate of un-reporting, due to several understandable reasons such as an already heavy workload, I believe these data represent the famous top of the iceberg and they indicate a much larger diffusion of acts not suited for the A&E context.

1.1 - Distribution per day

Chart 1 – Distribution per day

Table 1 – Distribution per day

|  |  |  |
| --- | --- | --- |
| **Day** | **Frequency** | **Percent** |
| Monday | 17 | 13% |
| Tuesday | 20 | 16% |
| Wednesday | 16 | 13% |
| Thursday | 18 | 14% |
| Friday | 21 | 17% |
| Saturday | 21 | 17% |
| Sunday | 9 | 7% |
| MISS | 4 | 3% |
| Total | 126 | 100% |

1.2 - Distribution per shift

Please consider that shifts are defined as following: Morning, from 6:01 to 12:00; Afternoon, from 12:01 to 18:00; Evening, from 18:01 to 00:00; Night, from 00:01 to 6:00.

Chart 2 – Distribution per shift

Table 2 – Distribution per shift

|  |  |  |
| --- | --- | --- |
| **Shift** | **Frequency** | **Percent** |
| Morning shift | 37 | 29% |
| Afternoon shift | 34 | 27% |
| Evening shift | 35 | 28% |
| Night shift | 16 | 13% |
| MISS | 4 | 3% |
| Total | 126 | 100% |

1.3 – Distribution per users’ role

Patients are perceived as the more improper group of users.

Chart 3 – Distribution per type of user

Table 3 – Distribution per type of user

|  |  |  |
| --- | --- | --- |
| **Role** | **Frequency** | **Percent** |
| Companion | 56 | 44% |
| Patient | 70 | 56% |
| Total | 126 | 100% |

1.4 - Distribution per age

The middle aged ED customers result the most represented group of perpetrators.

Chart 4 – Distribution per perceived age group

Table 4 – Distribution per perceived age group

|  |  |  |
| --- | --- | --- |
| **Age group** | **Frequency** | **Percent** |
| <18 | 7 | 6% |
| 18 - 25 | 10 | 8% |
| 26 - 35 | 24 | 19% |
| 36 - 45 | 18 | 14% |
| 46 - 55 | 29 | 23% |
| 56 - 65 | 20 | 16% |
| 66 - 75 | 8 | 6% |
| 75+ | 6 | 5% |
| MISS | 4 | 3% |
| Total | 126 | 100% |

1.5 – Distribution per gender

Data clearly indicates males as major perpetrators.

Chart 5 – Perpetrators’ perceived gender

Table 5 – Perpetrators’ perceived gender

|  |  |  |
| --- | --- | --- |
| **Gender** | **Frequency** | **Percent** |
| Female | 54 | 43% |
| Male | 71 | 56% |
| MISS | 1 | 1% |
| Total | 126 | 100% |

1.6 – Gender distribution per age group

Please note that MISS values are here excluded.

Chart 6 – Perceived gender distribution per perceived age group

Table 6 – Perceived gender distribution per perceived age group

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Age / Gender** | <18 | 18 - 25 | 26 - 35 | 36 - 45 | 46 - 55 | 56 - 65 | 66 - 75 | 75+ |
| Female | 2 | 4 | 8 | 10 | 13 | 11 | 1 | 3 |
| Male | 5 | 6 | 16 | 8 | 16 | 8 | 7 | 3 |
| Total | 7 | 10 | 24 | 18 | 29 | 19 | 8 | 6 |

1.7 – Security intervention

Security staff intervened in one case out of five.

Chart 7 – Security intervention

Table 7 – Security intervention

|  |  |  |
| --- | --- | --- |
| **Security intervention** | **Frequency** | **Percent** |
| Yes | 23 | 18% |
| No | 95 | 75% |
| MISS | 8 | 6% |
| Total | 126 | 100% |

1.8 – Description of the perpetrator

As observable the presence of perpetrators with mental health conditions is limited (11 out of 126 reported perpetrators, 9%) and so is that of those drunk (9 out of 126 perpetrators, 7%) or on drug (1 out of 126, 0.8%).

Table 8 – 1st codification of perpetrators’ characteristics

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Description** | **Frequency** | **Percent** | **Description** | **Frequency** | **Percent** |
| Kinship | 31 | 16% | Error | 6 | 3% |
| Body language | 26 | 14% | Dirty | 2 | 1% |
| Physical constitution | 22 | 12% | Off-duty doctor | 2 | 1% |
| Age | 17 | 9% | Convict | 1 | 1% |
| Hair | 11 | 6% | Drug addict | 1 | 1% |
| Mental health condition | 11 | 6% | Homeless | 1 | 1% |
| Alcoholic | 9 | 5% | Ill | 1 | 1% |
| Dress code - negative | 9 | 5% | In pain | 1 | 1% |
| Dress code - positive | 9 | 5% | Physical aspect | 1 | 1% |
| Race | 9 | 5% | Smelly | 1 | 1% |
| Role | 9 | 5% | Total | 188 | 100% |
| Dress code | 8 | 4% |  |  |  |

1.9 – Description of the unacceptable behaviour

Table 9 – 1st codification of the recorded unacceptable behaviour

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Description** | **Frequency** | **Percent** | **Description** | **Frequency** | **Percent** |
| Verbally abusive | 27 | 16% | Swearing | 5 | 3% |
| Aggressive attitude | 22 | 13% | Threatening | 5 | 3% |
| Demanding | 22 | 13% | Abuse of power\* | 5 | 3% |
| Complaining | 21 | 13% | Invasion of working area\* | 5 | 3% |
| Shouting | 18 | 11% | Insisting\* | 2 | 1% |
| Emotionally distressed | 17 | 10% | Sexual harassment\* | 2 | 1% |
| Not cooperative | 11 | 7% | Annoyed\*\* | 1 | 1% |
| Physically abusive | 11 | 7% | Racist\*\* | 1 | 1% |
| Rude | 9 | 5% | Total | 164 | 100% |
| Spitting\*\* | 6 | 4% |  |  |  |

**NB** \* indicates reported in Veneto only, \*\*indicates reported in Essex only

2 - Results per hospital

Total number of compiled checklist in Essex Hospital is 82. Total number of compiled checklists in Veneto Hospital is 43. Please note that the difference in submitted checklists is probably influenced by the different number of employed nurses despite the similar number of daily accesses.

In this section there are no additional comments as they might influence your perceptions and ideas.

2.1 – Distribution per day

Chart 8 – Distribution per day in Essex

Chart 9 – Distribution per day in Veneto

Table 10 – Distribution per day in both settings

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Essex** | | **Veneto** | |
| **Day** | **Frequency** | **Percent** | **Frequency** | **Percent** |
| Monday | 16 | 20% | 1 | 2% |
| Tuesday | 13 | 16% | 7 | 16% |
| Wednesday | 12 | 15% | 4 | 9% |
| Thursday | 12 | 15% | 6 | 14% |
| Friday | 16 | 20% | 5 | 11% |
| Saturday | 8 | 10% | 13 | 30% |
| Sunday | 3 | 4% | 6 | 14% |
| MISS | 2 | 2% | 2 | 5% |
| Total | 82 | 100% | 44 | 100% |

2.2 – Distribution per shift

Chart 10 – Distribution per shift in Essex

Chart 11 – Distribution per shift Veneto

Table 11 – Distribution per shift in both settings

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Essex** | | **Veneto** | |
| **Shift** | **Frequency** | **Percent** | **Frequency** | **Percent** |
| Morning shift | 25 | 30% | 12 | 27% |
| Afternoon shift | 19 | 23% | 15 | 34% |
| Evening shift | 24 | 29% | 11 | 25% |
| Night shift | 12 | 15% | 4 | 9% |
| MISS | 2 | 2% | 2 | 5% |
| Total | 82 | 100% | 44 | 100% |

2.3 – Perpetrator: Patients versus Companion

Chart 12 – Distribution per users’ role in Essex and Veneto

Table 12 – Perpetrator’s role in both settings

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Essex** | | **Veneto** | |
| **Role** | **Frequency** | **Percent** | **Frequency** | **Percent** |
| Companion | 32 | 39% | 24 | 55% |
| Patient | 50 | 61% | 20 | 45% |
| Total | 82 | 100% | 44 | 100% |

2.4 – Age distribution

Chart 13 – Age distribution in Essex

Chart 14 – Age distribution in Veneto

Tab 13 – Age distribution, Essex and Veneto

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Essex** | | **Veneto** | |
| **Age group** | **Frequency** | **Percent** | **Frequency** | **Percent** |
| <18 | 7 | 9% | 0 | 0% |
| 18 - 25 | 9 | 11% | 1 | 2% |
| 26 - 35 | 20 | 24% | 4 | 9% |
| 36 - 45 | 9 | 11% | 9 | 20% |
| 46 - 55 | 10 | 12% | 19 | 43% |
| 56 - 65 | 13 | 16% | 7 | 16% |
| 66 - 75 | 5 | 6% | 3 | 7% |
| 75+ | 5 | 6% | 1 | 2% |
| MISS | 4 | 5% | 0 | 0% |
| Total | 82 | 100% | 44 | 100% |

2.5 – Distribution per gender

Chart 15 – Distribution per gender in Essex and Veneto

Table 14 – Perpetrators’ gender in Essex and Veneto

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Essex** | | **Veneto** | |
| **Gender** | **Frequency** | **Percent** | **Frequency** | **Percent** |
| Female | 37 | 45% | 17 | 39% |
| Male | 45 | 55% | 26 | 59% |
| MISS | 0 | 0% | 1 | 2% |
| Total | 82 | 100% | 44 | 100% |

2.6 – Security intervention

Chart 16 – Security intervention in Essex

2.7 – Perpetrators descriptions

Table 17 – Descriptions of perceived perpetrators in Essex

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Descriptor** | **Frequency** | **Percent** | **Descriptor** | **Frequency** | **Percent** |
| Body language | 23 | 19% | Race | 5 | 4% |
| Kinship | 22 | 18% | Alcoholic | 2 | 2% |
| Age | 14 | 11% | Convict | 1 | 1% |
| Physical constitution | 12 | 10% | Dirty | 1 | 1% |
| Hair | 11 | 9% | Dress code - negative | 1 | 1% |
| Role | 9 | 7% | Dress code - positive | 1 | 1% |
| Mental health condition | 7 | 6% | Ill | 1 | 1% |
| Dress code | 6 | 5% | In pain | 1 | 1% |
| Error | 5 | 4% | Total | 122 | 100% |

Table 18 – Descriptions of perceived perpetrators in Veneto

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Descriptor** | **Frequency** | **Percent** | **Descriptor** | **Frequency** | **Percent** |
| Physical constitution | 10 | 15% | Dress code | 2 | 3% |
| Kinship | 9 | 14% | Off-duty doctor | 2 | 3% |
| Dress code - negative | 8 | 12% | Dirty | 1 | 2% |
| Dress code - positive | 8 | 12% | Drug addict | 1 | 2% |
| Alcoholic | 7 | 11% | Error | 1 | 2% |
| Mental health condition | 4 | 6% | Homeless | 1 | 2% |
| Race | 4 | 6% | Physical aspect | 1 | 2% |
| Age | 3 | 5% | Smelly | 1 | 2% |
| Body language | 3 | 5% | Total | 66 | 100% |

2.8 – Description of what happened

Table 19 – Descriptors used to picture the unacceptable behaviour experienced or witnessed, Essex.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Descriptor** | **Frequency** | **Percent** | **Descriptor** | **Frequency** | Percent |
| Verbally abusive | 27 | 15% | Rude | 10 | 6% |
| Aggressive attitude | 22 | 12% | Spitting | 6 | 3% |
| Demanding | 22 | 12% | Threatening | 6 | 3% |
| Complaining | 21 | 12% | Swearing | 5 | 3% |
| Shouting | 18 | 10% | Annoyed | 1 | 1% |
| Emotionally distressed | 17 | 10% | Racist | 1 | 1% |
| Physically abusive | 11 | 6% | Total | 177 | 100% |
| Not cooperative | 10 | 6% |  |  |  |

Table 19 – Descriptors used to picture the unacceptable behaviour experienced or witnessed, Veneto.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Descriptor** | **Frequency** | **Percent** | **Descriptor** | **Frequency** | **Percent** |
| Verbally abusive | 16 | 21% | Not cooperative | 6 | 8% |
| Swearing | 12 | 16% | Abuse of power | 5 | 7% |
| Shouting | 10 | 13% | Threatening | 5 | 7% |
| Demanding | 9 | 12% | Emotionally distressed | 4 | 5% |
| Complaining | 9 | 12% | Insisting | 3 | 4% |
| Aggressive attitude | 7 | 9% | Rude | 1 | 1% |
| Physically abusive | 6 | 8% | Sexual harassment | 1 | 1% |
| Invasion of working area | 6 | 8% | Total | 75 | 100% |

# ANNEX III – Full Qualitative Checklist Report

1 – Independent variable: Gender

Table 1.1 – Shift distribution

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Shift** | | | | | | | | | |  | |
| **Gender** | **Night shift** | | **Morning shift** | | **Afternoon shift** | | **Evening shift** | | **MISS** | | **Total** | |
| Female | 7 | 13% | 9 | 17% | 21 | 39% | 16 | 30% | 1 | 2% | 54 | 100% |
| Male | 9 | 13% | 27 | 38% | 13 | 18% | 19 | 27% | 3 | 4% | 71 | 100% |
| MISS | 0 | 0% | 1 | 100% | 0 | 0% | 0 | 0% | 0 | 0% | 1 | 100% |

Table 1.2 – Role distribution

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Role** | | | |  |  |
| **Gender** | **Companion** | | **Patient** | | **Total** | |
| Female | 32 | 59% | 22 | 41% | 54 | 100% |
| Male | 24 | 34% | 47 | 66% | 71 | 100% |
| MISS | 0 | 0% | 1 | 100% | 1 | 100% |

Table 1.3 – Age distribution

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Gender** | | | | | |
| **Age group** | **Female** | | **Male** | | **MISS** | |
| <18 | 2 | 4% | 5 | 7% | 0 | 0% |
| 18 - 25 | 4 | 7% | 6 | 8% | 0 | 0% |
| 26 - 35 | 8 | 15% | 16 | 23% | 0 | 0% |
| 36 - 45 | 10 | 19% | 8 | 11% | 0 | 0% |
| 46 - 55 | 13 | 24% | 16 | 23% | 0 | 0% |
| 56 - 65 | 11 | 20% | 8 | 11% | 1 | 100% |
| 66 - 75 | 1 | 2% | 7 | 10% | 0 | 0% |
| 75+ | 3 | 6% | 3 | 4% | 0 | 0% |
| MISS | 2 | 4% | 2 | 3% | 0 | 0% |
| Total | 54 | 100% | 71 | 100% | 1 | 100% |

Note: Variables inverted for editing purposes

Table 1.4 – Description of the perpetrator

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Gender** | | | |
| **Description** | **Female** | | **Male** | |
| Body language | 15 | 33% | 10 | 13% |
| Ethnicity | 2 | 4% | 7 | 9% |
| Holder of justifiable conditions | 3 | 7% | 10 | 13% |
| Intoxicated | 2 | 4% | 8 | 10% |
| Physical aspect | 12 | 26% | 31 | 39% |
| Social position | 12 | 26% | 14 | 18% |
| Total | 46 | 100% | 80 | 100% |

Note: Variables inverted for editing purposes

Table 1.5 – Type of impropriety

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Gender** | | | | | |
| **Situational impropriety** | **Female** | | **Male** | | **MISS** | |
| Attitudinal | 22 | 18% | 28 | 19% | 0 | 0% |
| Emotional | 13 | 10% | 7 | 5% | 0 | 0% |
| Interactional | 37 | 30% | 37 | 25% | 0 | 0% |
| Physical | 8 | 6% | 20 | 13% | 0 | 0% |
| Verbal | 44 | 35% | 57 | 38% | 2 | 100% |
| Total | 124 | 100% | 149 | 100% | 2 | 100% |

Note: Variables inverted for editing purposes

Table 1.6 – Distribution per security intervention

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Security intervention** | | | | | |  |  |
| **Gender** | **Yes** | | **No** | | **MISS** | | **Total** | |
| Female | 6 | 11% | 45 | 83% | 3 | 6% | 54 | 100% |
| Male | 17 | 24% | 49 | 69% | 5 | 7% | 71 | 100% |
| MISS | 0 | 0% | 1 | 100% | 0 | 0% | 1 | 100% |

2 – Independent variable: Role

Table 2.1 – Distribution per shift

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Shift** | | | | | | | | | |  |  |
| **Role** | **Night shift** | | **Morning shift** | | **Afternoon shift** | | **Evening shift** | | **MISS** | | **Total** | |
| Companion | 4 | 7% | 10 | 18% | 18 | 32% | 21 | 38% | 3 | 5% | 56 | 100% |
| Patient | 12 | 17% | 27 | 39% | 16 | 23% | 14 | 20% | 1 | 1% | 70 | 100% |

Table 2.2 – Distribution per gender

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Gender** | | | | | |  |  |
| **Role** | **Female** | | **Male** | | **MISS** | | **Total** | |
| Companion | 32 | 57% | 24 | 43% | 0 | 0% | 56 | 100% |
| Patient | 22 | 31% | 47 | 67% | 1 | 1% | 70 | 100% |

Table 2.3 – Distribution per Age

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Role** | | | |
| **Age group** | **Companion** | | **Patient** | |
| <18 | 0 | 0% | 7 | 10% |
| 18 - 25 | 2 | 4% | 8 | 11% |
| 26 - 35 | 12 | 21% | 12 | 17% |
| 36 - 45 | 7 | 13% | 11 | 16% |
| 46 - 55 | 18 | 32% | 11 | 16% |
| 56 - 65 | 9 | 16% | 11 | 16% |
| 66 - 75 | 3 | 5% | 5 | 7% |
| 75+ | 3 | 5% | 3 | 4% |
| MISS | 2 | 4% | 2 | 3% |
| Total | 56 | 100% | 70 | 100% |

Note: Variables inverted for editing purposes

Table 2.4 – Description of the perpetrator

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Role** | | | |
| **Description** | **Companion** | | **Patient** | |
| Body language | 13 | 28% | 12 | 15% |
| Ethnicity | 4 | 9% | 5 | 6% |
| Holder of justifiable condition | 3 | 7% | 10 | 13% |
| Intoxicated | 1 | 2% | 9 | 11% |
| Physical aspect | 12 | 26% | 31 | 39% |
| Social position | 13 | 28% | 13 | 16% |
| Total | 46 | 100% | 80 | 100% |

Note: Variables inverted for editing purposes

Table 2.5 – Type of impropriety

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | **Role** | | | |
| **Description** | **Companion** | | **Patient** | |
| Attitudinal | 27 | 21% | 23 | 16% |
| Emotional | 11 | 9% | 9 | 6% |
| Interactional | 42 | 33% | 32 | 22% |
| Physical | 4 | 3% | 24 | 16% |
| Verbal | 45 | 35% | 58 | 40% |
| Total | 129 | 100% | 146 | 100% |

Note: Variables inverted for editing purposes

Table 2.6 – Distribution per security intervention

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Security intervention** | | | | | |  |  |
| **Role** | **Yes** | | **No** | | **MISS** | | **Total** | |
| Companion | 3 | 5% | 48 | 86% | 5 | 9% | 56 | 100% |
| Patient | 20 | 29% | 47 | 67% | 3 | 4% | 70 | 100% |

3 – Independent variable: Age group

Table 3.1 – Distribution per shift

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Shift** | | | | | | | | | |  |  |
| **Age group** | **Night shift** | | **Morning shift** | | **Afternoon shift** | | **Evening shift** | | **MISS** | | **Total** | |
| <18 | 0 | 0% | 5 | 71% | 0 | 0% | 2 | 29% | 0 | 0% | 7 | 100% |
| 18 - 25 | 2 | 20% | 3 | 30% | 4 | 40% | 1 | 10% | 0 | 0% | 10 | 100% |
| 26 - 35 | 5 | 21% | 7 | 29% | 5 | 21% | 5 | 21% | 2 | 8% | 24 | 100% |
| 36 - 45 | 1 | 6% | 5 | 28% | 7 | 39% | 5 | 28% | 0 | 0% | 18 | 100% |
| 46 - 55 | 4 | 14% | 4 | 14% | 6 | 21% | 13 | 45% | 2 | 7% | 29 | 100% |
| 56 - 65 | 1 | 5% | 5 | 25% | 9 | 45% | 5 | 25% | 0 | 0% | 20 | 100% |
| 66 - 75 | 2 | 25% | 4 | 50% | 2 | 25% | 0 | 0% | 0 | 0% | 8 | 100% |
| 75+ | 1 | 17% | 3 | 50% | 0 | 0% | 2 | 33% | 0 | 0% | 6 | 100% |
| MISS | 0 | 0% | 1 | 25% | 1 | 25% | 2 | 50% | 0 | 0% | 4 | 100% |

Note: Variables inverted for editing purposes

Table 3.2 – Role distribution

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | **Role** | | | |  | |
| **Age group** | **Companion** | | **Patient** | | **Total** | |
| <18 | 0 | 0% | 7 | 100% | 7 | 100% |
| 18 - 25 | 2 | 20% | 8 | 80% | 10 | 100% |
| 26 - 35 | 12 | 50% | 12 | 50% | 24 | 100% |
| 36 - 45 | 7 | 39% | 11 | 61% | 18 | 100% |
| 46 - 55 | 18 | 62% | 11 | 38% | 29 | 100% |
| 56 - 65 | 9 | 45% | 11 | 55% | 20 | 100% |
| 66 - 75 | 3 | 38% | 5 | 63% | 8 | 100% |
| 75+ | 3 | 50% | 3 | 50% | 6 | 100% |
| MISS | 2 | 50% | 2 | 50% | 4 | 100% |

Note: Variables inverted for editing purposes

Table 3.3 – Distribution per gender

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Gender** | | | | | |  |  | |
| **Age group** | **Female** | | **Male** | | **MISS** | | **Total** | | |
| <18 | 2 | 29% | 5 | 71% | 0 | 0% | 7 | | 100% |
| 18 - 25 | 4 | 40% | 6 | 60% | 0 | 0% | 10 | | 100% |
| 26 - 35 | 8 | 33% | 16 | 67% | 0 | 0% | 24 | | 100% |
| 36 - 45 | 10 | 56% | 8 | 44% | 0 | 0% | 18 | | 100% |
| 46 - 55 | 13 | 45% | 16 | 55% | 0 | 0% | 29 | | 100% |
| 56 - 65 | 11 | 55% | 8 | 40% | 1 | 5% | 20 | | 100% |
| 66 - 75 | 1 | 13% | 7 | 88% | 0 | 0% | 8 | | 100% |
| 75+ | 3 | 50% | 3 | 50% | 0 | 0% | 6 | | 100% |
| MISS | 2 | 50% | 2 | 50% | 0 | 0% | 4 | | 100% |

Note: Variables inverted for editing purposes

Table 3.4 – Description of the perpetrator

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Description** | | | | | | | | | | | |  |  |
| **Age group** | **Body language** | | **Ethnicity** | | **Holder of justifiable condition** | | **Intoxicated** | | **Physical aspect** | | **Social position** | | **Total** | |
| <18 | 2 | 100% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 0 | 0% | 2 | 100% |
| 18 - 25 | 1 | 10% | 2 | 20% | 2 | 20% | 0 | 0% | 4 | 40% | 1 | 10% | 10 | 100% |
| 26 - 35 | 7 | 24% | 3 | 10% | 0 | 0% | 3 | 10% | 13 | 45% | 3 | 10% | 29 | 100% |
| 36 - 45 | 4 | 24% | 1 | 6% | 1 | 6% | 2 | 12% | 6 | 35% | 3 | 18% | 17 | 100% |
| 46 - 55 | 4 | 10% | 3 | 8% | 4 | 10% | 5 | 13% | 11 | 28% | 12 | 31% | 39 | 100% |
| 56 - 65 | 2 | 14% | 0 | 0% | 3 | 21% | 0 | 0% | 4 | 29% | 5 | 36% | 14 | 100% |
| 66 - 75 | 1 | 14% | 0 | 0% | 1 | 14% | 0 | 0% | 3 | 43% | 2 | 29% | 7 | 100% |
| 75+ | 4 | 67% | 0 | 0% | 1 | 17% | 0 | 0% | 1 | 17% | 0 | 0% | 6 | 100% |
| MISS | 0 | 0% | 0 | 0% | 1 | 50% | 0 | 0% | 1 | 50% | 0 | 0% | 2 | 100% |

Note: Variables inverted for editing purposes

Table 3.5 – Type of impropriety

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Type of impropriety** | | | | | | | | | |  |  |
| **Age group** | **Attitudinal** | | **Emotional** | | **Interactional** | | **Physical** | | **Verbal** | | **Total** | |
| <18 | 0 | 0% | 0 | 0% | 1 | 8% | 11 | 85% | 1 | 8% | 13 | 100% |
| 18 - 25 | 4 | 21% | 1 | 5% | 6 | 32% | 3 | 16% | 5 | 26% | 19 | 100% |
| 26 - 35 | 11 | 21% | 6 | 12% | 12 | 23% | 1 | 2% | 22 | 42% | 52 | 100% |
| 36 - 45 | 11 | 25% | 3 | 7% | 13 | 30% | 1 | 2% | 16 | 36% | 44 | 100% |
| 46 - 55 | 14 | 23% | 2 | 3% | 19 | 31% | 8 | 13% | 19 | 31% | 62 | 100% |
| 56 - 65 | 9 | 19% | 2 | 4% | 13 | 28% | 2 | 4% | 21 | 45% | 47 | 100% |
| 66 - 75 | 0 | 0% | 2 | 12% | 2 | 12% | 1 | 6% | 12 | 71% | 17 | 100% |
| 75+ | 1 | 7% | 3 | 21% | 5 | 36% | 1 | 7% | 4 | 29% | 14 | 100% |
| MISS | 0 | 0% | 1 | 14% | 3 | 43% | 0 | 0% | 3 | 43% | 7 | 100% |

Note: Variables inverted for editing purposes

Table 3.6 – Distribution per security intervention

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Security intervention** | | | | | |  |  |
| **Age group** | **Yes** | | **No** | | **MISS** | | **Total** | |
| <18 | 1 | 14% | 6 | 86% | 0 | 0% | 7 | 100% |
| 18 - 25 | 4 | 40% | 6 | 60% | 0 | 0% | 10 | 100% |
| 26 - 35 | 6 | 25% | 17 | 71% | 1 | 4% | 24 | 100% |
| 36 - 45 | 3 | 17% | 13 | 72% | 2 | 11% | 18 | 100% |
| 46 - 55 | 5 | 17% | 23 | 79% | 1 | 3% | 29 | 100% |
| 56 - 65 | 1 | 5% | 17 | 85% | 2 | 10% | 20 | 100% |
| 66 - 75 | 2 | 25% | 6 | 75% | 0 | 0% | 8 | 100% |
| 75+ | 1 | 17% | 5 | 83% | 0 | 0% | 6 | 100% |
| MISS | 0 | 0% | 2 | 50% | 2 | 50% | 4 | 100% |

4 – Independent variable: Description of the perpetrator

Table 4.1 – Type of impropriety

|  |  |  |  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | **Type of impropriety** | | | | | | | | | |  |  |
| **Descriptor** | **Attitudinal** | | **Emotional** | | **Interactional** | | **Physical** | | **Verbal** | | **Total** | |
| Body language | 20 | 34% | 9 | 16% | 12 | 21% | 7 | 12% | 10 | 17% | 58 | 100% |
| Ethnicity | 8 | 40% | 0 | 0% | 5 | 25% | 3 | 15% | 4 | 20% | 20 | 100% |
| Holder of justifiable condition | 5 | 17% | 1 | 3% | 7 | 24% | 5 | 17% | 11 | 38% | 29 | 100% |
| Intoxicated | 4 | 20% | 1 | 5% | 0 | 0% | 6 | 30% | 9 | 45% | 20 | 100% |
| Physical aspect | 18 | 26% | 3 | 4% | 22 | 31% | 4 | 6% | 23 | 33% | 70 | 100% |
| Social position | 20 | 32% | 2 | 3% | 14 | 23% | 3 | 5% | 23 | 37% | 62 | 100% |

# ANNEX IV – Participant Information Sheet – General (Essex)

**Participant** **Information Sheet – Check-list**

**Section A: The Research Project**

1. **Title of project**

A comparative, transnational case study comparing staff experience in dealing with perceived situational improprieties as aggression, incivility and anti-social behaviour in two emergency care settings

1. **Purpose and value of study**

The research will be an investigation on how staff from the Emergency Departments of [ESSEX] and of [VENETO] describe improper behaviours (as rudeness, harassment or anti-social behaviour) from patients and their companions, and how they cope and deal with these.

The main aims of the research are to investigate how staff perceives situational improprieties; how staff develops informal strategies to deal with them and which are the main differences between two culturally similar European settings. This qualitative check-list will help the researcher to understand what staff members perceive as improper behaviours or attitudes, which are their most relevant characteristics of them and of their perpetrator, and which words are used to describe them.

1. **Invitation to participate**

You are invited to take part in this work in order to share with us your experiences with improper behaviours (like rudeness, harassment, abuse, violence or anti-social behaviour).

Engaging in the research is entirely voluntary.

1. **Who is organising the research?**

The study is being conducted by Mr. Lorenzo Gangitano, a doctoral research student at Anglia Ruskin University, and is being supervised by Prof. Stephen Moore and Dr. Sarah Burch who are both members of academic staff in the Postgraduate Medical Institute (PMI) in Anglia Ruskin University. The research is implemented thanks to the cooperation of [ESSEX] Hospital and Azienda Ospedaliera [VENETO].

1. **What will happen to me if I take part**

You will be asked to complete anonymous qualitative check-lists reporting information on improper behaviour of patients and/or their companions in which you are involved in or you witnessed. You will not be asked to compile the whole check-list but you will be free to answer only to those question you believe are relevant. However, the average time to compile a check-list is less than two minutes.

At the end of your shift you will be asked to drop your compiled check-lists in a sealed ballot box placed in the staff room

You will be involved in this research for a total of 18 days in a period of three months. This research will not interfere with your usual job duties.

The researcher will not interfere with you during your working time; he will not influence your normal workday; he will not interfere with the normal activities of the Emergency Department; and any contacts will have place via e-mail or before/at the end of your shift.

Please remember:

* By completing and dropping a check-list you will be agreeing to participate to this activity.
* Check-lists are completely anonymous, no one will be able to read the contents of your compiled check-lists nor to link a compiled check-list with you. Confidentiality is guaranteed.
* The total time you will be involved in this activity depends on the number of check-lists you will complete. With an estimate of one check-list per day you will be directly involved in this research for 36 minutes in a time frame of three months

1. **What will happen to the results of the study?**

Anonymous compiled check-lists will be analysed for Ph.D. purposes only, exploring differences in the two care settings.

At the end of the study you, as participant, will receive a brief summary of the research results and your hospital will receive a more extended presentation of the final results.

1. **Source of funding for the research**

This research is founded by a research student bursary awarded by Anglia Ruskin University

1. **Contact for further information:**

If you have any questions or would like any further information about this project, please contact the researcher, Lorenzo Gangitano, by e-mail [lorenzo.gangitano@student.anglia.ac.uk](mailto:lorenzo.gangitano@student.anglia.ac.uk) or by regular post to Helmore building 308, East Road, CB1 1PT, Cambridge, UK

Supervisor:

Prof. Stephen Moore, Anglia Ruskin University

E-mail: [stephen.moore@anglia.ac.uk](mailto:stephen.moore@anglia.ac.uk)

Dr. Sarah Burch, Anglia Ruskin University

E-mail: [sarah.burch@anglia.ac.uk](mailto:sarah.burch@anglia.ac.uk)

Your internal contact during the whole research period will be

[NAME SURNAME], Clinical Research Unit Manager, Tel. [REMOVED]

E-mail:

[NAME SURNAME], Research Nurse, Tel. [REMOVED]

E-mail:

**Section B: Your Participation in the Research Project**

1. **Why you have been invited to take part**

This research aims to understand how staff in Emergency Departments perceive, deal and cope with improper behaviours (as rudeness, anti-social behaviour or harassment) from patients or from their companions. You are invited because you are a staff member of the Emergency Department of [ESSEX] Hospital.

1. **Whether you can refuse to take part**

Participation in the study is entirely optional – you can choose not to participate.

1. **Whether you can withdraw at any time, and how**

You can decide to withdraw from the study at any time without giving any explanation of your motivations, simply do not compile any check-list.

Please note: if you decide to withdraw from the study, due to check-list anonymity, it will not be possible to identify your check-lists and delete them. Therefore, dropped check-list will not be destroyed and will remain part of the data collection.

1. **Whether there are any risks involved and if so what will be done to ensure your well-being**

In order to prevent additional burdens

- Check-lists require two minutes to be compiled and could be compiled in the same place where the impropriety occurs (without leaving your work position) or at the end of your shift.

- Check-lists delivery and collection of not used check-lists will occur at the begin and at the end of your shift, avoiding absence from the workplace.

- Check-lists can be kept in a pocket of your coat/uniform, you do not have to go back to the staff room to take additional check-lists.

**Possible risks:**

- During this activity you may experience distress or discomfort because you could not have the time to compile them properly.

Is not necessary to compile them in all their parts, you are free to answer only to those question you consider relevant. As example, if you forget at what time the “fact” happened leave that question blank or give a general time window (i.e. morning shift, 2am-8am).

- During the compiling procedures you may experience distress due to the information reported.

This activity could address some sensitive issues so there is a potential risk of emotional harm. Please remember you are free to compile as many check-lists as you wish and check-lists could be partially compiled avoiding questions that may result too sensitive. Please remember that you can cease your participation at any time if you feel distressed.

1. **In the unlikely event that something should go wrong, agreement to participate in this research should not compromise your legal rights**

You could contact the research supervisory team for any concerns or complains you might have using the following contact details:

Prof. Stephen Moore email: [stephen.moore@anglia.ac.uk](mailto:stephen.moore@anglia.ac.uk)

Dr. Sarah Burch email: [sarah.burch@anglia.ac.uk](mailto:sarah.burch@anglia.ac.uk)

1. **What will happen to any information/data/samples that are collected from you**

Compiled check-list will be analysed by Mr. Lorenzo Gangitano only. He will transcribe your answers in password protected laptops or computers belonging to Anglia Ruskin University. Whereas original check-lists will be stored in secure locked filing cabinet placed in an Anglia Ruskin University building. The respect of the Data Protection Act (1998) is guaranteed.

1. **Whether there are any benefits from taking part**

This specific topic has been rarely investigated starting from what staff members perceive as improper. Also, informal strategies of coping and dealing with improper behaviours are often missing from academic studies. Taking part in this research you will help the researcher to investigate gaps in academic knowledge, promoting researches and policies that could ameliorate and improve your work condition

1. **How your participation in the project will be kept confidential**

Confidentiality is guaranteed. In writing the final thesis the names will be coded and the hospital will be referred to by a pseudonym.

Check-list are completely anonymous and inserted check-lists cannot be pulled out from the sealed ballot box.

All collected data will be stored safely.

Anonymity, confidentiality and privacy are not guaranteed if

- participants express the intent to harm themselves or others;

- illegal activities by participants come to light;

- unethical practice is revealed by staff working at organisations where the research is being carried out.

In these cases the researcher will evaluate the situation in consideration of the Serious Crime Act (2007) and he will decide, together with his supervisors, if to report the fact to a designed authority.

# ANNEX V – Participant Information Sheet – Interview (Essex)

Participant Information Sheet – Interview

**Section A: The Research Project**

1. **Title of project**

A comparative, transnational case study comparing staff experience in dealing with perceived situational improprieties as aggression, incivility and anti-social behaviour in two emergency care settings

1. **Purpose and value of study**

The research will be an investigation on how staff from the Emergency Departments of [ESSEX] and of [VENETO] describe improper behaviours (as rudeness, harassment or anti-social behaviour) from patients and their companions, and how they cope and deal with these.

The main aims of the research are to investigate how staff perceives situational improprieties; how staff develops informal strategies to deal with them and which are the main differences between two culturally similar European settings. This qualitative check-list will help the researcher to understand what staff members perceive as improper behaviours or attitudes, which are their most relevant characteristics of them and of their perpetrator, and which words are used to describe them.

1. **Invitation to participate**

You are invited to take part in this work in order to share with us your experiences with improper behaviours (like rudeness, harassment, abuse, violence or anti-social behaviour).

Engaging in the research is entirely voluntary.

1. **Who is organising the research?**

The study is being conducted by Mr. Lorenzo Gangitano, a doctoral research student at Anglia Ruskin University, and is being supervised by Prof. Stephen Moore and Dr. Sarah Burch who are both members of academic staff in the Postgraduate Medical Institute (PMI) in Anglia Ruskin University. The research is implemented thanks to the cooperation of [ESSEX] Hospital and Azienda Ospedaliera [VENETO].

1. **What will happen to me if I take part?**

You will be asked to participate to a 40-minutes interview, over a period of three months, concerning your experience with experienced or witnessed improper behaviours from patients and/or their companions; questions will be based on the analysis of compiled check-lists.

Interviews will take place on hospital premises, in a separate room close to the ED chosen with peculiar characteristics in order to guarantee you confidentiality. The interview day will be agreed according to your availability. The researcher will contact you using the contacts detail you can write in your consent form.

The interview will last approximately 40 minutes, will be digitally recorded and will be conducted by the researcher as follow:

* he will briefly recall your rights as participant and the aims of the interview;
* a standard initial set of questions will introduce a more conversational style interview;
* at the end of the interview the researcher will thank you, asking if you are willing to confirm your answers. If you confirm the interview will be saved, anonymised and transcribed.

Please note: You may be invited to a follow-up interview in order to investigate the most interesting topics arose during the first set of interviews. This second interview will be organised as the previous one but with different questions. As before, a suitable date will be verbally agreed between you and the researcher. Showing up at the agreed meeting you will confirm your consent to participate at a follow-up interview.

You are free to participate in first interview only.

The researcher will not interfere with your working time; the research will not influence your normal workday; the researcher will not interfere with the normal activities of the Emergency Department.

IMPORTANT: If more than twenty staff members will agree to be interviewed, the researcher will randomly select from ten to twenty participants among those who will return their Informed Consent (the same procedure will be applied to select participants for follow-up interviews). Therefore, even returning the dedicate consent attached to this Participant Information Sheet you may not be selected and invited for an interview.

1. **What will happen to the results of the study?**

Anonymised interviews transcription will be analysed for Ph.D. purposes only, exploring differences in the two care settings.

At the end of the study you, as participant, will receive a brief summary of the research results and your hospital will receive a more extended presentation of the final results.

1. **Source of funding for the research**

This research is founded by a research student bursary awarded by Anglia Ruskin University

1. **Contact for further information:**

If you have any questions or would like any further information about this project, please contact the researcher, Lorenzo Gangitano, by e-mail [lorenzo.gangitano@student.anglia.ac.uk](mailto:lorenzo.gangitano@student.anglia.ac.uk)

Supervisor:

Prof. Stephen Moore, Anglia Ruskin University

E-mail: [stephen.moore@anglia.ac.uk](mailto:stephen.moore@anglia.ac.uk)

Dr. Sarah Burch, Anglia Ruskin University

E-mail: [sarah.burch@anglia.ac.uk](mailto:sarah.burch@anglia.ac.uk)

Your internal contact during the whole research period will be

Ms [NAME] [SURNAME], Clinical Research Unit Manager, Tel. [REMVOED]

E-mail: [removed]

Ms [NAME] [SURNAME], Research Nurse, Tel. [REMOVED]

E-mail: [removed]

**Section B: Your Participation in the Research Project**

1. **Why you have been invited to take part**

This research aims to understand how Emergency Department staff perceive, deal and cope with improper behaviours (as rudeness, anti-social behaviour or harassment) from patients or their companions. You are invited because you are a staff member of the Emergency Department of [ESSEX] Hospital.

1. **Whether you can refuse to take part**

Participation in the study is entirely optional – you can choose not to participate

1. **Whether you can withdraw at any time, and how**

You can decide to withdraw from the study at any time without giving any explanation of your motivations. You can speak directly with the researcher or complete the withdraw part of your consent form, dropping it in the ballot box placed in the staff room.

Please note: any interviewee detail will be deleted, recorded interview and their transcriptions will be made anonymous. Therefore, once you will confirm your answers at the end of the interview, will not be possible to know which interview belongs to you: therefore confirmed interviews cannot be deleted or amended.

1. **Whether there are any risks involved and if so what will be done to ensure your well-being**

In order to avoid you additional burdens

- Interviews will take place during shifts statistically recognised as calm, otherwise, according to your availability, before or at the end of your shift.

Possible risks:

- During interview you may experience harm or emotional well-being due the information reported.

The researcher will be mindful that discussing the uncivil behaviour of patients or companions may cause you to become upset. Please remember that you are free to do not answer to questions you consider improper or intrusive. If you should experience emotional well-being the researcher will stop the interview encouraging you to seek help from the support service available through your employer. The researcher will leave the room giving you the necessary privacy.

- You may disclose confidential information about patients or staff which could harm the professional role of other participants.

During the first phase the researcher will remind you to do not disclose information which could breach confidentiality of patients or other staff members. Accidental statements and/or comments that could harm patients' or other staff members' privacy will not be considered and removed during the transcription process.

- You may be called back to your workplace during the activity.

The meeting day will be agreed in consideration of your job commitment. If, for any reason, you should be called back to your work position the interview will cease immediately and a new suitable date will be identified.

- If, for any reason, you may feel that interview confidentiality is not guaranteed the interview will cease and a different day or a different room will be agreed, whether possible.

In the unlikely event that something should go wrong, agreement to participate in this research should not compromise your legal rights

You could contact the research supervisory team for any concerns or complains you might have using the following contact details:

Prof. Stephen Moore email: [stephen.moore@anglia.ac.uk](mailto:stephen.moore@anglia.ac.uk)

Dr. Sarah Burch email: [sarah.burch@anglia.ac.uk](mailto:sarah.burch@anglia.ac.uk)

1. **What will happen to any information that are collected from you**

Recorded interviews will be transcribed and analysed by Mr. Lorenzo Gangitano only, he will transcribe your answers in password protected laptops or computers belonging to Anglia Ruskin University. Original records will be stored in password protected laptop or computers property of Anglia Ruskin University. The respect of the Data Protection Act (1998) is guaranteed.

1. **Whether there are any benefits from taking part**

This specific topic has been rarely investigated starting from what staff members perceive as improper. Also informal strategies of coping and dealing with improper behaviours are often missing from academic studies. Taking part in this research you will help the researcher to investigate gaps in academic production knowledge, promoting researches and policies that could ameliorate and improve your work condition.

1. **How your participation in the project will be kept confidential**

Confidentiality is guaranteed. In writing the final thesis the names will be coded and the hospital will be referred to by a pseudonym

Any details could lead to your identification as interviewee will be deleted and pseudonyms will be used.

All collected data (including names and contact details) will be stored safely.

Anonymity, confidentiality and privacy are not guaranteed if

- participants express the intent to harm themselves or others;

- illegal activities by participants come to light;

- unethical practice is revealed by staff working at organisations where the research is being carried out.

In these cases the researcher will evaluate the situation in consideration of the Serious Crime Act (2007) and he will decide, together with his supervisors, if report the fact to the designed authority.

PLEASE KEEP THIS TOGETHER WITH YOUR COPY OF THE CONSENT FORM

1. “All places where workers need to be or to go by reason of their work and which are under the direct or indirect control of the employer” (Ibid, p.5). [↑](#footnote-ref-1)
2. ‘… an image of self delineated in terms of approved social attribute*’*” (Goffman, 1967, p.5) It is the self’s representation of the interpreted role. Once it is lost the actor lose credibility and is labelled as deviant. [↑](#footnote-ref-2)
3. From this section on I will no longer use Goffman’s concept of primary framework as those authors who further developed Goffman’s social theory – among which Ensink – prefer the term frame. However, to be precise, primary social framework are social frames that enjoy full social validity – make sense – as they are, thus without requiring keying activity. Example of this is the cardiac massage. [↑](#footnote-ref-3)
4. Literally general doctors [↑](#footnote-ref-4)
5. Literally immediate care [↑](#footnote-ref-5)
6. Nel senso... è capitato anche ieri ... boh .. io sono ... io faccio la parte sala emergenze .. son qua da una vita .. c’è da togliere una stecco-benda .. che serve per immobilizzare un ginocchio .. no? .. chi meglio di me lo sa fare? ... se fosse mio padre .. mia madre o mio fratello o chiunque ... lo farei fare a uno come me .. la signora voleva il medico .. il medico sta roba qua non sapeva neanche come ... come si fa a toglierlo ... cioè per dire la percezione è questa ... però anche in questo caso capisco che è che è sbagliato il mio comportamento ... nel senso che .. dopo mi rendo conto che la persona vede nel medico ... la figura del pronto soccorso .. ma è anche giusto .. che è quella che ti deve dare delle risposte ... ma è anche giusto .. hai capito? ... ma nell’immaginario funziona così [↑](#footnote-ref-6)
7. No ... uno .. il fatto che quando io entro qua dentro ... ovviamente cambi personalità in un certo senso ... cioè porti una divisa quindi non sono più [NOME] fuori ma sono [NOME] che lavora ... e quindi ... scindo ... Nel senso .. questa non è la mia vita .. è il mio lavoro ... la mia vita sta fuori ... e quindi io [RIDE] arrivo già con una personalità diversa [↑](#footnote-ref-7)
8. Sì .. sì ... diciamo che c’è chi cerca di essere più diplomatico .. io no ... sì .. anche quella è un’arte ... nel senso che devi mantenere sempre la calma ... io a volte riesco a mantenerla .. a volte meno ... nel senso che io magari ... tendo ad essere un pochino più aggressiva .. ecco ... però ... ci sono dei miei colleghi che ci riescono molto bene ... cioè riescono quasi a far vergognare questa persona .. di quello che ha fatto [↑](#footnote-ref-8)
9. Io ... una cosa che ho potuto notare è che quando ci sono determinate persone ... all'accettazione ... e ... puntualmente .. ogni giorno c'è .. una discussione .. c’è una aggressione ... quindi vuol dire che dipende anche da come ti sai giocare ... [↑](#footnote-ref-9)
10. E ... allora ho visto usare tante strategie dell ... dell’accondiscendenza ... cioè ... un parente .. o un paziente dice “voglio essere visto prima degli altri perché sto male e non e tu non capisci niente” e loro dicono “ok” ... questo non va bene secondo me ... oppure ... ho visto estremi opposti .. cioè proprio perché mi hai insultato ... ti dico “guarda che ti aspetto fuori” .. cioè ... vieni dentro che ne parliamo e poi ... scatta magari anche un po’ la minaccia [↑](#footnote-ref-10)
11. Per un bambino ... si ha sempre un occhio ... po’ più di riguardo [↑](#footnote-ref-11)
12. Io sinceramente ... dipende .. dall’anziano che magari ha l’Alzheimer lo posso accettare ... nel senso che ... lo contestualizzo nella sua malattia ... dalla psichiatrica che magari è sotto effetto di sostanze stupefacenti .. non lo accetto comunque ... anche se lo prendo ... Io ho la prova qua .. tra l’altro .. di una ragazza che mi ha strappato la maglietta coi denti ... questa qui [indicando lo strappo] ... lei era stesa sul letto .. io dovevo metterle una flebo .. prenderle una vena .. così ... e lei è saltata su con la faccia e mi ha strappato la maglietta ... si .. e lì per fortuna c’era il poliziotto che mi ha fermato a me ... perché li ... io stavo per reagire ... non ho accettato quel comportamento li .. capito? .. poi arrivi anche un po’ ... sei un po’ intoll ... insofferente .. capito? [↑](#footnote-ref-12)
13. Allora .. a me l’etilista dà fastidio… a me l’etilista ... se potessi ... va ben ... perché sono .. veramente ... cioè una cosa, da gestire ... difficilissima … ti devi prendere le parole, e sai ... dici “Ma sì .. è ubriaco” e va ben .. però intanto … dopo ritornano .. sono sempre quelli .. e sono veramente ... da gestire .. tra i peggiori. [↑](#footnote-ref-13)
14. Secondo me manca proprio ... proprio l’educazione .. e ma ... lo vedo nelle persone più giovani .. proprio la base .. cioè il rispetto del lavoro degli altri ... secondo me manca proprio di fondo la pazienza insomma .. di aspettare dappertutto ... insomma .. è così ... se non ti va bene ... oh ... tante volte .. si pensa che tutto è dovuto ... non è così ... [↑](#footnote-ref-14)
15. Partiamo dal presupposto che qua l’utente viene pretendendo ... la maggior parte delle persone viene pretendendo ... loro ... soprattutto perché è un ospedale anche pubblico ... loro vengono qua e pretendono .. cioè ... cavolata ... “io pago le tasse ... Tu” .. tra l’altro .. “sei uno statale” .. cosa che noi non le paghiamo le tasse naturalmente “tu sei uno statale per cui io ti sto finanziando .. quindi pretendo che tu fai questo .. questo e questo” ... tante gente si presenta dicendo già cosa vuole fare "Io sono qua perché voglio i raggi .. l’ECG .. la visita cardiologica" ... Si beh ... tutti i giorni [↑](#footnote-ref-15)
16. Certo .. ognuno deve capire che chi ha di fronte è persona che ha studiato ... ma .. ripeto .. anch’io se vado dal carrozziere .. è il suo mestiere e mi fido di lui ... non sono certo io a dirglielo … a meno che non siano delle robe palesi ... però .. manca questa questione del rispetto della cultura degli altri ... se siamo messi qui e perché abbiamo fatto un percorso di studi .. qualcuno ci ha valutato e ha stabilito che possiamo fare questo mestiere ... non sei tu fuori a dirmi cosa devo o non devo fare perché io non vengo a casa tua a dirti cosa devi o non devi fare [↑](#footnote-ref-16)
17. Esatto ... "Si fermi per me" e soprattutto "gli altri non sono nessuno rispetto a me" .. perché è capitato fuori .. “io ho più male di quello lì”... questi discorsi ... e ti dicono “tu non capisci niente perché io urlo e ho male .. quello sta zitto e non ha male” ... invece quello che sta zitto forse l'è anca diverso .. non gha neanche il fià [↑](#footnote-ref-17)
18. Un altro .. cos’è stato ... qualche tempo fa .. era li che si faceva le fotocopie mentre aspettava ... si .. si .. si c’è la fotocopiatrice ed era li che si faceva le fotocopie e gl’abbiamo detto “cosa sta facendo?” ... “Una fotocopia tanto questo è un ospedale pubblico e io le tasse le pago” ... per dire ... per cui .. la gente arriva pretendendo ... tu ridi ma è vero [ride] [↑](#footnote-ref-18)
19. Si .. ma ne ho uno di tre giorni fa ... Non c’era più la scatoletta ma ... io non ero direttamente coinvolto ... perché ho evitato ... vabbè ... [el] ghavea na faccia .. no da delinquente .. di più ... il mio collega si è approcciato .. gli ha detto “guardi .. le dico solo ...” “No .. io qua .. chiamami qua .. chiamami la .. chiamami su .. non me ne frega niente .. chiamami il direttore” “Ma è una legge per tutti .. è una regola per tutti” “Non me ne frega niente...” [↑](#footnote-ref-19)
20. […]Anche perché ripeto .. **lo** farei [causa, TN] ma non ne ho voglia .. perché non **mi** sento ... tutelato dall’inizio .. cioè da un’azienda .. a livello legale .. a livello di poliziotti [...] [↑](#footnote-ref-20)
21. [...] Ok .. ho fatto la denuncia ma poi alla fine erano ... sotto sostanze stupefacenti e ... senza fissa dimora .. magari psichiatrici o simili ... cioè e non succede nulla [risata nervosa, TN] ... puoi far denuncia ma ... viene segnalato e basta [↑](#footnote-ref-21)
22. Poi secondo me c’è anche da dire una cosa .. non duri a lungo in un Pronto Soccorso [...] secondo me il problema fondamentale è che non sanno cosa li aspetti ... per cui ... è molto più tesa e molto più maleducata [...] quando sei in reparto .. siccome sanno già la diagnosi .. sanno già come andrà avanti l’evolversi della cosa .. si presentano con le pastine [...] è perché la sono più tranquilli ... e ... e fanno l’iter ... qua .. poveretti ... qua c’è il panico iniziale […] [↑](#footnote-ref-22)
23. A me non piace la figura dell’infermiere in reparto ... secondo me .. son due cose proprio diverse ... Sì siamo colleghi ... penso che se qualcuno mi sentisse dire questa frase qui mi ... probabilmente mi appende al muro ... però secondo me c’è una formazione completamente diversa ... qui c’è molta più autonomia per quanto il livello ... è sotto il medico [↑](#footnote-ref-23)
24. Ho un riscontro sia a livello ... come dicevo di certe persone che andiamo via che mi stringono la mano .. e quello può essere anche in altri reparti benissimo ... ho un riscontro anche da dire .. a livello di urgenza che è momento critico .. dire che ho tirato fuori dalle peste qualcuno .. ho contribuito almeno a dargli una chance in più .. dopo che ... l’esito sia quello che dev’essere .. ma intanto ho contribuito a un qualcosa. [↑](#footnote-ref-24)
25. Esatto ... "si fermi per me" e soprattutto "gli altri non sono nessuno rispetto a me" .. perché è capitato fuori .. “io ho più male di quello lì”... questi discorsi ... e ti dicono “tu non capisci niente perché io urlo e ho male .. quello sta zitto e non ha male” ... invece quello che sta zitto forse l'è anca diverso .. no’l gha neanche il fià [↑](#footnote-ref-25)
26. Secondo me la maggior parte delle cose che noi viviamo male è proprio per l’atteggiamento con cui vengono a chiederti le cose ... o la presunzione di dire “Io sono qua .. è mio diritto sapere…” ... è giusto che sia così .. però c’è modo e modo. [↑](#footnote-ref-26)
27. Secondo **me** è inaccettabile ... il discorso saltare delle gerarchie attribuite ... nel senso di che **delle volte** .. si va direttamente dal medico quando è un problema che posso risolvere **io** benissimo ... che **tante volte** il medico non sa ... però c’è questa figura medica .. c’è ancora 'el dotor' che viene identificato .. che dopo alla fine **ti** gira a **te** ... e allora dici ... “adesso **te** torni da **mi**” ... hai capito?” [↑](#footnote-ref-27)
28. [...] l’infermiere è ancora visto secondo me come 'padella e pulisci'. Lo dice il medico, lo dice ... le stesse cose le dico io, non valgono niente, le stesse cose le dice il medico e vanno via dicendo “Grazie, buongiorno, etc.” [...]. [↑](#footnote-ref-28)
29. Un altro .. cos’è stato ... qualche tempo fa .. era li che si faceva le fotocopie mentre aspettava ... si .. si .. si c’è la fotocopiatrice ed era li che si faceva le fotocopie e gl’abbiamo detto “cosa sta facendo?” ... “Una fotocopia tanto questo è un ospedale pubblico e io le tasse le pago” ... per dire ... per cui .. la gente arriva pretendendo ... tu ridi ma è vero [ride] [↑](#footnote-ref-29)
30. Cioè .. anche tanti .. magari medici .. che ... non lavorano qui .. ma magari lavorano in altre strutture .. pretendono di parlare con i colleghi quando arrivano da noi ... in realtà non funziona così ... o pretendono di entrare subito ... o pretendono ... ecco ... magari ancora prima di dirti cos’hanno .. ti fanno vedere il cartellino ... che sono dei medici .. che sono avvocati… magari .. che pensano magari di intimorirti… o che magari gli apri la porta ... hai capito? [↑](#footnote-ref-30)
31. A me una roba che dà tantissimo fastidio .. che proprio sai .. che tu ... [...] quando mi bussano al vetro ... se fossi da un'altra parte .. questo non mi darebbe fastidio magari .. vedi? ... ci sono cose che fuori mi danno più fastidio e cose meno. [↑](#footnote-ref-31)
32. No ... uno .. il fatto che quando io entro qua dentro ...ovviamente cambi personalità in un certo senso ... cioè porti una divisa quindi non sono più [nome] fuori ma sono [nome] che lavora ... e quindi ... scindo ... nel senso .. questa non è la mia vita .. è il mio lavoro ... la mia vita sta fuori ... e quindi io [ride] arrivo già con una personalità diversa [↑](#footnote-ref-32)
33. Allora .. a me l’etilista dà fastidio… a me l’etilista ... se potessi ... va ben ... perché sono .. veramente ... cioè una cosa .. da gestire ... difficilissima … ti devi prendere le parole .. e sai ... dici “Ma sì .. è ubriaco” e va ben .. però intanto … dopo ritornano .. sono sempre quelli .. e sono veramente ... da gestire .. tra i peggiori [↑](#footnote-ref-33)
34. I: Invece un atto .. un’accusa che arriva da un paziente malato di Alzheimer…

    VEN7: No .. niente ... m’hanno anche picchiata ma ... si .. no no .. lì ci passo proprio sopra .. è la malattia .. non è più lui .. è la malattia [↑](#footnote-ref-34)
35. Infatti .. è quello che volevo dire ... che alla fine però è un po’ ... anche un po’ ... parlo di me .. colpa mia ... perché io mi aspetto ... anche mi creo delle aspettative sulle persone ... e quindi magari dopo ci rimango ... ci rimango un po’ così se non reagiscono come poi io mi aspetto ... comunque è vero ... soprattutto familiari .. in triage .. familiari che li vedi che sono distinti .. sono i primi che ... sbottano e ... mancano di rispetto [↑](#footnote-ref-35)
36. E ... secondo me .. allora .. la persona che si approccia con più arroganza sono ... i sanitari ... in assoluto .. medici e colleghi ... quelli sono ... perché se uno mi arriva e mi dice “salve .. sono un medico” io gli dico subito .. perché adesso c’è l’ho pronta la parola .. “mi dispiace .. è un brutto problema ... Non so se riusciremo a curarla” ... no .. era perché ... cioè io mi presento .. vengo da te ... e ti dico “ciao eh ...” non so che lavoro farai domani .. però ... cioè ... non è che io ti do la corsia preferenziale perché sei medico ... non mi serve la tua professione ... e invece ci sono persone… secondo me sono quelle ... e allora pretendono molto di più quelle [↑](#footnote-ref-36)
37. Uno psichiatrico lo capisco .. puoi farmi quello che vuoi .. ma poi non è che ... un demente che ... un Alzheimer ed è anziano puoi fare quello che vuoi ... cioè cosa c’entra poverino? .. Non è colpa sua ... ‘na persona anziana e lucida che ne approfitta perché dice “sono anziano” .. ecco quello non lo capisco ... perché sei lucido lo stesso. [↑](#footnote-ref-37)
38. Sicuramente diciamo che non c’è il tempo .. e se dovessi arrabbiarmi con un bacino d’utenza così vario .. io vado a casa dopo quel giorno e mi trapiantano il fegato ... [↑](#footnote-ref-38)
39. Quella era talmente fuori… ma ero appena arrivata ... prima ero in terapia intensiva ed era diverso ... in ambulanza ho lavorato tanto su queste cose .. però erano i primi anni ... ero qua da pochissimo … ma no ma li in realtà ho visto proprio l’arroganza e l’ignoranza di questa ... mio padre mi insegnava “quando hai a che fare con un ignorante .. ignoralo” .. e io l’ho ignorata ... quindi alla fine c’è rimasta più male lei ... m’ha anche ringraziato quando è andata via ... sì ...eh ... poi è così… [ride] [↑](#footnote-ref-39)
40. Io la mia strategia è quella ... su una persona aggressiva, non affrontarla con lo stesso tono di voce ... non so ... appartarmi .. appartarmi .. ovviamente .. non qui dentro .. perché quello che succede lo dice lei .. ma lo dico anch’io ... però ... cominciare a ragionare [...] [↑](#footnote-ref-40)
41. ... faccio sbollentare la situazione… passano .. 10 minuti .. io mi calmo .. tu ti calmi ... dopodiché chiedo gentilmente se possiamo riparlare del problema ... posso essere io .. ad aver esposto una cosa nella maniera o nel tono sbagliato ma anche tu… **vieni** e ne discutiamo ... ecco tante volte ho avuto dei riscontri positivi ... [↑](#footnote-ref-41)
42. abbasso il tono io ... abbasso il tono io ... In questo modo lo inviti a seguirti .. cioè devi avere ... devi imparare nel nostro lavoro ad avere tu l’autorità ... cioè .. il coltello dalla parte del manico ce lo devi avere tu [↑](#footnote-ref-42)
43. ... tu sai che con loro bisogna usare il bastone più che la carota ... ma le conosci! [↑](#footnote-ref-43)
44. se uno arriva che “ma no .. guarda che sono qui che aspetto da 5 ore .. è impossibile .. veramente dovete ...” cioè tu ci metti la faccia ... se tu ci dici “guardi .. ha ragione lei .. è vero! .. Concordo con lei .. è una roba veramente indegna! .. 5 ore .. ma non è possibile una roba del genere! ... Guardi le consiglio di andare a protestare!” .. oppure ecco .. tu lo disarmi .. si disarmano un po’ gli altri… [↑](#footnote-ref-44)
45. Gli ripeto la stessa identica frase ... questo la prima volta mi guarda e si chiede cosa sto facendo ... alla terza volta che uno lo ripete .. si fa un po’ fatica a ripetere la stessa frase perché ... non mi viene spontaneo ... vedo che la persona cambia già atteggiamento e fa un passo indietro. [↑](#footnote-ref-45)
46. [...] sto in silenzio ... quando vedo che ... va avanti .. alla prima pausa che fa gli dico “ha finito? .. Mi lascia parlare?” [↑](#footnote-ref-46)
47. Sì .. sì ... da alcuni ho accettato .. da altri no ... cioè .. se per me quello che veniva a mediare stava facendo la cosa giusta .. in quel momento lì aveva una dialettica migliore della mia .. ed era riuscito a risolvere il problema prima di me .. ben venga ... però se vedo che mi mette i bastoni fra le ruote dove magari sto già riuscendo da sola … no ... me fa spira eh .. me fa spira... [ride] [↑](#footnote-ref-47)
48. E ... allora ho visto usare tante strategie dell ... dell’accondiscendenza ... cioè ... un parente .. o un paziente dice “voglio essere visto prima degli altri perché sto male e non e tu non capisci niente” e loro dicono “ok” ... questo non va bene secondo me ... oppure ... ho visto estremi opposti .. cioè proprio perché’ mi hai insultato ... ti dico “guarda che ti aspetto fuori” .. cioè ... vieni dentro che ne parliamo e poi ... scatta magari anche un po’ la minaccia [↑](#footnote-ref-48)
49. Nel senso che io magari ... tendo ad essere un pochino più aggressiva .. ecco ... però ... ci sono dei miei colleghi che ci riescono molto bene ... cioè riescono quasi a far vergognare questa persona .. di quello che ha fatto [...] [↑](#footnote-ref-49)
50. Dipende un po' dalla persona e ... c’è chi ha tanto da insegnarmi .. io sono qua da due anni e faccio triage da otto mesi ... c’è chi ha da insegnarmi tutto .. sulla comunicazione e che ha proprio un modo di rapportarsi ... difficilmente litiga con l’utenza ... c’è chi ... col primo paziente litiga [↑](#footnote-ref-50)
51. Mi viene un esempio ... c’è proprio un mio collega che quando ero affiancata a lui .. però era l’ultimo inserimento in triage quindi eravamo in tre invece che in due .. e io ero in mezzo e ... quando non sentivo ... perché tre infermieri che inseriscono ... non si sente nulla .... e ... mi alzo e mi avvicino al microfono e sentivo lui “siediti” ... questa era una delle correzioni che a me veniva spontanea ... e a me veniva da sorridere perché purtroppo non ci pensavo .. per me era un modo per avvicinarmi e per sentire ... l’utenza lo vede come un’aggressione [↑](#footnote-ref-51)
52. Per me .. per me [NOME] dipende molto da con chi lavoro ... dipende molto da quello ... poi se ci sono persone con personalità che intendo io .. con cui sto bene .. eccetera .. può venire chiunque e non mi spaventa ... se invece so di essere io la più forte di .. allora magari alle volte mi pesa un po’ di più [↑](#footnote-ref-52)
53. Aspetto che [lui] finisca per non ... non dar la percezione alla persona che c’è dall’altra parte che questo qua è nuovo .. un novello incapace .. allora … non lo puoi fare di fronte alla persona ... e dopo magari glie lo dico .. gli dico “magari è ... è meglio adottare sta tecnica qua e vedrai che una si tranquillizza di più” [↑](#footnote-ref-53)
54. i giovani magari un po’ meno ma ... se ne renderanno conto ... noi vecchi arriviamo .. chiaramente ti porti anche dei problemi da casa .. famiglia .. qua .. arrivi qua ... magari sei contento e sei disposto a subire... molto di più di quello che subisci di solito ... altri momenti no! .. quindi noi magari perdiamo la calma .. con una certa esperienza .. ci arriviamo da ... ci portiamo dietro qualcosa. [↑](#footnote-ref-54)
55. E io ho visto anche qualche collega più giovane che magari arrivava con la giornata un po' storta e ... magari vedersi una lista d'attesa ... esorbitante ... iniziavi il turno litigando fortemente ... cioè ... “Ciccio .. son le due ... son le 14 ... devi arrivare alle 21 ... come ci arrivi?” ... È quello .. è quello... però se tu vuoi gestire la faccenda così ... [↑](#footnote-ref-55)