Scoping workplace aggression in nursing: findings from an Australian study

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Aim. This paper reports a study of workplace aggression among nurses in Tasmania, Australia.

Background. There is international concern about a perceived rise in occupational violence as a major worldwide public health problem, with associated financial costs. There is reason to suspect that aggression towards nurses is increasing. For example, increased illicit drug use puts nurses at the sharp end in managing patients admitted with drug-related problems. Such people are often resistant to healthcare intervention, and often have associated disorders, including mental illness. Despite this increased awareness, comprehensive data on occupational violence in nursing are not available.

Method. A specially designed questionnaire was sent to all nurses registered with the Nursing Board of Tasmania ($n = 6326$) in November/December 2002, with 2407 usable questionnaires returned. The response rate was 38%.

Findings. A majority of respondents (63·5%) had experienced some form of aggression (verbal or physical abuse) in the four working weeks immediately prior to the survey. Patients/clients or their visitors were identified as the main perpetrators, followed by medical and nursing colleagues. Abuse influenced nurses' distress, their desire to stay in nursing, their productivity and the potential to make errors, yet they were reluctant to make their complaints 'official'. As well as reporting high levels of verbal and physical abuse, nurses were distressed because they could not provide the appropriate care to meet patients' needs. Few working environments were free of aggression.

Conclusion. Future research should try to determine the specific factors, including staff characteristics and environment, associated with the high levels of aggression reported in 'hot spots' where, on the basis of the present results, many staff experience high levels of verbal and physical abuse. Unless managers take steps to improve the situation, attrition from the profession for this reason will continue.

Keywords: nurse–patient relationships, nurse–physician relationships, occupational health, questionnaire, survey, violence, workforce issues

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Introduction

Over the past couple of decades there has been increased interest in determining the scale of aggression in nurses' work settings. This interest mirrors international concern about a perceived rise in occupational violence. The International Labour Office, International Council of Nurses, World Health Organisation & Public Services International (2002, p. 1) acknowledge that workplace violence 'has become a global problem crossing borders, work settings and occupational groups'. The International Council of Nurses (2001, p. 3) reports that violence is a major worldwide public health problem, and is overtaking infectious diseases as the main cause of mortality and premature morbidity.

Background

Aggression at work is increasingly viewed as a high interest story by the media. In the United Kingdom (UK), the presumed murder of Suzy Lamplugh, a real estate agent who disappeared while meeting an unknown client in 1986, was widely reported. During that year her mother set up The Suzy Lamplugh Trust, which is now a leading charity that supports education, training and research into personal safety and minimizing aggression in all its forms – physical, verbal and psychological (The Suzy Lamplugh Trust n.d.). Since then, media reports of aggression towards nurses have been supported by a number of authoritative reports and research studies; the latter have now reached a critical mass and their findings have begun to leak into the public arena (Ooi 2003).

At the same time, reports on the financial cost of aggression at work are beginning to appear. Crude attempts to estimate the financial cost of aggression/violence at work have produced alarming figures. The annual expense of workplace violence to American employers is thought to be in the region of $US 4–6 billion dollars (Mayhew & Chappell 2002). However, more recent data suggest that in Australia workplace bullying alone is estimated to cost up to $AUS 13 billion a year in lost productivity and absenteeism (Australian Capital Territory Workcover 2004) (1$AUS = 0·74$US = 0·43£ sterling = 0·62 €).

Healthcare leaders are now aware of the insidious consequences of aggression. Even minor acts of aggression can leave nurses emotionally traumatized (Whittington & Whykes 1989) and exert a negative effect on recruitment and retention (Wells & Bowers 2002).

Legislation in many countries places a duty of care on employers to provide a safe working environment for employees. The response of government and industrial organization has been to champion 'zero tolerance' policies in dealing with aggression. In 1999, the UK Department of Health, as part of its 'zero tolerance zone' initiative, directed the National Health Service to reduce incidents of violence by 30% by 2003 (Health & Safety Commission 1999). Australia's largest professional and industrial organization, the Australian Nursing Federation (ANF 2003/2004) also endorses a 'zero tolerance' response to aggression.

Until recently it has been unfashionable to talk about aggression occurring between colleagues in the same context as the caring role. However, nurses are now starting to recognize the issue of aggression within their own ranks. Alongside concerns about not being able to care adequately for patients, a major source of nurses' personal distress at work results from Horizontal Violence. The concept is not easy to define but can refer to overt behaviours, such as humiliation, sarcasm or rudeness, or to covert behaviours, such as denial of opportunities, gossiping and disregard for the welfare or safety of others. At the core of the concept is lack of respect for others (Farrell 2003).

Although there is a lack empirical evidence to show that aggression towards nurses is increasing, there is good reason to suspect that it is. The increase in illicit drug use has resulted in a public health crisis, and nurses are often at the sharp end in managing patients admitted with drug-related problems. People under the influence of drugs are often resistant to healthcare intervention. The situation may be further compounded by the fact that many of these patients have associated disorders, including mental illness.

Alongside the rise in substance misuse, the presumed increase in levels of aggression may also reflect what Nicole Billante (2002) refers to as a 'crisis of civility'. Over the past couple of decades, society has undergone major changes; the rules governing social interaction have been relaxed, and less respect is shown for authority. Patients are now frequently referred to as clients, users, consumers or customers, terms which imply that the person in need of health care should take an active/consumerist role, similar to that when choosing a new watch or a new car. With this role come implied rights, expectations and demands which were not perhaps claimed by the general public when patients were, and expected to be, patient!

Despite this increased awareness, comprehensive data covering all types of occupational violence are not available (Mayhew & Chappell 2002, pp. 13–18). In Australia, due to a limited number of studies and small sample sizes, the picture is cloudy surrounding the extent of aggression in nursing. The present study sought to expand our understanding of the nature and extent of aggression by surveying all Registered and Enrolled Nurses in one State in Australia.

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As well as attempting to estimate the prevalence of aggression, the study investigates the perpetrators of aggression, the experience of nurses in different work settings, nurses' actions following aggression, and the effect of aggression on their productivity and their desire to leave nursing. Finally, the distress caused by aggression was compared with other factors causing nurses distress at work.

The study

Aim

The aim of the study was to identify the occurrence of workplace aggression experienced by nurses in Tasmania, Australia.

Participants

All nurses registered with the Nursing Board of Tasmania ($n = 6326$) in 2002 were invited to participate in the survey. In Tasmania, in order to practise as a nurse, nurses are required to renew their registration on an annual basis; therefore, in any one year, some nurses may remain on the register even though they may have left the profession permanently.

Data collection

The Nursing Board of Tasmania distributed the questionnaire on our behalf. Participants were asked to comment on their experiences of workplace aggression during their most recent four working weeks. A reply-paid envelope was used to return completed questionnaires. In an attempt to maximize the participation rate, advertisements announcing the study were placed in the three local daily newspapers shortly before mailing of the questionnaire. Also, all respondents had the option to be entered into a draw to win one of ten $100 dollar (Australian) department store vouchers.

Measures

Following a literature review and input from focus groups with Registered Nurses, we developed a questionnaire; this was modified several times prior to the final version. Similar questions to those used by Farrell (1999) were used to determine the types of aggression experienced by nurses, perpetrators of aggression, action nurses took following aggression, and extent of workplace distress caused by aggression.

Providing a clear and inclusive definition of workplace aggression is difficult (Rippon 2000). However, focus group participants indicated the need for the questionnaire to define verbal and physical abuse; working definitions were therefore developed:

- Verbal abuse refers to any form of mistreatment, spoken or unspoken that leaves you feeling personally or professionally attacked, devalued or humiliated. It is communication through words, tone or manner that disparages, patronizes, threatens, accuses, or is disrespectful towards another (Zigrossi 1992, Anderson & Clarke 1996). Threatening behaviour includes the suggestion of physical violence via verbal interaction, in person or over the telephone, as well as physical postures that suggest an object or fist may be thrown. However, no physical contact eventuates.
- Physical abuse refers to any incident where a person experiences physical assault (e.g. being spat on, bitten, pushed, scratched or hit and so on) or sexual assault (defined as any forced physical contact including forcible touching and fondling, and forced sexual acts including sexual intercourse).

These definitions provided respondents with a common reference point on which to base their responses.

Demographic data were collected, including respondents' area of work.

Ethical considerations

Approval for the study was received from the University of Tasmania's Human Research Ethics Committee.

Data analysis

Data were analysed using SPSS™ version 10.0 (SPSS Inc., Chicago, IL, USA). Descriptive statistics were used to describe and summarize data. The chi-squared test was used to examine associations among variables.

Results

Response rate

A total of 6326 questionnaires were posted, with 2426 returned (17 had *returned to sender* and two had *retired* written on them, resulting in 2407 usable questionnaires), representing a response rate of 38%. However, the true response rate for nurses actually working at the time of study may be nearer 55%. Figures released from the Australian Institute of Health and Welfare (AIHW) indicates that only

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4400 Registered and Enrolled Nurses were actually working in 2001/2002 in Tasmania, the year immediately previous to when the study occurred (ANF 2003/2004).

Some of the questionnaires were incomplete but where responses to individual questions could be determined these were subject to analysis. Therefore not all the totals reported are 2407.

Characteristics of respondents

Table 1 indicates that the gender and age of respondents mirrors that of the total population of nurses in Tasmania (AIHW 2003).

Tasmania's nursing population mirrors the general population distribution across the three regions (AIHW 2003) and the response rate by region reflected actual nursing population distributions within the state reasonably well (Table 2).

Period prevalence of aggression

To aid accurate recall of events, respondents were asked to comment on any aggression they had experienced in the four working weeks immediately prior to completing the questionnaire. Nearly two-thirds (63·5%) of respondents reported that they experienced verbal and/or physical abuse during this period. About 50% of respondents reporting verbal abuse also experienced physical abuse. Few respondents reported experiencing physical abuse only.

Of those reporting abuse, the average number of verbal abuse episodes reported was 4·1, SD 3·64. The average number of physical abuse episodes was 2·6, SD 2·9.

Table 1 Gender and age of respondents compared with Tasmanian population of nurses (n = 2337)

	Study data	%	Tasmanian data*	%
Gender				
Male	168	7·2	396	9·0
Female	2169	92·8	4004	91·0
Total	2337	100	4400	100
Age (years)				
20–30	202	8·6	395	9·0
31–40	596	25·5	1174	26·7
41–50	908	38·9	1762	40·0
51–60	567	24·3	957	21·8
≥61	64	2·7	112	2·5
Total	2337	100	4400	100

*Estimated number of nurses working at the time of the survey.

Table 2 Regional distribution of survey respondents compared with general Tasmanian population (n = 2241)

	Tasmanian population	% of population in each region	% of respondents from each region
South	229,060	48·7	51·3
North	133,080	28·3	26·6
Northwest	108,236	23·0	22·1
Total	470,376	100%	100%

Types of aggression

In an attempt to provide a more precise picture of the types of abuse experienced by respondents, they were provided with a predetermined list of descriptions of both verbal and physical abuse, and were asked to 'check' all that applied. These lists were devised following discussion with colleagues and from a review of literature (Farrell 1999). The item 'other' was included to avoid the possibility of missing important items. Table 3 illustrates the types of abuse experienced by respondents.

Perpetrators of aggression

Of those abused, a majority indicated that patients or their visitors were the most likely perpetrators of either verbal or physical abuse. Nurse colleagues, doctors and other staff were next implicated as the perpetrators of abuse (Table 4). A small number of respondents indicated that 'unauthorized persons' were responsible for both verbal and physical abuse.

Area of practice and aggression

As can be seen in Table 5, very few areas were free from verbal or physical abuse. In general, a smaller number of respondents experienced physical abuse regardless of their area of practice.

Comparison between public and private hospitals

Significantly higher numbers of respondents reported experiencing verbal and physical abuse in public hospitals compared with private hospitals ($\chi^2 = 89{\cdot}426$, d.f. = 1, $P = 0{\cdot}001$ and $\chi^2 = 100{\cdot}502$, d.f. = 1, $P = 0{\cdot}001$, respectively).

Age and aggression

A significantly greater proportion of younger respondents (up to age 40) were likely to experience verbal and physical abuse compared with older respondents (41 and above) –

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Table 3 Types of abuse encountered by those who reported some form of abuse ($n = 1528$)

	Number of respondents	% of respondents who checked each item
Verbal abuse		
Rudeness	1319	82·1
Shouting	1094	68·1
Sarcasm	1028	64·0
Swearing	994	61·9
Unjustified criticism	960	59·7
Ridicule in front of others	607	37·8
Threat of physical abuse	425	26·4
Threat of harm	423	26·3
Rumour mongering	260	16·2
Other	55	3·4
Threat to your property	39	2·4
Threat to your family	35	2·2
Physical abuse		
Struck with hand, fist, elbow	513	69·3
Pushed or shoved	363	49·1
Scratching	360	48·6
Spitting	284	38·4
Biting	254	34·3
Struck with foot or knee	243	32·8
Struck with an object/thrown object	177	23·9
Hair pulling	111	15·0
Restraint (e.g. being pinned to a bed)	62	8·4
Other	49	6·6
Choking	44	5·9
Stabbing	6	0·8

Percentages do not add up to 100% as respondents could 'check' more than one type of abuse. About half of those reporting verbal abuse also reported physical abuse.

$\chi^2 = 36{\cdot}693$, d.f. = 4, $P = 0{\cdot}001$ and $\chi^2 = 16{\cdot}886$, d.f. = 4, $P = 0{\cdot}01$ respectively.

Gender and aggression

Of those reporting verbal abuse, males and female perpetrators were thought to be equally culpable. However, 67% of respondents who experienced physical abuse indicated that males were their most frequent abusers.

A significantly greater proportion of males were likely to be targets of both verbal and physical abuse compared with females ($\chi^2 = 6{\cdot}009$, d.f. = 1, $P = 0{\cdot}025$ and $\chi^2 = 13{\cdot}637$, d.f. = 1, $P = 0{\cdot}001$ respectively).

When controlling for age (≤40), young males and females experienced similar levels of verbal abuse; however, males were more likely to be targets of physical abuse compared with females ($\chi^2 = 5{\cdot}98$, d.f. = 1, $P = 0{\cdot}05$). Similarly, when controlling for older respondents (41 and above), we also found that males were more likely to be targets of physical abuse ($\chi^2 = 4{\cdot}81$, d.f. = 1, $P = 0{\cdot}03$).

Table 4 Perpetrators of aggression ($n = 1436$)

Source of abuse	Number of respondents	% of respondents who checked each item
Perpetrators of verbal abuse ($n = 1436$)		
Patient/client	1067	74·3
Patient/client visitor	507	35·3
Nurse colleague	412	28·7
Doctor	389	27·1
Nurse manager/supervisor	227	15·8
Allied health personnel	72	5·0
Ancillary staff	72	5·0
Administration	71	4·9
Unauthorized person	56	3·9
Other	38	2·6
Medical student	7	0·5
Perpetrators of physical abuse ($n = 580$)		
Patient/client	564	97·2
Patient/client visitor	41	7·1
Nurse colleague	21	3·6
Doctor	18	3·1
Unauthorized person	14	2·4
Nurse manager/supervisor	4	0·7
Ancillary staff	4	0·7
Other	4	0·7
Allied health personnel	3	0·5
Administration	2	0·3
Medical student	1	0·2

Percentages do not add up to 100% as respondents could 'check' more than one abuser.

Nurses' actions following aggression

In an attempt to determine the actions respondents took following incidents of aggression, the ten items developed by Farrell (1999) were used, together with two new ones 'Filed report/Incident form' and 'Reported the incident to the police'. These were developed following discussions with nurse colleagues. Respondents were asked to check all the actions they took and to rate each on the basis of 'Helped' or 'Didn't help'. 'Talking with colleagues' was by far the most likely and most helpful response following verbal or physical abuse. 'Taking no action' and 'Talking with the abuser' were not considered to be particularly helpful (Figures 1 and 2).

Aggression and nurse retention

Eleven per cent of respondents indicated that they had left a nursing position sometime during their careers because of

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Table 5 Aggression by area of practice ($n = 1447$)

Area of practice	No. of respondents reporting abuse	% Experiencing abuse*
Verbal abuse		
Corrective services	9	100
Psychiatric/mental health	91	84·3
Emergency nursing	81	76·1
School	3	75
Oncology	32	74·4
Medical settings	139	72
Nursing in private practice	3	72
Critical/intensive care	82	68·9
Aged care/dementia care	288	68·9
Pool/agency	38	66
Surgical settings	148	64·1
Education/academia	16	64
Operating room/day surgery	125	63·8
Mining/industrial/commercial	2	66·7
Paediatrics/child health/child care	57	57·6
Administration/management	69	54·3
Other	80	53·3
Community health service	74	51
Obstetrics/midwifery	79	50·3
Doctors' rooms/medical practice	24	40
Research	4	40
Physical abuse		
Emergency nursing	54	57·5
Psychiatric/mental health	59	54·6
Aged care/dementia care	204	48·8
Critical/intensive care	56	47·1
Medical settings	85	44
Surgical settings	82	35·5
Corrective services	3	33·3
Oncology	14	32·6
Pool/agency	18	31·6
Paediatrics/child health/child care	29	29·3
Nursing in private practice	2	28·6
Other	41	27·3
Education/academia	6	24
Administration/management	36	22·8
Operating room/day surgery	41	21
Research	2	20
Community health service	27	18·6
Obstetrics/midwifery	23	14·7
Doctors rooms/medical practice	5	8·3
Mining/industrial/commercial	0	0
School	0	0

*Refers to the percentage of respondents working in a particular practice area who experienced verbal or physical abuse. For example, 91 respondents working in psychiatric mental health nursing experienced verbal abuse, which equates to 84·3% of the total number of respondents (i.e. 108) who indicated that they worked in that practice area. A smaller number (59) and proportion (54·6%) experienced physical abuse.

aggression. Furthermore, 24% of respondents had considered resigning during their last four working weeks because of aggression. Two per cent of respondents indicated that they had left the nursing profession altogether, specifically because of aggression.

Aggression, errors and productivity

Of those who had experienced aggression, over two-thirds indicated that it *frequently* or *occasionally* contributed to their potential to make errors, or to affect their productivity.

Workplace distress and aggression

In an attempt to avoid accusations of highlighting aggression at the expense of other distress factors in nurses' work environments, respondents were presented with a predetermined list of possible stressors including aggression. Drawing on the work of Gray-Toft and Anderson (1981), Farrell (1999) used Tasmanian nurses' self reports to develop a nine-item instrument to determine the major causes of nurses' distress at work. These, together with two new items 'Conflict with allied health staff' and 'Abuse (verbal or Physical)' were used in the present study. Respondents were asked to check the item that caused them the most distress at work. Of the 87% of respondents who answered this question, 58·8% reported that their *workload* (which did not allow them enough time to complete tasks or support patients) caused them most distress at work (Table 6). A smaller number (24·5%) cites *abuse*, *lack of support* or *conflict with nursing, medical and allied health colleagues* as the most distressing aspect of their work.

Discussion

The results indicate that nurses were subjected to considerable amounts of aggression at work. Almost 64% of nurses reported some form of aggression (i.e. verbal or physical abuse) over their previous four working weeks. This finding is far in excess of that reported by Wells and Bowers (2002), who found, following a systematic review of the literature, that approximately 9·5% of general nurses working in UK hospitals reported assault in any one year. It also exceeds McKenna *et al.*'s (2003) findings, who reported that about one-third of New Zealand Registered Nurses in their first year of practice were subjected to threats and violent behaviour by patients. However, the findings are in keeping with the results from Winstanley and Whittington (2004) who found that 27% of healthcare staff were assaulted and 68% reported verbal aggression within the preceding year.

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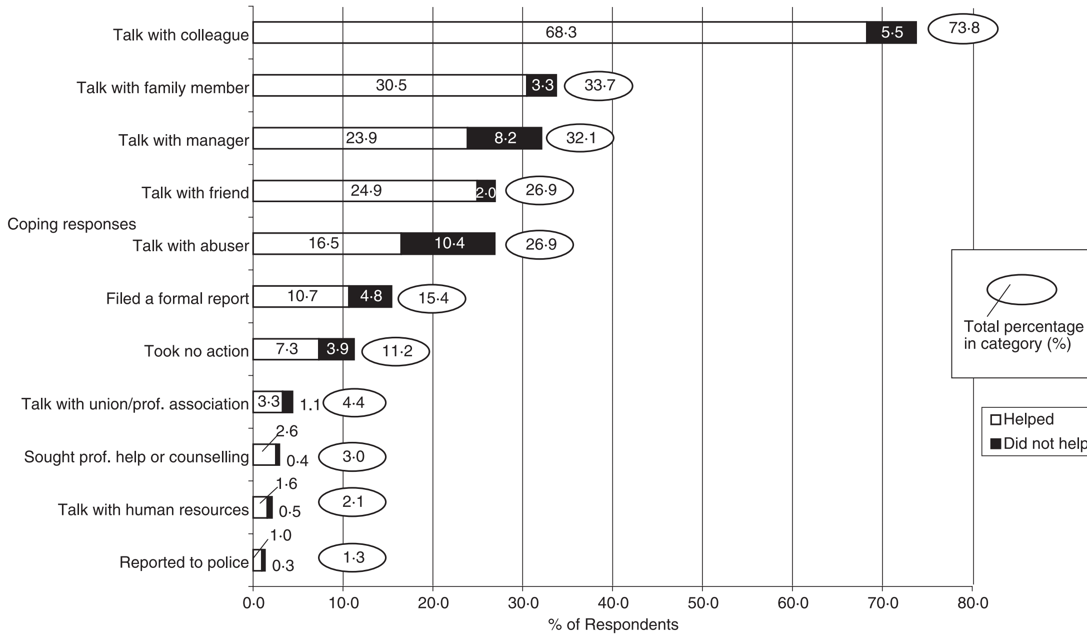

Figure 1 Nurses' actions following verbal abuse (n = 1394). Table colours changed to black & white and changed 'Didn't help' to 'Did not help'.

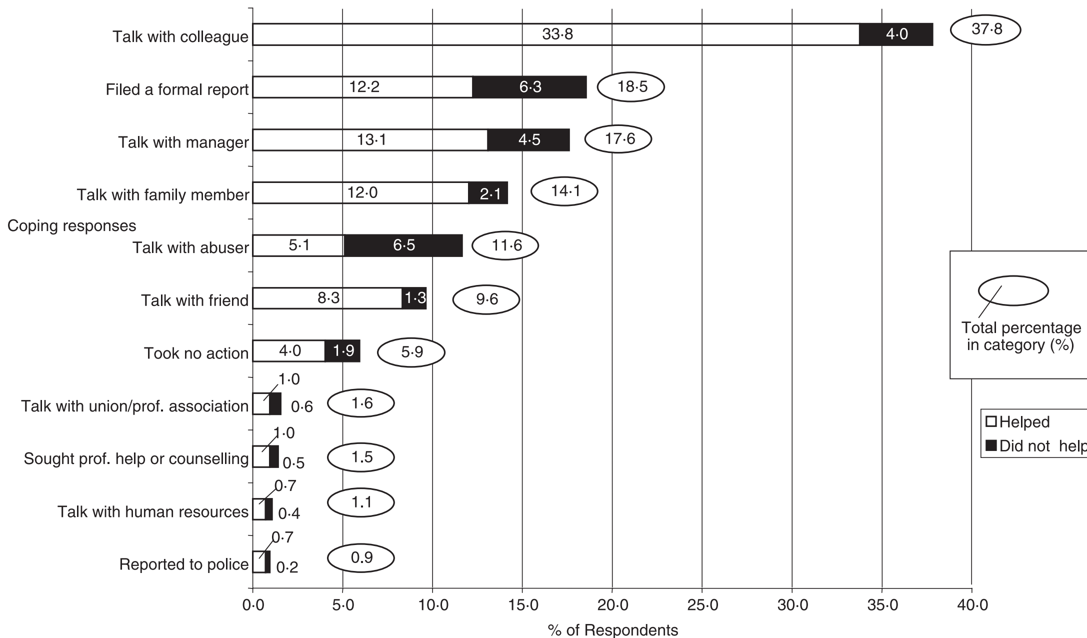

Figure 2 Nurses' actions following physical abuse (n = 417).

Australian studies also report comparable findings, such as Lyneham (2000), who found that 58% of emergency department nurses experienced verbal abuse and 14% were subjected to physical intimidation and assault at least once a week.

Our finding that verbal abuse was the most frequent type of abuse experienced by nurses across a range of practice settings is in keeping with many other studies. Indeed, as far back as 1987, Cox made the comment that verbal abuse is so common in nursing it is surprising that nurses remain in the

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Table 6 Causes of nurses' distress at work ($n = 2407$)

Most distressing aspect of work	Frequency	%
Workload (not enough time to complete work/support patients)	1231	51·1
Abuse (verbal &/or physical)	256	10·6
Conflict with other nurses (other than abuse)	157	6·5
Lack of staff support	90	3·7
Meeting own expectations	90	3·7
Conflict with medical staff (other than abuse)	74	3·1
Other	64	2·7
Inadequate preparation to meet patients' needs	54	2·2
Dealing with death & dying	38	1·6
Uncertainty regarding treatment (e.g. not knowing what to tell a patient)	26	1·1
Conflict with allied health staff	15	0·6
Missing data/scan error	312	13·0
Total	2407	100

profession (Cox 1987). Farrell (1999) reported that 30% of nurses experienced aggression on a daily or near daily basis, especially rudeness and abusive language.

Patients or their visitors, nurses, doctors and nurse managers/supervisors, in that order, were reported by respondents to be responsible for verbal abuse. Cox (1987) and Farrell (1999) reported that doctors, followed by patients' relatives were nurses' most frequent abusers. Although the present study did not find that healthcare colleagues were the most likely abusers, the fact that they were implicated by a significant number of respondents (approximately 25%) gives cause for concern. This number greatly outweighs that estimated in a European international review on workplace violence by Hoel *et al.* (2000) who suggest that, conservatively, 10% of people at work are subject to bullying by colleagues.

Physical aggression, while less common, was nevertheless reported by approximately 50% of staff working in a variety of settings, including emergency care, mental health nursing, aged care/dementia, critical care and medical wards. Winstanley and Whittington (2004) found that over 42% of medical department staff, 36% of surgical staff and over 30% of accident and emergency staff were assaulted. While respondents in the Winstanley and Whittington (2004) study included a high proportion of non-nursing personnel, including doctors and professions allied to medicine, nevertheless, nurses reported most assaults (43·4%).

The finding that males were twice as likely to be the perpetrators of physical abuse is perhaps in line with expectations. Whilst there is ongoing debate as to whether men are more aggressive than women, popular conceptions in Western culture are that aggression is mainly a male characteristic (Klama 1988, p. 74).

Regardless of age, male respondents were more likely to be targets of physical abuse. This might be a reflection of the influence of social norms on the perpetrators of aggression, where females are considered easy targets for verbal abuse, yet remain at least partially off limits for physical assault. Research in other occupations indicates that females are more likely to experience higher levels of verbal and sexual abuse, whereas men are subjected to more threatening behaviour and physical assaults (Fisher & Gunnison 2001).

Respondents reported less aggression in private hospitals compared with public ones. Possible reasons for this difference may lie in the fact that public hospitals generally have a greater proportion of unplanned admissions, including a far greater proportion of accident and emergency and trauma cases, which may account for the higher incidence of stressed and potentially abusive patients, relatives and staff in public settings.

Following aggressive incidents, respondents reported that they received most help from talking with colleagues, rather than with their manager or trade union or their professional organization. This suggests that most nurses are still reluctant to make their experiences of aggression official. In a Queensland study, 65% of nurses thought that administrators failed to listen or to respond adequately to their concerns (Day 2005). Non-reporting of incidents is sometimes referred to as the 'dark figure' of occupational violence and it is estimated that about 80% of incidents go unreported (Mayhew & Chappell 2002, p. 15). A possible explanation for this may be that in order to survive in hostile environments traumatizing or distressing thoughts and emotions are either consciously or unconsciously suppressed. In this way, individuals are protected from overwhelming anxiety or helplessness. As far back as 1983, Lanza (1983) suggested a similar line of defence employed by nurses to come to terms with aggression from patients. By seeing aggression and bullying as part of the job, staff become de-sensitized to working alongside 'difficult' patients or colleagues. Such coping mechanisms may become more likely where nurses do not feel supported by their managers or administrators when incidents arise.

The major distress factor for nurses at work surrounded workload issues (i.e. not having enough time to complete work, support the patient), Approximately a quarter of total respondents indicated that verbal and/or physical abuse, conflict with other nurses, doctors and allied health staff, and lack of staff support as important distress factors too. These results contrast with those of Farrell (1999) who, following a survey of Tasmanian hospital nurses ($n = 240$), found that

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What is already known about this topic

- Aggression at work is common across nursing work environments.
- Patients, visitors, medical and nursing colleagues are the perpetrators.
- Even 'minor' aspects of aggression can have lasting impact on staff.

What this paper adds

- The work environment was both distressing and dangerous for nurses.
- Abuse influenced nurses' distress, their desire to stay in nursing, their productivity and the potential to make errors, yet they were reluctant to make their complaints 'official'.
- Nurses had either left or were considering leaving the profession because of aggression in their workplace.

almost half of the respondents indicated that aggression caused them most distress. However, Gray-Toft and Anderson (1981) found that nurses' distress at work was related to three sources: work load, feeling inadequately prepared to meet their patients and their families' emotional demands, and death and dying.

A number of factors may account for differences in results between these studies. In Farrell's study it was left up to respondents to nominate a particular stressor, whereas in the present study, as in the Gray-Toft and Anderson's study, a predetermined list of items was presented to respondents. In addition, the representativeness of study samples and changes in working environments may also be factors. Currently, in Australia, there is an ageing workforce and a worsening national shortage of experienced nurses, coupled with an increase in the number of casual workers. Evidence is emerging which suggests that nurses feel disillusioned with their work. Following interviews with Australian nurses who had voluntarily left nursing, Cheung *et al.* (2004) report that the major catalyst in making their decision was inadequate numbers of nursing staff (especially permanent and experienced staff), and an inadequate skill mix at their workplaces. Respondents in their study thought that patient-care was compromised due to their consequent excessive workloads.

Another cause for concern in the present study were the findings that 24% of respondents had considered resigning on account of workplace aggression and that 2% indicated that they had left nursing altogether on account of abuse at work. In Australia, nurses are a scarce commodity and by 2006 the predicted shortage of nurses is expected to rise to 31,000 (Campaign for the Future of Nursing & Midwifery 2005).

The present findings point to a work environment that is both distressing and dangerous for staff. The immediate costs of aggression in the workplace are associated with individual victims, employers and society as a whole (Mayhew & Chappell 2002, p. 31), and it is also likely that patient-care will be compromised (Arnetz & Arnetz 2001; Cheung, Bessell &Ellis 2004). Indeed, in this present study, many respondents indicated that abuse contributed to their potential to make errors, or to affect their productivity.

Study limitations

First, while there is no reason to suppose that the level of aggression reported by Tasmanian nurses is any different to that experienced by nurses in the rest of Australia, nevertheless, without further studies, using similar methods, we will be unable to rule out the possibility that our results are relevant to the Tasmanian context only.

Secondly, a major factor responsible for our findings may be the restricted time frame in which respondents were asked to recall events, but we are not aware of other studies using a similar time period with which direct comparisons can be made.

Thirdly, aggression was carefully defined and included a distinction between verbal and physical abuse and this may have captured a greater range of incidents than previous studies. Nevertheless, apart from problems associated with differences in study designs, a major impediment to obtaining accurate data on the nature and extent of aggression will remain so long as we lack an agreed definition of what constitutes aggression (Rippon 2000).

Fourthly, while the true response rate is probably in the region of 50%, which is considered acceptable in studies of this kind (Carey & Seibert 1993), it cannot be known if the non-respondents differed significantly from respondents in their views.

Conclusion

It would be useful if, in future, researchers adopt a similar time frame and definition of aggression, so that our findings can be compared with those from other populations of nurses.

Future research should try to determine the specific factors, including staff characteristics and environment, associated with the high levels of aggression reported in the 'hot spots', i.e. in such areas as emergency departments, psychiatric settings, oncology, aged care and medical wards where, on

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the basis of present results, many staff experience high levels of verbal and physical abuse. The findings indicate that many nurses are working in environments in which they cannot provide the care that they think is best for patients and at the same time are experiencing high levels of verbal and physical abuse. It is not surprising therefore that some nurses have left the profession altogether. In an era that acknowledges employers' duty of care for employees, it is a sad reality that nurses, who are at the interface of patient care, continue to feel so vulnerable.

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Author contributions

GF and CB were responsible for the study conception and design and drafting of the manuscript. GF, CB and PB performed the data collection and data analysis. GF, CB and PB obtained funding and provided administrative support. GF and PB provided statistical expertise. GF made critical revisions to the paper.

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