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Workplace Ostracism, Emotional Labor, Nurse-Patient Relationship and Turnover Intention: A Process Model of Workplace Ostracism and Its Consequence in Nursing Professional

GOU Li

Thesis submitted as partial requirement for the conferral of the degree of

Doctor of Management

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Declaration

I hereby declare that the submitted dissertation is the result of my independent research under the guidance of my tutor. Except for the acknowledgement, the dissertation submitted does not contain any materials that have been used by others or by the author herself to obtain a degree and certificate from any educational institution. And as far as I am concerned, except for the quotations marked in the text, this dissertation does not contain any published works written by others or collectives.

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Name: 

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Abstract

As a sort of “cold violence”, workplace ostracism is widely reported and becomes a non-ignorable problem among nursing professionals. In the context of tense nurse-patient relationship and high turnover intention of nurses in China, there is a need to understand the relationship between workplace ostracism, nurse-patient relationship, and turnover intention.

Drawing on emotional regulation (surface acting, deep acting) and conservation of resources theory, this study develops a hypothesized model to examine the major study variables. Employing a time-lagged survey design, participants from one large public hospital in China completed a survey at two points. Structural equation modeling was used to test the relationship between workplace ostracism and turnover intention via emotional labor (surface acting vs deep acting) and nurse-patient relationship.

Findings provided support for the hypothesized model. Specifically, 1) the path from workplace ostracism to surface acting shows a significant positive coefficient, just as well as the path to deep acting; 2) while the path from surface acting to nurse-patient relationship shows a significant coefficient, there is an absence of relation between deep acting and nurse-patient relationship; 3) nurse-patient relationship had a significant negative direct effect on turnover intention. Overall, the results suggest that only surface acting as an emotional regulation strategy mediates the negative relationship between workplace ostracism and nurse-patient relationship, which negatively influence turnover intention.

Our study contributes to the literature in the following ways. First of all, this study introduces emotional labor in the process of workplace ostracism and its consequences. Second, this study narrows our knowledge gap about the path between workplace ostracism and turnover intention with a nurse sample in an under-researched setting - Chinese public hospital.

Keywords: Workplace Ostracism; Emotional Labor; Nurse-Patient Relationship; Turnover Intention; Chinese Nurses

JEL: M54; M12

Resumo

Como uma espécie de "violência fria", o fenómeno da exclusão no local de trabalho (ostracismo) é largamente reportado e torna-se um problema incontornável em enfermagem. Especialmente no contexto da tensão atual entre enfermeiros e pacientes na China e a tendência de saída dos enfermeiros, a relação entre o ostracismo no trabalho, a relação entre enfermeiro e paciente e a intenção de saída merece mais investigação.

Com base na teoria da regulação emocional e na teoria da conservação de recursos, este estudo estabelece um modelo para medir as principais variáveis. O método de pesquisa incluiu medidas repetidas com um intervalo de tempo numa recolha de dados junto de enfermeiros de um hospital público na China. Por via de um modelo de equações estruturais analisámos a relação entre o ostracismo no trabalho e a intenção de saída voluntária do local de trabalho examinando o papel do trabalho emocional (representação superficial e ação profunda) bem como do relacionamento enfermeiro-paciente.

Os resultados apoiam a relação entre o ostracismo no trabalho, a ação profunda, a representação superficial, a relação enfermeiro-paciente e a intenção de saída voluntária estabelecidas no modelo hipotético. Nomeadamente, que: 1) o ostracismo no trabalho tem uma correlação positiva entre a representação superficial e a ação profunda. 2) existe uma correlação negativa entre a representação superficial e a relação enfermeiro-paciente, mas a relação entre a ação profunda e a relação enfermeiro-paciente não é significativa. 3) existe uma correlação negativa direta entre a relação enfermeiro-paciente e a intenção de saída voluntária. Em suma, a representação superficial desempenha um papel enquanto estratégia de regulação emocional, funcionando como mediador no ostracismo no trabalho e na relação enfermeiro-paciente, tendo o relacionamento enfermeiro-paciente um impacto direto na intenção de saída voluntária.

Esta investigação contribui primeiro, pela introdução do trabalho emocional como um estudo do processo de ostracismo no trabalho e a relação enfermeiro-paciente no local de trabalho. Em segundo lugar, fornece apoio empírico para o estudo da relação entre o

ostracismo no trabalho e a intenção de saída voluntária no âmbito da enfermagem num contexto pouco estudado – o hospitalar público chinês.

Palavras-chave: Ostracismo no trabalho; trabalho emocional; relação enfermeiro-paciente; intenção de saída; enfermeiras chinesas

JEL: M54; M12

摘　要

作为一种“冷暴力”，工作场所职场排斥现象在护理行业普遍存在，目前已经成为不可忽视的问题。尤其是在当前中国护患关系紧张、护士离职倾向突出的背景下，职场排斥与护患关系和离职倾向之间的关系值得进一步探索和研究。

基于情感调节理论和资源保存理论，本研究建立假设模型对主要变量进行测量。采用时滞调查法，对中国一家公立医院的护士进行两个时间点的调查。通过建构结构方程模型，分析工作场所职场排斥与离职倾向之间的关系，并检验情绪劳动（浅层扮演与深层扮演）和护患关系在此过程中的作用。

研究结果对假设模型中工作场所职场排斥、深层扮演、浅层扮演、护患关系和离职倾向的关系提供了支持。具体如下：1）工作场所职场排斥对浅层扮演和深层扮演分别呈现正相关关系。2）浅层扮演和护患关系之间呈现负相关关系，但深层扮演与护患关系之间的关系不显著。3）护患关系和离职倾向之间有直接的负相关关系。总而言之，浅层扮演作为情绪调节的一种策略，在工作场所职场排斥和护患关系之间起到中介作用，护患关系对离职倾向产生直接的影响。

本研究的贡献在于以下方面。首先，引入情绪劳动作为工作场所职场排斥和护患关系之间影响过程的研究。其次，为护理行业工作场所职场排斥与离职倾向之间的路径研究提供来自中国公立医院护士样本的实证，丰富了这个领域的文献。

关键词：工作场所职场排斥；情绪劳动；护患关系；离职倾向；中国护士

JEL: M54; M12

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The exciting scene when I received the letter of admission is still echoing in front of my eyes. At this moment, I am holding the thesis with mixed feelings. The results of four years study are not only the intoxicating fragrance poured out by my own sweat, but also with help and support from my teachers, families and friends. I would like to express my sincere gratitude in this dissertation!

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Contents

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List of Abbreviations

WO	Workplace Ostracism
EL	Emotional Labor
SA	Surface Acting
DA	Deep Acting
ICN	International Council of Nurses
ACC	Anterior Cingulate Cortex
OCB	Organizational Citizenship Behaviors
NPR	Nurse-Patient Relationship
PAC	Post-Anaesthetic care
NICU	Neonatal intensive care units
ICU	Intensive care unit
WBSNs	Web-based social networks
HRIS	Human relations importance scale
HRES	Humanistic relationship experience scale
VSI	Verbal and social interaction
TI	Turnover Intention
PTSD	Post traumatic stress disorder
LMX	Leader–member exchange
SSS	Subjective social status
OC	Organizational commitment
EI	Emotional intelligence
CWB	Counterproductive work behavior
COR	Conservation of Resources Theory
PCA	Principal component analysis
EFA	Exploratory factor analyses
CFA	Confirmatory factor analysis

Chapter 1: Introduction

1.1 Research background

In recent years in China, there has been increasing needs for nurses, due to improved people's living standards, healthcare demands and aging population. However, China faces the shortage of nursing staff as many other countries do (Health News, April 11 2016). The insuficiency of nurses in hospitals is having a deleterious effect on health management system, which has become a common problem around the world (Oulton, 2016). High turnover of nurses is a key reason for the shortage of nurses. According to The 2015 China Health Care Development Report, the phenomenon of Chinese nurses' turnover is getting more prominent with a turnover rate around 10.2%-11.2%. Inaddition, many other countries have implemented various preferential policies to attract Chinese nurses and nursing graduates, thus increasing the shortage of Chinese nursing human resources.

The continuous loss of nurses will seriously affect the development of the Chinese nursing profession, the composition of the medical structure, the stability of health organizations and the quality of nursing services in hospitals, according to Ministry of Health, 2010 China Health Statistics Yearbook. Nurses' turnover behavior leads to insufficient nurse resources, thus increasing nurses' workload and pressure. Nurses' turnover affects the work interests and attitudes of other nurses in a team which impacts negatively on nursing quality and medical safety (Hua, 2014). Turnover of nurses is costly to the hospitals as the hospitals need to invest a lot of time and financial resources to recruit new nurses to meet the job needs and to train the newly recruited nurses (Hua, 2014). The significant proportion of turnover costs results from nurses' replacement, elucidating us on the importance of nurse retention.

The International Council of Nurses (2009) contended that medical institution should identify the causes of nurses' turnover and set specific measures to reduce the turnover of nurses. Indeed, the 2015 China Health Care Development Report indicated that relevant

departments are expected to take measures to cope with this problem via the development of Chinese nurses teams, especially in improving nurses' welfares and reducing the turnover rate. Therefore, the frontline nursing managers need to have in-depth understanding of the causes of nursing turnover and take effective measures to reduce turnover rate to the lowest possible level. As the director of nursing unit in a Chinese hospital, I am interested and motivated to explore this issue in my doctorate study.

As a strong cognitive precursor to turnover behavior (Tett & Meyer, 1993), turnover intention (TI), is one of the prior topics studied and researched compared with other Human Resource Management phenomenon (Alhamwan & Mat, 2015). The turnover intention in nursing has been recognized as a serious problem in both developed and developing countries. For instance, research in Ireland indicates that 23% of the samples have the intention to leave their current job, and one third of the nurses thought their occupation pressure was very high (Mccarthy, Tyrrell, & Lehane, 2007). Fourty-one percent of the nurses in the USA are dissatisfied with their job, planning to leave their present job (Alhamwan & Mat, 2015). In China, the nurses' turnover intention is generally high (Ju & Yang, 2012; He, 2010). Current turnover intention of nurses has reached 56.9% (The China Health Care Development Report, 2015). In Yang's (2014) survey of 721 nurses in six hospitals, 18.7% of nurses reported high turnover intentions and 33% of nurses have changed jobs. Similarly, more recently in Yang's (2017) study, 19% of nurses expressed a strong turnover intention.

At present, many scholars have studied the reasons for nurses' turnover intention at both organizational and individual levels as it is discussed later in the literature review. However, the impact of potential interpersonal factors among workplaces (for instance workplace ostracism) is still limited in research in nursing professional. Influenced by the cultural accumulation of circle culture and sectarianism, as well as exclusion to dissidents and cultivation of trusted subordinates, workplace ostracism (WO) is common in Chinese organizations (Ye, Ni, & Huang, 2015). In addition, as a country with manifest hierarchy, there is more likely to have workplace ostracism when people are on the same level of economic distance or different levels in job (Zhou & Cao, 2010). Therefore, workplace

ostracism may have a far-reaching impact on Chinese nurses. Before conducting this study, three nurses are interviewed about the phenomenon of workplace ostracism in nursing professional, including its causes and consequences. Results of interview showed that workplace ostracism is widespread among nurses, which brings lots of negative consequences. The analysis of 276 employees and 92 executives has shown that mean of ostracism from employees is 2.14 of which 1.96 is caused by executives, indicating that the ostracism from employees is higher than that from executives (Ye, Ni, & Huang, 2015). Hence, this study focuses on the ostracism phenomenon among colleagues in nursing and investigates workpace ostracism's impact on turnover intention of nurses.

Workplace ostracism has significant negative effects on individuals and organizations, including increasing emotional burden (such as creating stress, emotional burnout), leading to poor work attitudes (such as job dissatisfaction, lacking of affective commitment), turnover intention (Gormlry, 2011), and turnover (Yin & Liu, 2013). Workplace ostracism also has negative impact on nurses' working environment (Gormlry, 2011), affecting nurses' work behaviors and attitudes (Tsai, 2011).

Workplace ostracism influences nurses' psychology and actual behavior, which may change their emotional labor (EL) and further impact on care quality and nurse-patient relationship (NPR). Emotional labor is a process regulating emotional display to meet organizational emotional display rules (Gabriel, Daniels, Diefendorff, & Greguras, 2015). Nurses engage in emotional labor, including managing and expressing their emotions to patients, patient families, and their colleagues (Delgado et al., 2017). However, frequent emotional labor will lead to job stress, emotional exhaustion (Mittal & Chhabra, 2011; Cipriano, 2015 ; Noor & Zainuddin, 2011), lower job satisfaction (Zhang & Zhu, 2008) and job performance (Li, 2012), which will affect the quality of patient care and nurses-patients relationship. At present, academic research on doctor-patient relationship is relatively mature, while there is limited research on nurse-patient relationship (Ye, 2016). With the movement of Health China and the continuous deepening of the medical and health system reform, and increasing demands for quality medical care, an increasing attention is paid to nurses-patients

relationship. However, due to the defects of nursing laws and medical system construction in China, nurse-patient relationship has been deteriating for years, leading to nurse patients conflicts. As patients indicated, their experience of satisfaction in nursing care is at a medium level resulting from interpersonal interactions with nurses (Boscart, 2015). At present, nurse-patient disputes and violences towards nursing continue to occur. In 2001, the International Council of Nurses (ICN) suggested that nurses may be subjected to three times more violence than other industries. Overall, there is a trend of increasing tension between nurses and patients in China, such as reduced trust and increased conflicts (Ye, 2016; Zhang, Zhang, & Lan, 2011). Therefore, this study attempts to examine the relationships among workplace ostracism, emotional labor, nurse-patient relationship and turnover intention in the context of Chinese hospital.

1.2 Research objective and research questions

The objective of this research is to analyze the influence of workplace ostracism on nurses' turnover intention via emotional labor (surface acting and deep acting) and nurses-patients relationship. The main research questions include:

(1) What are the current levels of the workplace ostracism, emotional labor, nurse-patient relationship, turnover intention in Chinese nurses?

(2) How does workplace ostracism influence turnover intention via emotional labor (surface acting vs deep acting) and nurse-patient relationship?

1.3 Research structure

The thesis falls into six parts: introduction, literature review and theoretical framework, research methods, research results, discussion, conclusion and suggestions. The specific content of each part is as follows:

Chapter 1: In introduction chapter, research gaps, research objective and research questions are discussed.

Chapter 2: Literature review and theoretical framework. This chapter conducts a review of literature on the theories of workplace ostracism, emotional labor, nurse-patient relationship and turnover intention, including the concepts, anticedents, outcome variables and the associations between the variables. This chapter is concluded with hypotheses and research model.

Chapter 3: Research design and methods. This chapter persents the research sample, measurement and reports the field data collection procedure. Then, it introduces the pilot study process and analyzes the reliability and validity of the scales of workplace ostracism, emotional labor (surface acting vs deep acting), nurse-patient relationship, and turnover intention with confirmatory factor analysis.

Chapter 4: Research results. Firstly, the chapter reports the descriptives, and correlations analsysis results. Then, it reports the variance analysis results. Finally, it reports and compares the results of structural equation model analysis with different models.

Chapter 5: This chapter discusses the key research findings, particularly interpreting the results in the context of current Chinese public hospital.

Chapter 6: In the last chapter, the research conclusions are drawn and implictions for stakeholders are discussed.

Chapter 2: Literature Review

This part will review the literature on workplace ostracism, emotional labor (surface acting and deep acting), nurse-patient relationship and turnover intention, as well as the relations between these variables. Based on these, research hypotheses and research model are proposed.

2.1 Workplace ostracism

2.1.1 Ostracism and workplace ostracism

In 1986, Zippelius (1986) put forward the word "ostrakismos" to document deviant or abnormal behavior related to exclusion and shunning. Lancaster (1986) used "ostracism" to determine exclusion in the field of animal reproduction. Ostracism is a term referring generally to exclusion of individuals or groups from others (Williams, 1997a). As a social pain, ostracism is seen as "The Kiss of Social Death" (Williams, 2007a). It is not only a person's revoltive behavior, but also a response to such behaviors (Williams, 1997b). In English, there are many terms for ostracism, such as "shunning", "exile", "to send to coventry", "to freeze out", "the silent treatment" and "the cold shoulder". Whatever it is called, it is the experience of a person or a group of being ignored and excluded by others (Williams & Gerber, 2005).

Ostracism is reflected in many groups and organizations. For instance, among animals the infertile one will be refused by others (Goodall, 1986). In human childhood, ostracism is a risk factor in peer rejection and violation (Hymel & Rubin, 1990). Less prosocial behavior is also reflected in ostracized adolescents (Coyne, 2011). Older people would express less intense pain from ostracism than younger adults (Hawkley, Williams, & Cacioppo, 2011). Other research also showed ostracism in different field or groups: cyberspace (Ochoa et al., 2011), jury (Roberts, 2013), overweight and obese youth (Salvy et al., 2011), different race (Goodwin, Williams, & Carter-Sowell, 2010) and religion (Aydin, Fischer, & Frey, 2010).

Williams (1997a) proposed and discussed varied types of ostracisms. Physical ostracism includes banishment, exile, being kept in a separate room for a period of time. Sometimes physical ostracism involves simply leaving or being left alone. Social ostracism describes instances that people are ignoring or being ignored. From this, ostracism people might force dehumanizing experience, including silent treatment, cold shoulder, and freezing out to the target (Bastian & Haslam, 2010). Role prescribed ostracism stands for temporary roles in which a person playing one role does not acknowledge or speak to someone playing the other role, an act visible in the inattention people typically give waitstaff in restaurants. Punitive ostracism is seen in ignoring by the means of exile, banishment, shunning and the silent treatment and is then intended to be deliberate and aversive. Preemptive in nature and not used as an offensive weapon, defensive ostracism anticipates or gains control over the situation. If the ostracizer sees his/her victims as undeserving of attention we are faced with oblivious ostracism. At work, when colleagues are not familiar with the language, resorting to speaking native language and ignoring the feelings of colleagues is called language isolation (Hitlan et al., 2006). Two or three persons communicating with each other while others around them does not know what they are talking about is also a phenomenon of language isolation. The range of ostracism can be different. Full ostracism means when one person is ignored by all members in a group. Partial ostracism means being excluded by some members of a group (Banki, 2012). Besides, the degrees of ostracism can be separated as partial and complete.

Workplace ostracism is a type of social stonewalling directed at one of the co-workers, refusing to cooperate or to include the other in all social situations when such would be required. Ferris et al. (2012) suggest that workplace ostracism is an act of making the ostracized marginalized by organizational members in the workplace by the means of interpersonal neglect and authority use so as to set up obstacles to job duties and career development. Examples of workplace ostracism can be seen in social rejection and exclusion, ignoring, and evading, or other types of avoidance of an individual or a group (Robinson, Reilly, & Wang, 2013). Workplace ostracism is also get involved in other interpersonal

psychological mistreatments, such as misapplied supervision, incivility, or bullying, that reflect the "darker" part of organizational behavior (Leung, Wu, Chen, & Young, 2011).

Ferris et al. (2008) argued that workplace ostracism is a phenomenon in which individuals are aware of being neglected or isolated by others in work place. This phenomenon is reflected in different gender, age and other demographic characteristics of employees. Workplace ostracism from different sources can be separated to supervisor ostracism, coworker ostracism (Wan, Chan, & Chen, 2016) and ostracising subordinates (Huang, Wang, Zhao, Jin, & Yan, 2015). In this study, we focus on the coworker ostracism. And we refer to the person or persons who perform the act of ostracism as an "ostracizer". The person or persons who are ostracized are the targets of ostracism.

2.1.2 Forms of workplace ostracism

Compared with other negative behaviors in the workplace (such as aggression, theft), the forms of workplace ostracism are relatively concealed, similar to the invisible violence in horizontal violence of nurses in workplace (Gou, 2016), less involving physical attacks and verbal offenses. Therefore, it belongs to "cold violence" in workplace (Xie & Yan, 2016). The common workplace ostracism behaviors are interpersonal isolation, limited information, value neglect and support imbalance. Partial ostracism refers to an obstruction of information on the part of a group to exclude one of its members (Jones, Carter-Sowell, Kelly, & Williams, 2009). In organizations, being refused when attempting to find or maintain an alliance with others is an example of ostracism. The entire organization's behavior of rejecting and isolating a member is called organizational avoidance and it is also a form of workplace ostracism (Robinson et al., 2013).

As an individual subjective perception, workplace ostracism affects the growth and development of individuals and organizations in a subtle way (Huan, Wang, Zhao, Jin, & Yan, 2015). Averting of eye gaze is a mode of ostracism, which is the nonverbal hint to forecast the silent treatment (Wirth, Sacco, Hugenberg, & Williams, 2010). Sometimes ostracism is not necessarily an intentional or punitive behavior. In the case when we are absorbed in doing our

own work and ignoring the feelings of our companions can also be ostracism. However, at this point, it is difficult for us to judge whether the ostracism from others is deliberate or unintentional. This is why ostracism sometimes is difficult to judge and identify. In addition, someone working hard and performing well and then envied by others, someone enthusiastic and energetic but faced with cold shoulder are all ostracism phenomena. Ostracized by friends or close peers than strangers, people would have the punitive or defensive reaction more negatively (Nezlek, Wesselmann, Wheeler, & Williams, 2012).

2.1.3 Impact of workplace ostracism

Even though ostracism could create some prosocial responses, having some positive effects, like being more helpful, strengthening interpersonal bonds (Williams, 2007b). However, many evidences from researches showed that ostracism has negative consequences for both ostracizer and victim. Research has shown that ostracizers would have the impairment of physical energe in dealing with the tough task and experience ego depletion after ostracizing others (Ciarocco, Sommer, & Baumeister, 2001). To the target, workplace ostracism will create an unhappy and sad experience of them (Ferris, Brown, Berry, & Lian, 2008), mainly focus on interpersonal conflict in workplace from a negative perspective. This part discusses the influence of workplace ostracism on individuals, organizations and nurses as below.

2.1.3.1 Impact on individual

Workplace ostracism has negative influences on individual’s physiology, psychology and actual behavior, thus attracting extensive attention from a large number of managers and organizational behaviorists (Hu et al., 2016).

First, when individuals are in a workplace ostracism situation, they will involuntarily produce a series of physiological responses. When an individual is ostracized, it causes brain activity occuring in the active region in the same as mapping area of the physical pain (Eisenberger et al., 2003). As a result of ostracization an individual will experience physical pain. Ostracism can create greater degree of dorsal anterior cingulate cortex activation, which

relates to lower trait of self-esteem (Onoda et al., 2010). Anterior cingulate cortex (ACC) is also more active during ostracism and correlates positively with self-reported distress (Eisenberger, Lieberman, & Williams, 2003). Ostracism-induced wrath is directly related to increased relative left frontal activity, creating asymmetric frontal cortical activity. Ostracism can increase blood flow changing the temperature in facial area. Two experiments from Paolini et al. (2016) made psycho-physiological mechanisms their focus. The result showed an intense autonomic response by the target who has been ostracized (vs. inclusion), through an increase facial temperature in nose and the perioral area, comparing to the baseline phase, which could create stress. Exclusion by in-group members compared to out-group members, it will lead to greater facial thermal variations. Furthermore, right-hand contractions caused great self-reported anger in response to ostracism (Peterson, Gravens, & Harmon-Jones, 2011).

Secondly, ostracism leads to phychological consequences. When targets are ostracized, the immediate effects are painful. Wesselmann et al. (2009) described the feeling of receiving ostracism as “Feel Your Pain”. They argued that people who suffered ostracism reported lower overall positive mood. Ostracized targets could experience negative psychological consequences (e.g. angry, sad) and lower levels of belonging, self-esteem, control, meaningful existence (Jones et al., 2009; Ferris, Brown, Berry, & Lian, 2008). They also had greater social pain (i.e. the pain related to social disconnection), less basic need satisfaction (Wirth, Turchan, Zimmerman, & Bernstein, 2014; Smith & Williams, 2004; Fayant, Muller, Hubertus, Joseph, Hartgerink, & Lantian, 2014). With people experiencing reductions in the satisfaction of needs, along with negative affect and anxiety, the pain of ostracism is felt at both the psychological and neurophysiological levels (Williams & Gerber, 2005). Moreover, workplace ostracism is positively correlated with psychological distress (Wu, Yim, Kwan, & Zhang, 2012). Apart from ostracized person, the ostracizors also create negative affects such as shame, guilt, and anger (Legate, DeHaan, Weinstein, & Ryan, 2013). Long-term evasion leads to feelings of worthlessness and distance of which an unexpected manifestation is apparent self-ostracization, most often nothing more than an escape route from being at the

mercy of others. False self-ostracization can result in psychological disturbances, high levels of depression, suicidal ideation, and suicide attempts, as well as other indicators of psychological difficulties (Williams & Nida, 2011).

As a further consequence, ostracism leads to changing of individual's behaviors. It could lead to negative health behaviors, such as increased unhealthy eating. Study has shown that ostracized overweight participants craved more for food (Salvy et al., 2011). Ostracism may contribute to limited physical activity. People who are ostracized might intend to keep sedentary but not joining public activities (Barkley, Salvy, & Roemmich, 2012). Even, ostracized people may indicate higher levels of dishonest behavior by cheating more undeserved money (Poon, Chen, & DeWall, 2013). Ostracized people may change their social behaviour to seek inclusion (Chow, Tiedens, & Govan, 2008). People tend to conversely invest into relationship outside of the conflict zone offering solace instead of space for repair (Smart & Leary, 2009). The sting of refusal can be soothed if people perceive (or even imagine) the possibility of relationship alternatives that could include them. The motivation for inclusion is usually low when people perceived panoply of alternative relationships is limited or where they have suffered violent rejection. Ostracism could create individual's motives to antisocial and socially avoidant responses (Smart & Leary, 2009). Social exclusion is associated with feelings of anger linked with antisocial behavior. In an experiment, the ostracized adolescents were less likely to assign the most profitable amount of money to a partner or include other participants (Coyne, 2011). The participants also do not like to work with other students in the game (Twenge, Baumeister, DeWall, Ciarocco, & Bartels, 2007). The extra-role play and prosocial behaviors among members are reduced by ostracism (Balliet & Ferris, 2013).

Moreover, the influence of workplace ostracism on individuals also includes the negative effects on their families. When an individual is ostracized from work, there is a work-family conflict (including time, stress, and behavioral conflicts), such as work stress that causes employees to feel exhausted and unable to enjoy family life after returning home thus reducing family satisfaction (Liu, Kwan, Lee, & Hui, 2013).

2.1.3.2 Impact on organization

Workplace ostracism has also an impact on organization. Exclusion is negative for any group dynamics and performance (e.g. decrease liking and trust of group members) (Jones et al., 2009), leading to anti-social behavior manifested in refusal to help or support others in job-related tasks. The rejection behavior relates to the occurrence of counterproductive work behavior, which refers to "a set of volitional acts" that map out an intention to harm the organizations and their stakeholders (clients, co-workers, customers, and supervisors) (Zhao, Peng, & Sheard, 2013). "Out-of-the-loop" individual manifests negative behavior (e.g. lower levels of competence) after being prohibited access to task-related information. They may do not complete their duty, meeting all the formal performance requirements of the job (Wu, Wei, & Hui, 2011), and then reducing investment in work and produce negative attitudes, resulting in bad service performance (Leung, Wu, Chen, & Young, 2011; Wu et al., 2011). The negative effects of workplace ostracism not only affect the direct performance of employees, but also the contextual performance, which refers to the behavior outside the job, including the interpersonal skills, maintenance of good working relationship and tendency to help the colleagues to accomplish the task. Research shows that the more serious workplace ostracism is, the lower the contextual performance (Yan, 2012). After a long time, employees' workplace commitments (Hitlan, Kelly, Schepman, Schneider, & Zárate, 2006) and employee motivation would reduce, also affects the output of work (Pi, 2012).

Workplace ostracism has an impact on employees' organizational citizenship behavior (Hitlan et al., 2006). The reduction of organizational citizenship behavior may lead to employees' reduction of loyalty to organization. Ferris's (2008) study showed that there is a significantly negative relationship between workplace ostracism and organizational citizenship behavior. Furthermore, the behavior of exclusion can lead employees to find other employment opportunities (Ferris, Brown, Berry, & Lian, 2008). After being ostracized, there is a decrease in employees' sense of belonging to organization, reduction of emotional attachment, strengthening employees' marginalized feelings (Ye, Ni, & Huang, 2015), thereby increasing turnover intention.

2.1.3.3 Impact on nursing

The work particularity and social requirements lead to the pressure and intensity of nursing work. In this working environment, workplace ostracism might bring more pressure to nurses in a subtle and concealed way, affecting nurses' health and the quality of nursing work. Workplace ostracism will cause damage to the relationship resources among employees. Relationship resources are the factors existing in the organization to help nurses meet the job requirements, reducing the physical and psychological pressure and stimulate the positive psychology for work engagement. If the relationship resources are lost or reduced, it will destroy nurses' inner balance, and nurses' emotional needs will not be satisfied. Nurse's insider identity may reduce due to the loss of resources and social network. When nurses feel workplace ostracism, their social network, which is a necessary interpersonal network in nursing organization, will be weakened, and then nurses' insider identity be reduced in organizations by depleting the social network (Hu, He, & Yu, 2016). Study showed that reduced insider identity created employees' job dissatisfaction and turnover intention (Knapp et al., 2014).

Furthermore, workplace ostracism affects psychological capital of nurses, harming for job performance (Huang, Wang, Zhao, Jin, & Yan, 2015). The positive competition, such as confidence, resilience, efficiency in an organization stems from psychological capital. So, workplace ostracism leads to lower psychological capital and lower job performance. Nurse work performance is the achievement and contribution made in the nursing activity, related to nursing behavior. Therefore, the negative effects of workplace ostracism directly or indirectly affect the nursing outcome. In addition, study showed that workplace ostracism in nurses affected both nurses' organizational identification and employee silence, which has a negtive effect on patients' safety (Gkorezis, Panagiotou, & Theodorou, 2016).

Workplace ostracism consequences in recent studies are summarized in Table 2-1.

Table 2-1 Workplace ostracism consequences

Classification	Contents	Author,Year	Mediator	Moderator
Behavior	antisocial behavior	Rosalind & Chow, 2008		
	performance and intrinsic motivation	Donald & Lustenberger, 2010		
	dishonest behavior	Poon et al., 2013		
	unhealthy eating	Salvy et al., 2011		
	turnover intention	Ye,Ni, & Huang, 2015	marginalization	job security, job performance
	self-humanity	Bastian & Haslam, 2012	Immorality, social disconnection	
	prosocial, antisocial, and socially avoidant behavioral responses	Smart, 2009		
	counterproductive work behavior	Robert & Hitlan, 2009; Yan, 2014		
	proactive behavior	Liu, et al., 2015	organization-based self-esteem	neuroticism
	organizational commitment, organizational citizenship behaviors	Hitlan et al., 2006		
	in-role behavior, organizational citizenship behavior	Chung, 2014	coworker conflict	
	information exchange	Gkorezis et al., 2016	self-serving behavior	
	organizational citizenship behavior, deviant behavior	Chung, 2017	person–organization fit	
	hospitality employees' counterproductive work behaviors	Zhao et al., 2013		
	employee silence	Gkorezis et al., 2016	organizational identification	

Table 2-1 Workplace ostracism consequences

Classification	Contents	Author,Year	Mediator	Moderator
physical and mental	physical activity behavior	Barkley & Salvy, 2012		
	depression	Niu & Sun, 2016		resilience
	depressive symptom	DeWall et al., 2012	self-control	
well-being	turnover, well-being and work-related attitude	O'Reilly et al., 2015	belonging	
	family satisfaction	Ye, 2015	marginalization	job security, job performance
employee performance	employee performance	Ferris et al., 2015		
		Wu et al., 2011	employee organization-based self-esteem	
	service performance, work engagement	Leung et al., 2011		neuroticism
customer perception and behavior	customer service perceptions, customer	Wan, 2016		
	coproduction, customer control and relational values			

2.2 Emotional Labor (EL)

2.2.1 Emotional labor

Emotional labor describes a set of activities individuals modifying either feelings or expressions in response to the display rules of the organization or job (Hochschild, 1983; Grandey, 2000). Brotheridge and Grandey (2002) conceptualized emotional labor in two main ways. In the first place, job-oriented emotional labor indicates the amount of emotional strain an employee invests into the activities in profession. Secondly, employee-oriented emotional labor shows the ongoing process of active maintanance of emotional labour put into safeguarding work requirements. The concept of emotional labor is different from emotional work. Emotional work refers to the management of one's feelings to create an observable facial and bodily display used in the personal context with relatives and friends to monitor emotional investment and management (Erickson, 2005). On the other hand, emotional labor is used in occupational contexts (Hochschild, 1983). Many service professionals, such as nurses (Bolton, 2001), flight attendants, bill collectors (Berkeley, 1983), library employees (Matteson & Miller, 2013), coaches (Lee & Chelladurai, 2015), paralegals (Lively, 2002; Pierce, 1999), hotel employees (Chen et al., 2012), government frontline employees (Raman, Sambasivan, & Kumar, 2016) resort to this technique performing emotions that correspond to their job's demands.

The antecedents of emotional labor mainly focus on job context as well as individual worker. These antecedents include organizational display rules, and duration of interactions (Gosserand, 2003), cultural differences (Allen, Diefendorff, & Ma, 2014), abusive supervision (Carlson, Ferguson, Hunter, & Whitten, 2012; Wu & Hu, 2013), negative affectivity and political skill (Liu & Eacute, 2004), personality factors of employees (Raman et al., 2016). Moreover, Morris and Feldman (1996) argued that emotional labor is influenced by four factors: frequency of appropriate emotional display, attentiveness to required display rules, emotions to be displayed, emotional dissonance.

In emotional labor, emotional expressions (such as smiles and friendly comments) and emotional input can give rise to good work performance for employees (Brotheridge & Lee, 2003). Adjusting their emotional performance at work, employees can better interact with others, sometimes has too a certain commercial value which may be converted into payment and tips (Thomas & Abhyankar, 2014). A survey from the sample of hotel staff has showed that when staff displays positive emotions contributing to a positive working environment and atmosphere, job satisfaction and identification show positive correlation. This in turn influences high figures in the measurement of staff organizational citizenship behaviors (OCB) within a department (Lu, Shih, & Chen, 2013). OCB will make important contributions to the variance in organizational effectiveness (Podsakoff & MacKenzie, 1997), leading to better work performance. Among paralegals, work with emotional labor has significant consequences for the reproduction of the labor process in the large bureaucratic firms and for the psychological well-being of workers (Pierce, 1999). In nursing, there is a correlation between job-satisfaction, patient-nurse rapport and fulfillment and deep acting (Delgado, Upton, Ranse, Furness, & Foster, 2017).

There are “costs” of emotional labor, as emotional labor may have negative influences on employee’s well-being (Morris & Feldman, 1996). If the actually felt emotions by the employee are not incompatible with the emotions that are displayed, the negative results occur. Researches have shown that employees’ emotional labor was positively correlated with job stress (Jung & Yoon, 2014), emotional exhaustion, depersonalization (Mittal & Chhabra, 2011) and turnover intention (Jung & Yoon, 2014).

However, it has been studied that different emotional labor strategies are correlated with different results. Hochscbild's (1983) suggests that emotional regulation can be done in two different approaches, namely surface acting and deep acting. In the former a person manages the external emotions and in the latter they consciously change their internal feelings. Owing to the possibility of experiencing and displaying suitable emotions might be faced by employee at the same time. Ashforth and Humphrey (1993) suggested another strategy: genuine expression. However there are some differences between genuine expression and

deep acting of which the tenet one is that genuine acting produces genuine expression and does not allow conscious acting and performing (Lee & Chelladurai, 2015). Because surface acting and deep acting are two dramaturgical ways in emotional labor that effortfully modify displays (Grandey, 2003a), this study focuses on surface acting and deep acting.

2.2.1.1 Surface acting (SA)

Surface acting refers to modifying emotional expressions as demanded by the organization or job so as to adhere to the display rules (Totterdell & Holman, 2003). For example, nurses need to display care and kindness, waiters need to put on a smiling face and police officers need to be calm and cool in job (Thomas & Abhyankar, 2014). Surface acting mainly changes the external expression in emotional labour (Beal, Trougakos, Weiss, & Green, 2006), in that, employees put extra efforts to suppress their genuine feelings and express the emotions as demanded by the organization so as to adhere to organizational display rules (Grandey, 2000), which is characterized by outward displays of emotion that do not match the worker's true feelings in their job (Carlson, Ferguson, Hunter, & Whitten, 2012). There is an inconsistency between the individual's inner feelings and the organizational requirements, through visible forms of emotion, such as facial expression, sound, body language to carry out their behavior according to the requirements of the organization. Surface acting involves suppressing, intensifying, or faking emotions. Owing to the internal emotions of the individual unchanged, Grandey (2000) suggests that surface acting implies intentional dishonesty, which would create depersonalization (Mittal & Chhabra, 2011) , job burnout (Matteson & Miller, 2013) and lower job satisfaction (Kammeyer-Mueller et al., 2013).

2.2.1.2 Deep acting (DA)

Deep acting refers to a moderation of feelings in order to meet the external expectations (Grandey, 2003a). In deep acting, Employees need to first experience the internal feelings through psychological mechanisms, such as cognitive change and attention deployment, before showing the organizational desired emotional expression in the workplace (e.g. smile)

(Grandey, 2000). Through this behavior, individuals complete emotional regulation through internal psychological processing such as positive thinking and imagination (Bai, 2006). Performer also intentionally set authenticity to receiver (Carlson, Ferguson, Hunter, & Whitten, 2012). Deep acting stands behind the employee's emotional capacity to provoke the object's affective state though a display of honesty and sympathy. So, deep acting is called "acting in good faith" (i.e. trying to experience the desired emotion so that a natural display will follow) (Grandey, 2000).

Deep acting is often represented as beneficial because felt and displayed emotions are aligned (Brotheridge & Grandey, 2002). Various studies have suggested that deep acting has positive benefits to individual and organization. For instance, deep acting is correlated with raised sense of personal achievement (Brotheridge & Grandey, 2002), high level of job satisfaction (İrigüler & Economics, 2016; Li & Tan, 2009), enhanced job performance and reduced burnout (Lee, An, & Noh, 2015), as well as better work outcomes (Kammeyer-Mueller et al., 2013). In spite of the benefits of deep acting, there are some side effects to it. Because both forms of emotional labor, such as "surface acting" and "deep acting" create a situation in which there is either emotional dissonance or a need for more performative effort (Kumar & Shankar, 2010). Research has suggested that deep acting is correlated with lower positive affect (e.g. excited; alert; cheerful; determined; and happy) (Judge, Woolf, & Hurst, 2009).

2.2.2 Emotional labor in nursing professional

Stereotypical images of nursing that portray nurses as "angels" and natural care-givers require that nurses identify emotional labour as a main part of the nursing profession in making patients safe and comfortable. Nursing has long been distinguished as an occupation that requires extensive amount of emotional work (Bolton, 2001), in that, nurses appear to be defined by the ideal of care and are expected to match their emotions to patients. Emotional labor is seen as part of the normal procedure of nursing professional (Gray, 2010). Many nurses consider emotional labour to be the most important part of the work and a central

aspect of patient care (Gray, 2010), exemplified for instance by presenting an acceptable and caring facial expression (e.g. professional face, smiley face, humorous face) to the job (Bolton, 2001). Emotional labour engaged by nurse involves two aspects: nurses' autonomous response, resulting from professional commitment (e.g. role identification) and their personal work strategies, including surface acting or deep acting (Huynh, Alderson, & Thompson, 2008).

Emotional labour can create some benefits to nursing professional. It can enhance nurses' personal and professional accomplishment, increasing the connection between the nurse and the patient as well as improve job satisfaction. For organizational aspect, nurses who engage in emotional labor can have more unit productivity and create cheerful environment (Huynh et al., 2008).

However, to deal with these emotions effectively, nurses need a high level of skill as well as honesty and tenacity. Such a high degree of personal investment can cause negative effects. Study has shown that emotional labour is positively correlated with emotional strain, feelings of estrangement, depersonalization, burnout (Huynh et al., 2008), and lower job satisfaction which affect nurses' turnover intention (Kim & Lee, 2014a). According to the survey for mental health of hospital nurses, emotional labour is related with both "workplace interaction stress" and "daily stress" levels (Mann & Cowburn, 2005). Surface acting can consume a great deal of personal energy since employees are asked to hide their true emotions and display fake ones at the same time (i. e. discrepancy between displayed and real emotional states) (Mikolajczak & Menil, 2007). Since research has documented well the mind-body connection, the incongruence felt emotionally will lead to negative health outcomes on physical, psychological and social sides (Thomas & Abhyankar, 2014). Hence, repeated surface acting, by pretending to be authentic, can lead to emotional exhaustion, burnout (Cipriano, 2015) and lower job satisfaction (Chou, Hecker, & Martin, 2012).

2.3 Nurse-patient relationship

2.3.1 Concept of nurse-patient relationship

Nursing is an important, therapeutic, interpersonal process (Peplau, 1991). Effective nursing is based on both good relationships with patients and the nurse's ability to establish a connection with the patient (Wiechula et al., 2016). A well-succeeded relationship is the one that entails continuous, frequent, and private interaction building a sense of trust and willingness to share problems (Forchuk & Westwell, 2000). Nurse-patient relationship stands for interaction in the caring relationship involving the elements of persons, health, surroundings, and nursing profession (Granados & Gámez, 2009).

There are different perspectives regarding the essential meaning of nurse-patient relationship. Peplau's (1952) interpersonal relation form of nursing highlights a mutual nurse-patient relationship, in which, both parties take effort to become comfortable with each other and work together to understand their reciprocal reactions. Similarly, Courtney et al. (1996) contend that nurse-patient relationship stands for a partnership, where the passive and active roles delineate partner and chief relatiohship. However, Hagerty and Patusky (2003) argue that nurse-patient relationship is not only a linear relationship (i.e. establishing trust-work-end relationship), but involves four states of relatedness: connection, disconnection, enmeshment, and parallelism, based on levels of involvement and comfort.

To further emphasize the nurse's perspective, nurse-patient power relationship has been described (Kettunen, Poskiparta, & Gerlander, 2002). Nurses' power is correlated with their medical knowledge but also depends on the way patients' influence the flow of interaction (i.e. counsel with questions, interruptions in conversation, and extensive disclosure) with the professionals, in which also nurses participated. In nurse-patient relationship, there is a phenomenon in which a nurse working with two different clients, establishing different relationship with either one based on the desirable outcomes within a given period of time. Treating each patient differently is called uniqueness of individual nurse-client relationship (Forchuk, 1995). In psychiatric care, the nurse-patient relationship (one-to-one) takes on a

more individualistic character directed at counseling, crisis intervention, and individual psychotherapy (Lego, 1999). Other terms such as caring relationship, helping relationship, purposeful relationship (Kiteley & Vaitekunas, 2006), care partnership (Griffith, 2013) are also used to illustrate the key concept of the interpersonal process that happens between the nurse and his or her patient.

2.3.1.1 Nurse-patient relationship in different settings

Different service settings can significantly impact on nurse-patient relationship that may have different characteristics. Nurse-patient relationship in some units should focus on the "time stage". In accident and emergency department, nurses are expected to be kind and courteous even at a hectic pace. The frenzy and strain of their job should ideally be counterbalance with expressions of kindness and friendliness in order to enhance satisfaction and the sense of value (Baillie, 2005). Post-anaesthetic care (PAC) nurses establish meaningful relationship with the patients narrowed to pre and post-operative limited time. The research in PAC found that pertaining to this nurse-patient relationship was decreased to three topics: communication, being an advocate and being remembered (Reynolds & Carnwell, 2009).

In some units, nurses need to engage in more interactions. For instance in neonatal intensive care units (NICU), the character of the unit environment and the ongoing interactions brings patients' parents and nurses into closer relationships. The closeness between patients' parents and nurses is of vital importance and helps to enhance their well being (Fegran & Helseth, 2009). In the perspective of patient's parents, their relationship with nurses is the most important factor affecting satisfaction during the period of hospitalization of their child and they tend to describe nurses as teachers, guardians, and facilitators (Reis et al., 2010). Their perceptive engagement, cautious guidance, subtle presence with nurses can promote this relationship. Critical care nurses in intensive care unit (ICU) experience deep relationships with patients via connection with patients' bodies, rather than through verbal or non-verbal means of communication. The relationship with patients is regarded as "symbiotic" and it affects nurses' self-perception and personal identity. These relationships evoke intense

feelings of love, empathy and care, and influence the way nurses perceive and make sense of their role and their world (Vouzavali et al., 2011). In palliative care unit, trust, caring and reciprocity are important elements of nurse-patient relationship. Consecutively, they foster space for comfort, acceptance of illness and ultimately good death experence. Certain behavior expressive of care, affection and empathy depend on personal qualities and show excellence in nursing, contributing as well to nurses' job satisfaction and a sense of an accomplished mission (Mok & Chiu, 2004).

Nurse-patient relationship in psychiatry wards is most of the time unseen in the daily practice. Studies have pointed to this relationship with patients as "therapeutic relationship in the shadow" (Pazargadi et al., 2015). Rask and Brunt (2007) has showed a conceptual model that is representative of the interaction between patients and nurses comprising the following six elements: "building and keeping relationships", "supportive and encouraging interactions", "social skills training", "reality orientation", "reflective interactions" and "practical skills training". The six categories in the model differ but are interlinked with each other at the same time, which sheds light on different actions nurses can be used to establish a caring relationship with patients in forensic psychiatric care.

2.3.1.2 Phases of nurse-patient relationship

Establishing a good nurse-patient relationship contains explicit and implicit nurse-patient communication, which is a vital step in the process in helping the patient to recover (Lotzkar & Bottorff, 2001; Castledine, 2004). However, there are some difficulties encountered in building this relationship affected by various factors, including patient assignment systems, work ability of nurse and the amount of time nurses spend with patients. Peplau (1991) has described nurse-patient relationship as having four phases. The first phase of the relationship, "orientation", results in expression of needs and feelings, when the nurse and the patient first meet as strangers and develop mutual trust. When the patient's first impression is somewhat clarified, that leads to the second phase which is "identification" consisting of understanding the situation's benefits according to needs and requirements as well as predictions and expectations for both nurses and patients. The third phase is "exploitation" in which the

patient exploits the basis of self-interest and needs, trying to get most of the value of the service. The fourth phase is “resolution” when the patient moves from a hospital environment to participation in the community life. In this phase the patient should strengthen the personality for new social interdependent relationships. These four phases are overlapping and solution-oriented through cooperation. They also be identified in pre-hospital nurse-patient relationship or post, and each phase includes several different parts (Berntsson & Hildingh, 2013). These phases are showed in Figure 2-1. There is another research that conceptualizes the process of nurse-patient relationship as six phases: “reaching out”, “removing the masks of anonymity”, “acknowledgement of connection”, “reaching a level of truthfulness”, “reaching a level of solidarity” and, finally, “true negotiation of care” (Halldorsdottir, 2008).

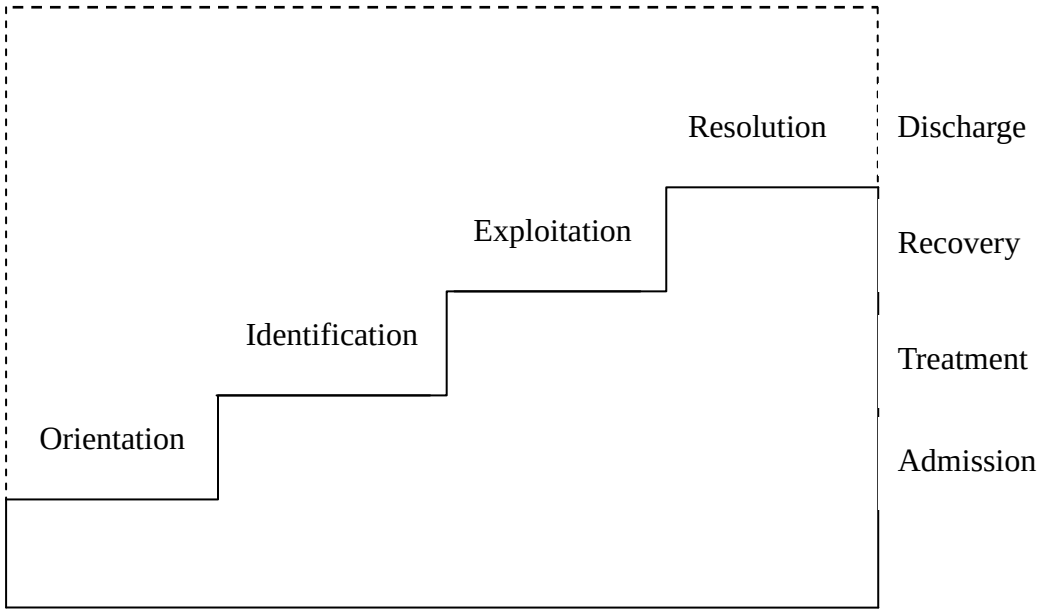

Figure 2-1 Phases in NPR

Sourse: Peplau (1991)

2.3.2 Importance of nurse-patient relationship

The role of the nurse is to nurture a positive attitude to therapy, something that in turn

will influence positively the well being of the patient (Moyle, 2003). Nurse-patient relationship runs through the whole process of medical activities. It is inseparable from the doctor-patient relationship. Disharmony of nurse-patient relationship will affect the smooth implementation of doctors' orders and patient treatment programs, which is an important cornerstone of doctor-patient relationship. Good nurse-patient relationship is conducive to the development of nursing activities during the treatment of patients, improving nursing quality and promoting patients' recovery. Therefore, the harmony of nurse-patient relationship is related to the overall image (Wang, 2014) and stable development (Ye, 2016) of the hospital. In the process of medical treatment, nurse is the medical employee who spends the most time with patients. So, nurse-patient relationship is the most basic and active social relationship in the process of medical activities. Paying attention to the healthy and orderly development of nurse-patient relationship is of great significance not only to modern nursing activities, but also to the whole medical and health service.

To sum up, nurse-patient relationship is important for 10 reasons (Castledine, 2004). (1) help patients make informal decisions; (2) avoid isolating and dehumanizing patients; (3) act as an advocate for vulnerable patients and those unable to express their wishes; (4) nurture cooperation and understanding; (5) help in patient assessment and problem solving; (6) help patients cope with their problems; (7) help patients undertake, or carry out for them, activities of living and human needs; (8) nurse dying patients and those with terminal illnesses and palliative care needs; (9) teach and promote health education; (10) learn about new ways of nursing and caring for people in a changing world.

2.3.3 Antecedents of nurse-patient relationship

The antecedents of nurse-patient relationship consist of helping factors and hampering factors as discussed below.

2.3.3.1 Helping factors

(1) Communication

The effective communication between nurses and patients is a fundamental element of

nurses' work, which plays an important role in nurse-patient relationship and positive patient care (McGilton, Robinson, Boscart, & Spanjevic, 2006). The main factors related to communication are role allocation, different use of language and registers, and nursing setting (Fleischer, Berg, Zimmermann, Wüste, & Behrens, 2009). Besides, non-verbal communication, such as eyegaze, head nodding and smiling are essential methods to convey warmth, love and support to patient (Caris-Verhallen, Kerkstra, & Bensing, 1999). The patient-centred communication that engages patient to participate and negotiate in decision-making regarding their own care promotes the quality of patient care (McCabe, 2004). Effective communication is not only beneficial to patient, but also to nurses, because when nurses enhance their commucation skills with patient, they will feel better about their job and have better relationship with patient (McGilton et al., 2006). Some researchers have suggested that humour can also be used as a technique founding of good relationship (Tanay, Wiseman, Roberts, & Ream, 2014).

(2) Trust

Trust is also fundamental to effective nurse-patient therapeutic relationships (Bell & Duffy, 2009). The development of trust is a correlative phenomenon, a process, during which trust can be reduced and re-built (Dinç & Gastmans, 2013) and usually requires a foundation. This foundation expects nurses to exhibit a number of capacities such as competence, compassion, awareness of risks and the power balance with patient (Bell & Duffy, 2009). At the root of good nurse-patient relationship, patient care (i.e. genuinely caring for the patient as a person and as a patient), wisdom (i.e. combination of knowledge and experience) and competence (i.e. having the necessary skills required in the relevant area of nursing and being competent in connecting with patients) are important. Patient trust can only be built if this three are present and are essential for its maintenance (Halldorsdottir, 2008).

(3) Empathy

Empathy is an important reason for developing a successful nurse-patient relationship, due to the non-judgmental listening, the ability to convey warmth and understanding involved in it. Empathy is different from sympathy, since the manifested feelings for the patient do not

just interfere with the tasks undertaken to help them solve problem in hospital, but need understanding with them. Too much sympathy for a patient may lead to the nurse getting over the boundaries that let the patient and the nurse to engage safely in a therapeutic, caring relationship. On the other hand, too little sympathy and empathy may lead to an abuse of professional boundaries (Castledine, 2004).

(4) Active and complementary role

The active and complementary roles of both patients and nurses are important. Nurses and patients should take actions to gain and demonstrate acceptance of each other. The patients' positive tone and nonverbal behaviors (e.g. smiling, direct eye contact) communicate acceptance effectively to nurse. In response to these overtures, the nurse should use some of the patient's terminology, listen attentively to patient's concerns, provide the care and give assistance without any hesitation. Nurse also need to express friendly gestures and willingness in conversation, these responses appear to create an acceptable and positive atmosphere that reinforce the interest in patient and their efforts to establish the connection (Lotzkar & Bottorff, 2001).

(5) Attention to initial requests and connection

It is the way one respond to initial requests as quite vital in developing the relationship, including consistency, pacing, listening, positive initial impressions, and attention to comfort and control (Forchuk & Westwell, 2000). Besides initial requests, enhancing patient connection in this process is a worthwhile skill to practice (Mitchell & RN, 2007). Under the theoretical framework of the theory of modeling and role-modeling (MRM), patient's connection is a relationship that "begins at the moment of initial contact between nurse and client with recognition that the relationship itself is integral to the nurse's ability to model the client's world". There are many principles that apply to the nurse-patient connection: not to be offended by a patient's manner, sharing personal thoughts and experiences, appropriate silence (Erickson et al., 2006).

2.3.3.2 Hampering factors

The model of nurse-patient relationship often started the same, but numerous, changing outcomes are discovered when the relationships do not experience same progress. Research reported factors that functioned as barriers to nurse-patient relationship were classified into three main categories: nurse-related, patient-related and organization-related (Pazargadi et al., 2015). Nurse-related barriers include "negative personality characteristics", "work stress", "inadequate skills", "pattern-taking", and "negative attitude of nurses towards nurse-patient relationship". Patient-related barriers include the "patient's lack of knowledge" and "failure to communicate with others". Organizational barriers to the relationship were "manpower shortage", "large number of patients" and "work overload". Nurse-patient relationship also is hampered by inconsistency, unavailability, and unrealistic expectations of nurse and patient (Forchuk & Westwell, 2000).

Scholars have explored the causes of tense nurse-patient relationship in China (He, Zhang, & Lan, 2011). The main reasons are high medical expenses and biased media orientation (He, Zhang, & Lan, 2011) that lead to patients dissatisfaction and mistrust of the overall health service which hamper the development of healthy and positive patient-nurse relationship. Besides, other factors related to nursing profession such as insufficient number of nursing staff, unbalanced nursing team structure, and lacking of theoretical knowledge and professional skills of nurses (Zhuan et al., 2014; Wang, 2014) contribute to the growing tention and conflict of nurse-patient relationship in China. Lastly, limited communication and understanding between nurses and patients are important reasons for nurse-patient relationship issue in the country (Lin & Liu, 2015).

2.4 Turnover intention

2.4.1 Definition

Turnover is a gradual process of employees' departure from their current position to another (Naz & Gul, 2014). The intention is the extension of will, a state of mind before the

occurrence of turnover behavior. Since turnover intention is the antecedent of turnover, having a good predictive effect on actual turnover behavior (Ju & Yang, 2012; Alexander, Lichtenstein, Oh, & Ullman, 1998), this research focuses on the turnover intention. Some alternative terms of turnover intention were used by scholars, such as "anticipated turnover" (Gormley, 2011), "intent to leave" (Mccarthy, Tyrrell, & Lehane, 2007) and "intention to quit" (Alexander et al., 1998; Sager, Griffeth, & Hom, 1998). Turnover intention is an individuals own estimated probability, which is subjective, that they are permanently leaving the organisation or changing their job to some degree in the near future (Vandenberg & Nelson, 1999; Sousa-Poza & Henneberger, 2004). It is the previous thinking of the individual who is dissatisfied with the current status of work and has intention to leave the position in search of a better job opportunity and is a willingness or attempt to leave the current workplace voluntarily (Takase, 2010; Sager et al., 1998). Tett and Meyer (1993) indicate that turnover intention is the last consecutiveness of withdrawal cognitions, a set to which thinking of giving up and intent to search for alternative employment belong as well.

In short, turnover intention is widely pointed to a attitudinal (thinking of giving up), decisional (intention to leave), and behavioral (looking for a new job) process proceeding voluntary turnover, which is a determinant of actual turnover behavior (Mosadeghrad, Ferlie, & Rosenberg, 2011) and a key stage before the real turnover happens (AlBattat & Som, 2013).

2.4.2 Turnover intention in nursing

Nursing turnover represents a major topic for health care managers, notably during the global nursing workforce shortage, one of the most popular subjects in the field of Human Resource Management. This part will review antecedents of turnover intention involving organizational and individual factors.

2.4.2.1 Organizational factors

(1) Professional characteristics

Nursing as a caring profession includes some special characteristics like working for people, keeping alert in work, and shift work schedule causing some problems that related the intentions of the worker to leave the job (Zedeck & Jackson, 1983). Hospital employees reported low levels of quality of working life (i.e. disturbance handling, job security, participation and wages), which was positively correlated with turnover intention (Mosadeghrad et al., 2011). Owing to the these characteristics of their profession, nurses suffered more frequently from work-related emotional trauma and eventually post traumatic pressure disorder (PTSD), leading to emotional stress and burnout of nurses, which is positively correlated to turnover intention (Sung, Seo, & Kim, 2012).

The system and the type of hospital also play a role to develop the tendency of turnover intention. Research has shown that dissatisfaction with hospital systems involving payment, working situation, hospital policy, and promotional opportunities, affected nurses' turnover intention. Workers in hospitals operated by an external organization are more possible for having depersonalized environment that can more likely lead to leaving (Hwang & Chang, 2008). In tertiary hospital that may have heavy workload and work tasks, the turnover intention is higher than that of secondary hospital (Yang & Hong, 2014). Nurses in some departments may express more inclination to quit. For instance, in psychiatric units, staff members who spend the most time with psychiatric patients are at the greatest risk of experiencing an assault, the characteristics of the unit may cause lack of control and risk of violence and relate to dissatisfaction with job, then, lead to turnover intention (Alsaraireh, Griffin, Ziehm, & Fitzpatrick, 2014). Other research showed that nurses' turnover intention is pretty high in emergency department, pediatric department (Zhao et al., 2013; Yang, Lv, Zhou, Liu, & Mi, 2017a) and psychiatry department (Liu, 2016; Wang & Zhou, 1999).

In addition, the difference of turnover intention is also reflected in the form of employment of nurses. Contract nurses often lack the sense of belonging in the unit, and there are still obvious gaps between regular and contract nurses in salary treatment, position

promotion and opportunity to study abroad (Yang & Hong, 2014). Therefore, the turnover intention of the contract nurses is higher than regular nurses (Jin, 2016). It is not only the work environment in hospital that is related to anticipatory turnover (Gormley, 2011) but the external work environment as well. The external environment such as limited resources and budget cuts cause working load and hostile atmosphere leading nurses to have greater turnover intentions (Zeytinoglu & Denton, 2007).

(2) Supervision

Research has shown that integrity in nursing leadership behavior has a positive impact on nurses' intention to remain, and this relationship is enhanced with the increase of conflict among groups (Kang et al., 2017). And the positive supervisory communication (Kim & Lee, 2009) and supervisor support (Galletta, Portoghese, Penna, Battistelli, & Saiani, 2011) are negatively associated with role stress and turnover intention. According to leader–member exchange (LMX) theory (Ballinger, Lehman, & Schoorman, 2010), high-quality leader-member relationship is the tenet for reaping psychological benefits. This exchange gives us the vocabulary to build the rules for specific units' functioning and the work satisfaction reported by nurses with higher levels of LMX and lower levels of turnover intention (Portoghese, Galletta, Battistelli, & Leiter, 2015). In addition, perceived fairness by employee in human resource management such as performance appraisal or promotion opportunities positively impacts the nurses' commitment in work and negatively relates their quitting intention (Rubel & Kee, 2015).

(3) Advancement opportunities

According to the Need Hierarchy Theory (Udechuk, 2009), self-actualisation is at the top of human needs' pyramid. Promotion opportunities and challenge lead workers to their milestones and goals creating a sense of emotional attachment (Takase, Teraoka, & Yabase, 2016). Perceived advancement opportunities by employees contribute to a reduction in nurses' turnover intentions (Takase et al., 2016). Little career advancement or simply "just applying for whatever jobs are available" will lead to a higher turnover intention (Scanlan & Still, 2013). Nursing profession is quite complex in a sense that it shows career demands at

different career stages, which means that successful career development programmes should take into account at different moments and needs of nurses in their working life (Chen, Chang, & Yeh, 2003a). If nurses find the development programmes do not satisfy their career needs, then a gap exists between career needs and career development programmes. That is positively associated with turnover intention (Chang, Chou, & Cheng, 2007; Chen, Chang, & Yeh, 2003b) though influencing their work performance or attitudes.

(4) Work reward

Salary and welfare are associated with the security and stability of people's life. Individual would view "the salary was good" as a key attraction in the job (Scanlan & Still, 2013). So, poor salary was an important predictive factor affecting turnover intention (Wang, 1999). Raising the value of salary and welfare related to treatment by the respective medical organization significantly reduces the turnover intention. Research has shown that in small and medium-sized medical institutions, the turnover intention figures correspond with little salary satisfaction, little cooperation and poor implementation of improvements (Kudo et al., 2006). Besides, the fulfillment of psychological contract also contributes to a reduction in nurses' turnover intentions (Takase et al., 2016). Psychological contract corresponds to an employee's set of believes regarding the mutual obligations between employee and organization. When fulfillment of the psychological contract is experienced, the employee feels obliged to reciprocate and thus contributes more to the organization.

2.4.2.2 Individual factors

(1) Stress and burnout

There are high demands and high risks in nursing profession and thus nurses' work stress is related to turnover intention. Among the stress factors, there are inadequate salaries, age experience, staff deficit, insecurity and lack of advancement in the career. Study indicated that occupational stress was positively associated with nurses' turnover intentions (Mosadeghrad, 2013; Yang et al., 2017a; Lee, Lee, & Bernstein, 2013). Research investigated the rural hospital showed that workplace stress directly influenced job satisfaction and job performance,

and then created turnover intention (Chao, Jou, Liao, & Kuo, 2015). Researches suggest that the high the level of job burnout perceived by nurses is important factor for their turnover intention (He, 2010; Scanlan & Still, 2013).

(2) Work dissatisfaction

Job satisfaction is a physical and psychological state influenced by the work conditions and the work itself. It is a subjective reaction of employees to the overall situation of work. Whether a well-qualified employee commits to the job depends on the job satisfaction. Job dissatisfaction or low levels of job satisfaction have been found to be a strong and consistent predictor of intention to leave as well as to turnover (Mccarthy et al., 2007). Research showes female nurses, married nurses, nurses with an associate nursing degree exhibit higher job satisfaction than male nurses, single nurses, and nurses with a bachelor nursing degree (Alsaraireh et al., 2014). Receiving good remuneration and recognition and being challenged by one's work is associated with higher job satisfaction. Mediocre salary and staff conflicts to leaders were correlative of lower job satisfaction (Scanlan & Still, 2013). Nursing is a job that requires more interaction with people and where interpersonal communication is very important. Communication satisfaction is personal satisfaction based on effective communication with others and organizations. Study indicated that nurses' communication satisfaction with colleagues, superiors and leaders has a negative correlation to turnover intention (Naz & Gul, 2014). Also, nursing work requires more emotional labor affecting job satisfaction (Lee, Ok, & Hwang, 2016) which influences turnover intention (Kim & Lee, 2014b). Hence, these factors expressed above all related to nurses' intentions of quitting their job by significantly decreasing their job satisfaction.

(3) Psychological detachment

The employee's relationship with the organization, the implications for the employee to continue in the organization depend on the psychological phenomenon called organizational commitment (OC). It refers to the multi-dimensional psychological attachment of an individual to the organization as an important factor in employee's retention. Research showed that organizational commitment belongs to the attitudinal component while turnover

intention is part of the decisional component in work to predict turnover. Employees' organizational commitment and job satisfaction are closely inter-related and lead to turnover intention (Mosadeghrad, Ferlie, & Rosenberg, 2008). As one of the dimensions of occupational commitment, affective occupational commitment refers to values and a desire to act in ways that are consistent with membership of the occupation. Lower occupational commitment is correlated to employees' intention to change jobs (Parry, 2008).

Moreover, work engagement in organization attribute to the fact that enthusiastic employees often experience more positive affections and emotions such as happiness, enjoyment, ecstasy and rejoice, have better physical and mental health, also can transfer their work engagement to others (Bakker, Schaufeli, Leiter, & Taris, 2008). Study has pointed that personal resources (i.e. resilience, self-efficacy, optimism and self-esteem) have direct positive effect on work engagement, which have a negative effect on turnover intention (Shahpouri, Namdari, & Abedi, 2016).

Another variable factor that can explain "why do people leave?" and "why do they stay" is job embeddedness. Job embeddedness involves three dimensions: organizational fit, organizational links, organizational sacrifice. These three are foretelling of the intention to leave and shed light on other factors such as job satisfaction, organizational commitment, job alternatives, and job search (Mitchell, Holtom, Lee, Sablynski, & Erez, 2001). Lower job embeddedness, self-efficacy and organizational commitment were identified as the most likely paths to turnover intention (Kim & Kang, 2015). In organization, employees who are reluctant to change to another hospital, or would not change the job may show high loyalty to the organization or profession. Research has shown that poor loyalty was the significant factor affecting nurses' turnover intention (Hwang & Chang, 2008).

(4) Other factors

Scholars point out some of the demographic factors relate to turnover intention. It has shown that turnover intention of married nurses is lower than that of unmarried nurses. The older the nurses are and the longer the nursing experience, the weaker the turnover intention (Liu, 2016; Wang, & Zhou, 1999). Among these, the nurses who have worked for one to five

years have a high turnover intention (Naz & Gul, 2014). In some secondary hospitals, nurses aged between 30 and 39 have a higher turnover intention.

Besides, nursing competence also plays a role to relate to turnover intention. From Competence-Turnover Intention Model (Meyer, Stanley, Herscovitch, & Topolnytsky, 2002), nursing competence is benefited by the number of organizational rewards given to emploees and establishes a negative correlation with the level of exhaustion, which can in due course affect the workers's turnover intention through affective commitment.

Previous researches suggest that the following factors also contribute to nurse turnover intention. For instance professional self-concepts, personality (Seok, 2013), kinship responsibilities (Mccarthy et al., 2007), nurse-physician collaboration (Galletta, Portoghese, Carta, Aloja, & Campagna, 2016), role ambiguity (Brien-Pallas & Murphy, 2010), patient relationships and job content (Tourangeau, Cummings, Cranley, Ferron, & Harvey, 2010) can all be the predictors of turnover intention.

The organizational and individual antecedents of turnover intention are summarized and reported in Table 2-2 and Table 2-3, respectively.

Table 2-2 Organization antecedents of turnover intention

Classification	Antecedents	Author,year	Mediator	Moderator
Professional characteristics	job characteristics	Portoghese & Galletta,2015	job satisfaction	leader–member exchange
	job stress,quality of working life	Mosadeghrad & Ferlie, 2011		
	job stress,bullying	Lee, Younju, Lee, & Mihyoung, 2013		
	hospital type	Hwang & Chang, 2008		
	the quality of work	Al-Hussami & Epidemiologist, 2013		
Climate and culture	work environment	Gormlry, 2011		
	nursing organizational culture	Kim, 2014		
	external work environment,workload	Zeytinoglu & Denton,2007	job Satisfaction	
	organizational culture, self-leadership,empowerment	Choi, Seunghye, & Jang, 2014		
	ethical work climates	Filipova, 2007		
	organizational climate	Seok & Sook, 2013		
	perceptions of work climate	Hwang & Chang, 2009		
	nurse-physician collaboration	Galletta & Portoghese, 2016		

Table 2-2 Organization antecedents of turnover intention

Classification	Antecedents	Author,year	Mediator	Moderator
Advancement opportunities	perceived fairness of performance appraisal, promotion opportunity	Rubel & Kee, 2015		
	career needs,career development programmes	Chang & Chou, 2007	organizational commitment	
Leadership and organization surpport	leadership’s impact	Furtado & Batista, 2011		
	leader–member exchange	Ballinger & Lehman, 2010		
	perceived organizational support	Filipova, 2007		
	supervisory communication	Kim & Lee, 2009		
	supervisor support and organizational support	Galletta & Portoghese, 2011		
	role of internal marketing	Lee & Kim , 2011		
	fulfillment of the psychological contract	Takase & Teraoka, 2016		

Table 2-3 Individual antecedents of turnover intention

Classification	Antecedents	Author,Year	Mediator	Moderator
Individual characteristics	kinship responsibilities	Mccarthy, 2007		
	emotional Intelligence	Trivellas & Gerogiannis, 2013		
	nursing competence	Takase & Teraoka, 2014	affective commitment	
	professional self-concepts, personality	Seok & Sook, 2013		
	perception of health	Al-Hussami & Epidemiologist, 2013		
	personal resources and job resources	Shahpouri & MA, 2016		
	self-efficacy	Kim, Yumi, Kang, & Youngsil, 2015		
	nurses' organisational socialisation	Tomietto & Rappagliosi, 2015		
Work dissatisfaction	job satisfaction	Mccarthy, 2007; Alsaraireh & Griffin, 2014; Choi, Seunghye, & Jang , 2014		
	satisfaction with system	Hwang & Chang, 2008		

Table 2-3 Individual antecedents of turnover intention

Classification	Antecedents	Author,Year	Mediator	Moderator
Stress and Burnout	burnout	Scanlan & Still, 2013		
	workplace Stress	Chao, Jou, Liao, & Kuo, 2015		
	occupational Stress	Mosadeghrad, 2013		
	compassion fatigue	Sung & Seo, 2012		
Psychological Detachment	career plateau, job embeddedness,organizational commitment	Kim,Yumi,Kang, & Youngsil, 2015		
	normative organizational commitments	Al-Hussami & Epidemiologist, 2013		
	loyalty	Hwang & Chang, 2008		
	job embeddedness,organizational citizenship behavior	Kim, Lee, & Choi, 2012		

2.5 Research hypotheses

2.5.1 Workplace ostracism and turnover intention

Ostracism experience in workplace may promote the victim to have a turnover intention (Ye, Ni, & Huang, 2015). As discussed earlier, ostracism leads to a variety of responses, including antisocial and aggressive behavior and a stunned and affectless state. Employee may attempts to flee the situation (Williams, 2007b) because people are always more interested in continuing with the group that included them in the first place and not be excluded (Wirth et al., 2014). Ostracized individuals want to avail themselves of a moving away response from ostracism (i.e., seeking solitude). They expressed stronger desires to be alone and less desire to stay in the same group, but preferred to join a new group (Ren, Wesselmann, & Williams, 2016). Before the actual turnover behaviour, people still have a period time to form intentions to quit but do not quit suddenly. They may want to experience the confidence in repairing relations with those who exclude them. However, these individuals may eventually leave the workplace if their efforts to rebuild socially with their current coworkers fail (Renn, Allen, & Huning, 2013).

Work environment is an important factor related to early turnover behavior (Gormley, 2011). Both terms, organizational climate and work climate, are comprised of different attributes assumed by those who thrive in those environments. The former refers to interpersonal and managerial networking, job architecture, autonomy and supervisiory base and unity. The latter is informed by the features directly or indirectly identifies by workers. The consequences of ostracism that emerge because the excluded person is deprived of the access to task-related capital, relationships and associations and all the data that circulates solely between different member of a group (Robinson et al., 2013) will influence work environment.

Ostracism affecting dissatisfaction of the job has effect on to determine leaving the organization (Aydogdu & Asikgil, 2011). From the multi-stage process of turnover intention,

the first step is psychological responses that might result in employees' emotional and attitudinal withdrawal reactions (Takase, 2010). When employees feel satisfied with their job they do not quit (Portoghese et al., 2015), by contrast, if person are dissatisfied with their work, they are likely to leave from the organization. People who have chronic exposure to ostracism could deplete coping resources, resulting in depression and helplessness (Williams, 2007b), which influences work attitude and causing work dissatisfaction (Ferris et al., 2008).

Social Identity Theory (Tajfel, 1978) attempting to explain cognitions and behaviors with the help of some phenomenon from group-processes. The social identity in the organization determines the classification of employees to their own groups (Trepte, 2006). If individual's perception is not recognized by the organization or ostracized by the organization, the social identity is low, and then the marginalized phenomenon occurs. Ostracism has a negative impact on social identity, thus people avoiding ostracism by leaving the group. Workplace ostracism also reduces the sense of self-efficacy of employees by worsening interpersonal relationships within the organization, causing cognitive and emotional changes, such as depression, so that individuals are aware of individual-organization mismatch and people-position mismatch, and then incorrect decisions are made, thus turnover intention occurring (Yin & Liu, 2013). Besides, ostracism also positively relates to turnover intention though impacts on affect-based trust (Costigan & Insinga, 2012), role ambiguity (Mulki, Jaramillo, & Locander, 2008), gratification delay and impairing time management (Renn et al., 2013) and organizational commitment (Ferris et al., 2008).

Based on the above review, we propose the following hypothesis:

Hypothesis 1: Workplace ostracism is positively correlated with turnover intention.

2.5.2 Workplace ostracism and nurse-patient relationship

In medical institutions, nurses are the most exposed medical personnel with patients in the process of medical treatment. Poor attitude or caring quality caused by any factor may lead to tension and even conflict for nurse-patient relationship. In the process of formation of nurse-patient relationship, nurses are in a relatively active position due to the professional

identity. The attitudes and behavior of nurses play an important role in the establishment and development of nurse-patient relationship. Research has also shown that ostracized participants experience lower positive mood (e.g. good, pleasant, friendly, and happy) and relatedness (e.g. trust, interact with others) than includes participants, which in turn, results in lower intrinsic motivation in work (Lustenberger, 2010). Ostracized participants also perceive the group to be more burdensome than included participants (Wirth et al., 2014).

Workplace climate influenced obviously by ostracism in organizations is substantial in shaping an individual's workplace attitudes and behaviors. Research indicates that ostracized person rates the ostracizing players less positively, both in terms of personality and attractiveness (Zadro, Boland, & Richardson, 2006), usually manifesting increased temptation to act aggressively toward the interaction partner (Wirth et al., 2010). On the other hand, ostracism can lead to emotional numbness, making the ostracized person less likely to select words of either positive or negative on emotional valence (Harris, 2009) in relationship with coworkers. Since high-quality relationships with other individuals in the workplace are seen as increasing ‘‘embeddedness” in the organization (Mitchell et al., 2001), mutual support from each other can be feeding constructively into nurse–patient interactions and hence into patient welfare (Cleary et al., 2012). As such, nurses work within teams and the way the team interacts can impact on nurse-patient relationships (Wiechula et al., 2016). Workplace ostracism positively relates to coworker conflict, supervisor conflict and task conflict, as a result, ostracized employees will feel anger and foster antisocial behavior (e.g. behaviors designed to harm another) (Chow et al., 2008), and consecutively relates to lower in-role behavior and organizational citizenship behaviors (Chung, 2015). In addition, workplace ostracism leads to marginalization of workers and increases the interpersonal distance between employees and other people in the work group (Ye, Ni, & Huang, 2015).

Furthermore, workplace ostracism might affect the attachment of employees, which then impact on the care quality of nursing work. As exclusion increases, targets feel more threat to their needs and put less effort into group tasks. They may aim at self-gain rather than group gain (Banki, 2012), and perceive the world in a more threatening way (Zadro et al., 2006),

which further influence the work behavior. Ostracism could cause counterproductive work behaviour (CWB) in workplace. There are two CWB, one is interpersonal CWB, which formed though ostracism via co-workers, whereas organizational CWB fromed though ostracism by supervisors (Hitlan & Noel, 2009). CWBs are behaviors that are intentionally conducted by workers and harm organizations and its members (Yang & Treadway, 2018). Common CWB include absenteeism, late arrival, early retreat, bad words, rumors, and vandalism (Luo et al., 2015).

Moreover, ostracism can contribute to a dwindling of the quality of work performance, an idea already proven by the Conservation of Resources Theory that defends people's protective behavior towards resources seen as absolute value (Leung et al., 2011). The personal capital (e.g., self-esteem) and work resources (co-worker support) stand behind effectiveness and enhance the workers' capacity to perform (Thomas & Hobfoll, 2004). Provided these resources, in their nature often scarce, are a propeller of personal growth their deficiency can redirect workers' focus and energy from performing their tasks well to compensating for the lack of resources, which can then result in failure to meet deadlines, requirements and responsibilities (Wu et al., 2011). Other researchs have also shown that workplace ostracism is negatively correlated with job performance (Ferris et al., 2008).

Based on the above review, we propose the following hypothesis:

Hypothesis 2: Workplace ostracism is negatively correlated with nurse-patient relationship.

2.5.3 Nurse-patient relationship and turnover intention

The establishment and maintenance of the nurse-patient relationship is a complex process. It is a purposed correlation with the main goal of promoting the values, interests, and health outcomes of the patients (Porr, 2009). In this process, a nurse and a patient affect each other reciprocally and are mutually dependent upon each other (Vouzavali et al., 2011). Bad nurse-patient relationship will bring negative results for both nurses and patients. At present in China, reports on nurse-patient disputes and hospital violence are increasing, and the

nurses-patient relationship is becoming increasingly tense and severe. This indicates that the current nurse- patient relationship is not desirable (Zhuan, Duan, Ma, & Lei, 2014).

Improper job requirements and poor working conditions lead to resource imbalances. Medical disputes and tense atmosphere not only bring economic loss and other negative effects to the hospital, but also affect the stability and working enthusiasm of the nursing staff (Ding, 2015). The tension between nurses and patients creating resourses loss of nurses, leads to increased pressure, resulting in job burnout, poor job performance and lower job satisfaction, thus increasing turnover intentions (Wang & Yang, 2015). Tense relationship between nurses and patients also leads to a decrease of nurses' professional satisfaction, mental health and nursing quality (Zhuan, Duan, Ma, & Lei, 2014), which brings unpleasant experiences to nurses and reduces their emotional commitment to organization. As commitment wears down, a person is likely to engage in possible job searching behavior either in the present or in the near future. Research has shown that affective commitment negatively relates to turnover intention (Moreno-Jiménez & Gálvez-Herrer, 2012), that is, the lower the emotional commitment, the higher the turnover intention (Chang, 1999; Lu, Zhang, Zhang, Zhou, & Wang, 2013).

When faced with the loss of individual resources, individuals tended to take action to prevent the continued loss of resources (Cao, 2014). For individuals, exiting from the current bad environment was an adaptive response to protect psychological needs and avoid the pain of workplace ostracism, so they may respond in an evasive manner. The conservation of the resources theory (Hobfoll, 2001) serves as a blueprint for a comprehension of the above. The theory suggests that negative result occurs when certain valued resources are lost, are inadequate to meet demands, or do not yield the anticipated returns. It further elucidates that attitudinal elements and particular behavioural, such as creating turnover intention or actual turnover behabior, are outcomes of resource depletion (Knudsen, Ducharme, & Roman, 2006).

Based on the above review, we propose the following hypothesis:

Hypothesis 3: Perception of nurse-patient relationship is negatively correlated with

turnover intention.

2.5.4 Workplace ostracism, emotional labor (SA & DA) and nurse-patient relationship

From conservation of resources theory (COR), people will strive to retain, protect, and establish resources, given that when such resources are limited (Hobfoll, 2001). As an emotional event and "social pain" (Eisenberger & Lieberman, 2004), workplace ostracism had been proven a lot of negative impact on employees in previous studies not only threats to employees' basic social needs, such as belonging, self-esteem, control, and the meaning of existence, but also brings more emotional load to the individual, such as job stress, emotional burnout, depression (Wu et al., 2012), that may change employees' behavior and attitude. Therefore, as an interpersonal stressor, ostracism threatens the social resources of the target, which can be drawn upon when needed, to solve a problem or cope with a challenging event (Wu et al., 2012). Individuals may mobilize resources to counter ostracism in order to adopt the conditions in workplace by employing emotional regulation strateges including surface acting and deep acting. So, ostracism prompts emotional regulation (Poon et al., 2013). Both ostracized individual and the perpetrator showed regulating emotions. Ostracized individuals will tend to show more social information and work harder on group tasks, they respond more pro-socially than included individuals (Williams, 1997a). And the perpetrators of ostracism would view themselves as less human. If perpetrators view their behavior as immoral, they may feel self-dehumanized and desire to reestablish moral status and reconnect with other prosocial behavior, rather than a callous perpetuation of harmful behavior (Bastian et al., 2012). In this case, individuals will modulate exaltation and logic that mutally control emotions, adjusting the facial and bodily expressions to the moment (Grandey, 2000). Therefore, employees may perform emotional labor to make emotional adjustments when ostracizing or being ostracized (Liu & Eacute, 2004).

The process of emotional regulation includes the individual's existing emotion, the time of emotional adjustment and the way of expressing emotion (Gross, 1998). It involves two processes: antecedent-focused process (corresponds with the process of deep acting) and

response-focused process (corresponds with the process of surface acting) (Grandey,1998). Effective emotional regulation serves as a useful measure of emotional work people produce in adjusting to emotionally challenging situations. From Totterdell and Holman's (2003) emotional labor model, after experiencing emotional events such as emotional experiences (happiness, unhappiness, and boredom), employees generated emotional adjustments, and use surface acting and deep acting.

Based on the above review, we propose the following hypotheses:

Hypothesis 4a: Workplace ostracism is positively correlated with surface acting.

Hypothesis 4b: Workplace ostracism is positively correlated with deep acting.

Different emotional regulation strategies used by nurse may impact on the nurse-patient relationship in different way. In other words, surface acting and deep acting may influence the quality of nurse-patient relationship in different way. This will be discussed next.

2.5.4.1 Surface acting and nurse-patient relationship

From conservation of resources theory, employees who perform surface acting will deplete emotional resources, makes them extremely emotionally tired, predisposing them to pressure, burnout and other negative outcomes (Carlson, Ferguson, Hunter, & Whitten, 2012), that will impact on the quality of nusing work and nurse-patient relationship.

First of all, surface acting has a significant positive correlation with physical health problems (Thomas & Abhyankar, 2014). Surface acting creating state anxiety has an effect on insomnia (Wagner, Barnes, & Scott, 2014). Ongoing hindrance of normal emotions leads to a general acute physiological activity, which can have an extremely negative impact on different bodily systems from the cardiovascular to the nervous system, depleting the immune defences. This can result in a number of civilizational illnesses such as hypertension and cancer (Grandey, 2000).

Furthemore, In surface acting, faking emotional expression, and at the same time realizing that the expression is actually fake, one could not be his/her real self. Thus,

problems will arise when the true inner feeling felt by a person does not match those emotions displayed in the job. As a result, it exhibits more general tendencies to devalue themselves and experience fewer positive emotions, reporting higher levels of negative emotion episodes (e.g. anger, anxiety, sadness, and shame options) that are much more difficult to manage emotion compared to those who have lower levels of surface acting (Beal et al., 2006). Suppression of genuine feelings is stressful, because individuals tend not to enjoy continuous falsification of true emotions. Hence, engaging surface acting over a long period of time may result in emotional stress. It has been argued that surface acting ultimately leads to emotional exhaustion (Grandey, 2000). There are some professions showed the similar situation. For instance, nurses' surface acting (Yoon & Kim, 2013), coaches' surface acting (Lee & Chelladurai, 2015) and teachers' surface acting (Zhang & Zhu, 2008) significantly predicted emotional exhaustion. Individuals experiencing surface acting will have severe stress and burnout. This high emotional workload will constitute organizational barrier to effective work (Pazargadi et al., 2015), and has important impact on nurse-patient relationship (Schoombee, Van, Merwe, & Kruger, 2014).

Besides, surface acting will influence employee's work attachment, and then affect the work performance. In surface acting, when employees expend energy to constantly overcome felt emotions to meet the employer's expectations, it is unlikely that they develop high personal commitment to the organization. Study has revealed that frequent use of surface acting reduces organizational commitment while increasing the intentions to leave the organization (Rathi, Bhatnagar, & Mishra, 2013). That is, surface acting positively associated with turnover intentions (Chau, Dahling, Levy, & Diefendorff, 2009) and work withdrawal (Scott & Barnes, 2011; Scott, Barnes, & Wagner, 2012). This may reduce the loyalty about the unit, affecting the quality of nursing work. Surface acting is also harmful to workers by increased feelings of self-estrangement (Sloan, 2014), from that decreased job satisfaction and work performance (Chen et al., 2012). In addition, in surface acting, the service objective (e.g. patients and family members) may observe the fake emotions of employee (e.g. nurses). This is also a factor affecting the relationship between nurse and patient (Grandey, 2000).

Based on the above review, we propose the following hypothesis:

Hypothesis 5a: Surface acting is negatively correlated with nurse-patient relationship.

2.5.4.2 Deep acting and nurse-patient relationship

By performing deep acting, employees can obtain some valuable resources, therefore, promote service, and this may positively relate to the nurse-patient relationship as well. Research has argued that deep acting is observed to have a negative relationship with health problems (Thomas & Abhyankar, 2014), emotional exhaustion (Hwa, 2012; Rathi et al., 2013) and burnout (Noor & Zainuddin, 2011). Since emotionally stressed nurses are less likely to be seen as sincerely warm and pleasant, they might easily experience a poor work performance that breaks the relationship with patient. Deep acting convinces employees that they really feel the way they are trying to express, may lead to an expression that is perceived as more genuine and lower emotional stress. Thus, deep acting may be positively related to patient's service.

Deep acting also leads to more affective deliveries including showing sincerity, enthusiasm, warmth, friendliness and courtesy to customer (Grandey, 2003a). Nurses could produce a more genuine response that does not conflict with their values and feelings. If nurses using deep acting, they can get in touch with patient's emotional state and try to understand the experiences of patients. Deep acting allows nurses to invoke empathy and to connect with patients in order to show compassion and an understanding of their experiences and concern in work (Cipriano, 2015). This deep-level regulation is associated with a heightened sense of personal accomplishment, suggesting positive benefits to the aspect of work (Brotheridge & Grandey, 2002). Besides, deep acting do not relate to work-to-family interference, which may create negative health and job outcomes, such as psychological distress, job burnout, job and life dissatisfaction (Cheung & Tang, 2009). Hence, engaging in deep acting may have more belifits to develop nurse-patient relationship.

Based on the above review, we propose the following hypothesis:

Hypothesis 5b: Deep acting is positively correlated with nurse-patient relationship.

In short, ostracism as emotional event may promopt emotional regulations of nurses by employing surface acting and deep acting, which in turn influence nurse-patient relationship. Such process is illustrated in Figure 2-2:

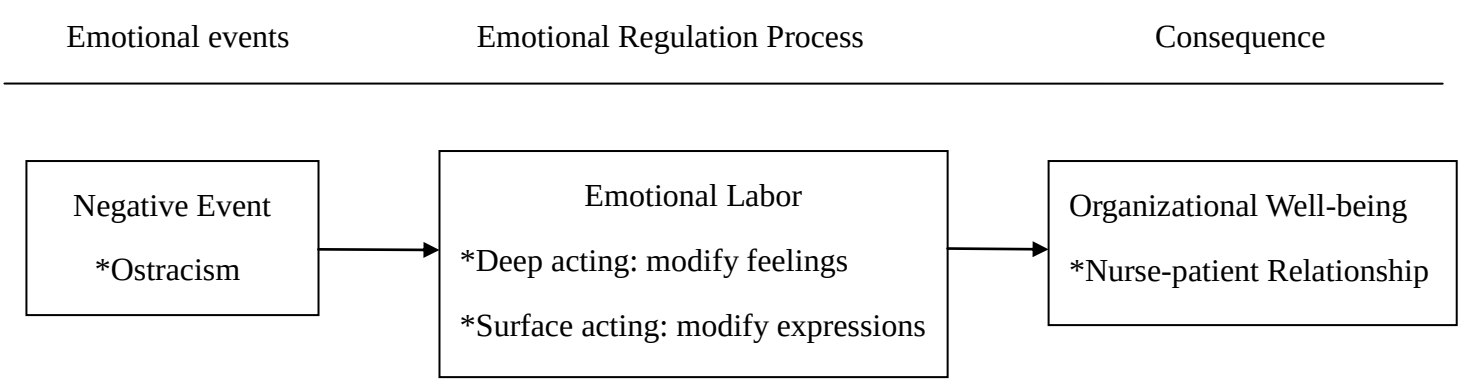

Figure 2-2 Process of workplace ostracism and its consequence

Given the above six hypotheses and the logic in Figure 2-2, we expect: 1) surface acting partially mediates the negative relationship between workplace ostracism and nurse-patient relationship; 2) deep acting particially mediates the negative relationship between workplace ostracism and patient-nurse relationship; 3) nurse-patient relationship particially mediates the positive relationship between workplace ostracism and turnover intention. Thus, we propose the following hypothses:

Hypothesis 6a: Surface acting partially mediates the relationship between workplace ostracism and nurse-patient relationship.

Hypothesis 6b: Deep acting partially mediates the relationship between workplace ostracism and nurse-patient relationship.

Hypothesis 7: Nurse-patient relationship partially mediates the relationship between workplace ostracism and turnover intention.

Based on the above analysis, the hypothesized research model is proposed in Figure 2-3:

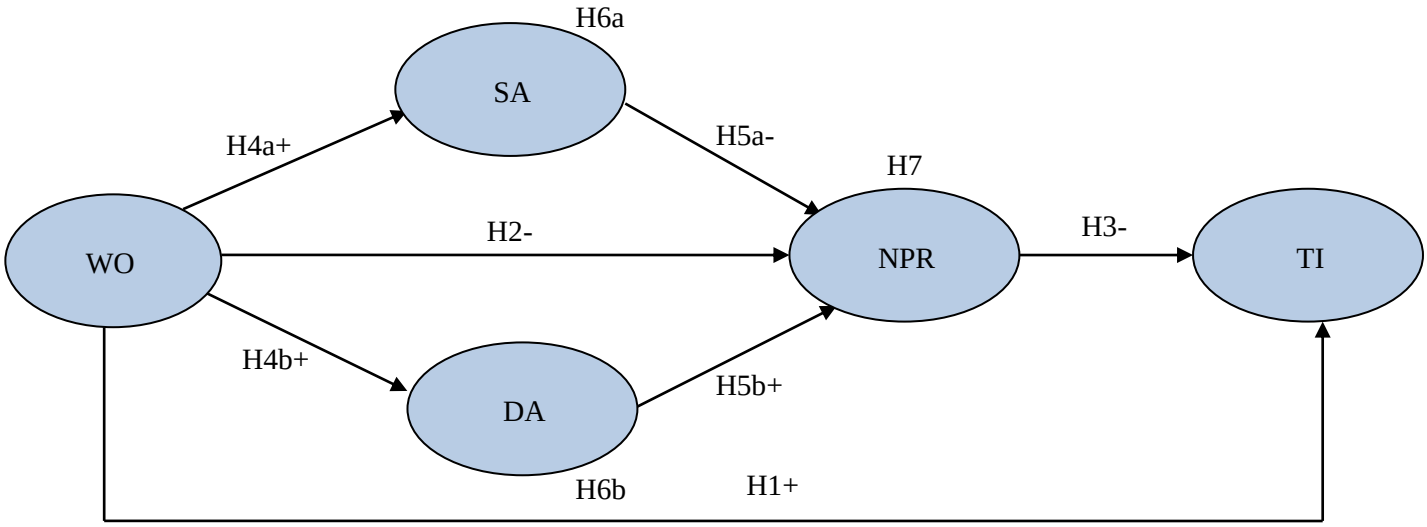

Figure 2-3 Research model

Note: WO = workplace ostracism; SA = surface acting; DA = deep acting; NPR = nurse-patient relationship; TI = turnover intention.

Chapter 3: Research Methods

Following the previous literature review and hypotheses, this chapter reports and discusses the research methods, including the participants, data collection and measurements.

3.1 Research participants

The study sample was obtained from nurses in a tertiary hospital in Sichuan, China. This hospital holds 3,439 beds and 2,510 nurses, which were divided into ten sub-branches.

Inclusion criteria sampling are the following: 1) regular and contract nurses with professional certificates; 2) the informed consent voluntarily participating in this research; 3) no history of mental illness.

Using convenient sampling method, this research chose four subbranches of the hospital. Then, 420 nurses were selected as the survey participants by random sampling method.

3.2 Measures

According to the theoretical model, this study includes five key variables: workplace ostracism, surface acting, deep acting, nurse-patient relationship and turnover intention. In addition, the survey also includes demographic variables. The measures for different variables are described as follows.

3.2.1 Measure of workplace ostracism

Workplace ostracism was measured by “workplace ostracism questionnaire” that was developed by Ferris et al. (2008). In order to reduce the subjective defensive psychology of the participants to the word “ostracism”, words like “working environment” have been used to replace “ostracism”.

The scale is anchored on the Likert score of six-level (from 1 - never to 6 - always). The

participantss are required to recall the frequency of the behavior in the past that conforms to the described items. Items with poor scores are deleted or revised after exploratory analysis and confirmtory analysis about the scale. Totally, ten items are used in this study (e.g. *"Others ignored you at work"*). The mean score represents the overall situation of workplace ostracism. The higher the score is, the more workplace ostracism the participants feel.

3.2.2 Measure of emotional labor

This scale is formulated by translating the scales from Brotheridge and Lee (2003) and Grandry (2003b). Items with poor scores are deleted or revised after exploratory analysis and confirmtory analysis about the scale. Eight items are used in this study, including five items of surface acting (e.g. *"Put on a 'mask' in order to display the emotions I need for the job"*) and three items of deep acting (e.g. "*Try to actually experience the emotions that I must show*").

The scale is anchored on the Likert score of six-level (from 1- never to 6- always). The mean score represents the overall situation of emotional labor. The higher the score, the more emotional labor the participants exposed.

3.2.3 Measure of nurse-patient relationship

The construction of nurse-patient relationship requires the joint efforts of nursing, patients and other factors. Due to the important role of nursing in nurse-patient relationship, this research chose the dimension "nursing" for measuring nurse-patient relationship. Derived from the scale of "doctor–patient relationship of China" by Zeng, Ma, and Gou (2018), this scale has been developed by the research team itself. It involves seven items (e.g. "*I always patiently tell patients or their families of the nursing treatment I have been doing", "I always take good care of patients*"). The scale is anchored on the Likert score of six-level (from 1 - totally disagree to 6 - totally agree). The higher the score, the better the caring and nurse-patient relationship.

3.2.4 Measure of turnover intention

Turnover intention was measured by the Chinese scale of turnover intention that was developed by Weng and Xi (2010). There are four items (e.g. "*Basically, I didn't think about leaving this unit*").

The scale is anchored on the Likert score of six-level (from 1 - totally disagree to 6 - totally agree). Among them, the first and the second questions are reverse scoring questions to test the subject's validity. Higher scores indicate higher level of turnover intention.

3.2.5 Demographic characteristics

According to literature review, demographic variables in this study include gender, age, marital status, professional title, education background, department, working experience, organizational tenure, and employment form, which are described as follows.

Gender includes male and female. As for age, the subjects are divided into three groups (Group1: 25 years or less; Group2: 26 to 40 years; Group 3: above 40 years). The marital status includes married, single and others (e.g. divorced).

The professional title includes five levels: nurse, senior nurse, supervisor nurse, co-chief superintendent nurse, chief superintendent nurse. The nursing educational background ranges from secondary specialized school, junior college, bachelor, to master or above.

The department includes surgery department, internal medicine department and pediatric department. As for work experience and organizational tenure, the subjects were divided into three groups (Group1: 1year or less; Group 2: 2 to 5years; Group 3: above 5 years).

Employment forms of this study include regular nurse and contract nurse. In China, there are two main forms of nurse employment. Regular nurses are the formal employees who normally have permanent employment relationship with the hospitals. While the contract nurses are contract-based employees of hospitals, which is a temporary hire.

3.3 Data collection

In order to minimize the possible common method bias issue, this study used a time-lagged survey that was conducted at two time points (T1and T2 with interval of three months). The first round of questionnaires was conducted in July 2017 while the second in November 2017. The questionnaire was distributed at the field, retrieving questionnaire when they are completed. After the questionnaires were returned, examing all questionnaires and eliminating the invalid ones following some criteria, such as the rate of missing data more than 50%; inconsistent answers for the items of same construct; same answers for different questionnaires. Questionnaires that existed in both rounds of the survey were matched to obtain the final valid data set.

3.3.1 First round survey

The research team puts questionnaires into envelopes. Each envelope has a questionnaire cover letter on it including a code for each participant. The first round questionnaire included “demographic information”, “workplace ostracism” and “emotional labor”. A total of 420 questionnaires were administered and 405 questionnaires were actually collected, with a return rate of 96%. Five invalid questionnaires were removed from the 405. In the end, 400 questionnaires were checked and recorded. After data entry, descriptive analysis method was used to check the correction of the input data. Among these data, the minimum value of the data was not less than one, and one of the maximum values of the Likert score option was 44 points which should be four after recheck the original data in questionnaire. “Exclude cases pairwise” is used for exclusion of missing values.

3.3.2 Second round survey

After the first round of questionnaire, removing the missing and invalid ones, the envelopes of the valid questionnaire were kept for the second round use. The investigator matches the name and code of the nurse on the list to the code on the envelope, and then distributes the questionnaires to participants. The second round of the questionnaire included

scales of “nurse-patient relationship” and “turnover intention”. A total of 400 questionnaires were sent out to the participants whose questionnaires were valid in first round of survey, and 390 questionnaires were actually returned with return rate of 98%. A preliminary checking of 390 questionnaires was performed, and 11 invalid questionnaires were excluded. In the end, 379 questionnaires were checked and recorded. After data entry, descriptive analysis method was used to check the correction of the input data. Among these data, the minimum value of the data was not less than one while the maximum value was not more than six, indicating that the data is entered without errors.

3.3.3 Matching two questionnaires

This part introduces the matching process of the data from two rounds of survey. The questionnaires were removed as invalid matches in any of the following case: 1. The nurses already filled out the first round of survey, but for any reason, they did not fill out the second round of survey; 2. Both two rounds of questionnaire have been filled out, but one of them was invalid. At the end, 379 valid questionnaires were used for subsequent hypothesis analysis. Data collection process is illustrated in Figure 3-1:

3.4 Research quality control

(1) In order to enable respondents to fill in the answers more realistically, every questionnaire is put into envelope, and the respondentes are coded so that the two rounds can match to the same person. Simple instructions are written on the surface of the envelope to inform respondents that there is no right or wrong answer. The research uses anonymous forms.

(2) Pilot test described later is conducted before the formal investigation. Through factor analysis, the questionnaire is revised and rearranged to ensure the reliability and validity of the questionnaire.

(3) Members in research team are all master’s degree or above and trained about the research method before investigation. The survey is carried out by three postgraduates.

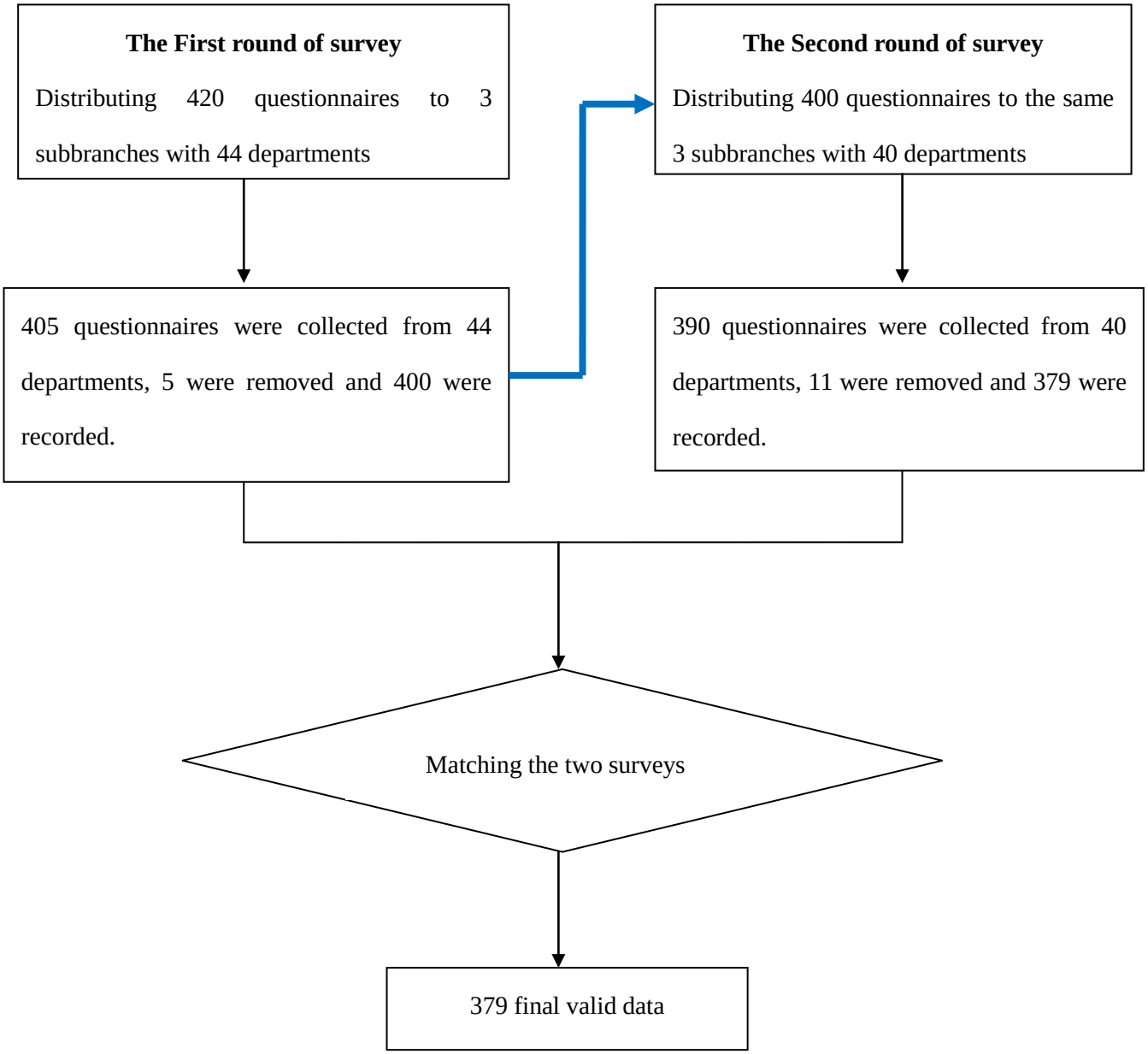

Figure 3-1 Data collection process

3.5 Statistical analysis

The SPSS19.0 and AMOS20.0 statistical softwares are used to analyze data including descriptive analysis, correlation analysis, confirmatory factor analysis, exploratory factor analysis, variance analysis, as well as structural equation model. Reliability analysis is used to test the stability and consistency of the scale with internal consistency coefficient (Cronbach's alpha) and to verify the stability and consistency of the scale. Independent sample t-test and ANOVA are used to analyze the demographic characteristics of the main variables. Pearson correlation analysis is used to test the correlation between key variables. Through maximum likelihood estimation, confirmatory analysis is to check whether the factor structure model fits the collected data, and whether the items can be used as a measurement to latent variables. Structural equation models were employed to test the hypotheses and research model. In confirmatory factorial analysis and structural equations model, the ratio between Chi square and degrees of freedom (CMIN/DF) should be below three with admissible significant p-value; the Comparative Fit Index (CFI) over .92; Root Mean Square Error of Approximation (RMSEA) below .07; and Standardized Root Mean Square Residual (SRMR) below .08. Whenever fit indices reject the model, we opted for conducting exploratory factor analyses (EFA). EFA is suitable when KMO (>.60), MSAs above .50, a significant ($p<.01$) Bartlet's X 2 statistic, and all communalities above .50. The criteria of relevant fitting indices are shown in Table 3-1.

3.6 Pilot test

3.6.1 Compilation of the pilot test questionnaire

The pilot questionnaire consisted of three scales: workplace ostracism scale, emotional labor scale, nurse-patient relationship scale. In order to ensure the content structure validity of the questionnaire, items statements needed to be concise and easy to understand, as well as suitable for the surveyed group to fill out. The study first invited five participants to carefully review the items, make comments on pilot questionnaire and identify whether it was difficult

to understand or create any ambiguity. Then six experts were invited to discuss the items of the questionnaire one by one to revise the items as well as to modify the repeated and ambiguous ones. The six experts all have master's degree or above and have more than ten years of working experiences, of which three were female nursing specialists and among the three males, one is nursing specialists and two are management experts. The pilot questionnaire consisited of ten items in the workplace ostracism scale, eight items in the emotional labor scale, and seven items in the nurse-patient relationship scale after revision.

Table 3-1 Criteria of fitting indices

Fit index	**Code**	**Critical value**
Chi-square - DOF ratio	CMIN/DF	< 3.0
Comparative Fit Index	CFI	>.92
Root Mean Square Error of Approximation	RMSEA	<.07
Standardized Root Mean Square Residual	SRMR	<.08
Incremental Fit Index	IFI	>.90
Normal Fit Index	NFI	>.90
Relative Fit Index	RFI	>.90

Source: Bentler (1990); Wu, M. L (2009); Browne and Cudeck (1993); Jöreskog and Sörbom (1996)

3.6.2 Survey and results analysis of pilot test

Research team adopted the random distribution of the pilot test questionnaire. Before answering the questionnaire, researchers told the respondents that the results of this study were completely confidential, only used for scientific research. They then explained the answering method of the questionnaire, and responded to questions raised by the participants on the spot.

One hundred and twenty questionnaires were distributed and 120 were actually returned,

the return rate being 100%. Three questionnaires were eliminated and 115 were actually analyzed. Questions raised by participants were recorded when collecting the questionnaires. Afterwards, except for the two invalid, data from 118 questionnaires was recorded into SPSS for analysis. First, through descriptive analysis, we checked if some errors in the input data. The minimum value of the data was not less than one, and the maximum value was not greater than six, which indicated that the data was entered correctly. In the software analysis, "exclude cases pairwise" was selected to analyze the observations with missing values in variables not involved in the subsequent analysis. Excluding the proportion of missing values, frequency analysis showed that the average age of the participants was 37.6 years old, with average nursing experence of 9.8 years. The proportion of female was 96.5%; The married accounted for 65.2%, while singles 31.3%; as for the professional title, senior nurse accounted for 65.2%, supervisor nurse 17.4%, nurses 14.8%, and co-chief superintendent nurse 1.7%; as for the employment form, 67.0% were contract nurses while 32.2% regular nurses; as for the educational background, bachelor degree nurses accounted for 64.3%, junior college 31.3%, and master or above 1.7%.

3.6.2.1 Factor analysis on scale structure

(1) Workplace ostracism

The ten items of the workplace ostracism scale were subjected to principal component analysis (PCA) using SPSS Prior to performing PCA. The suitability of data for factor analysis was assessed. The Kaiser-Meyer-Oklin value was 0.81, exceeding the recommended value of .60 (Kaiser1970, 1974) and Bartlett's (1954) test of Sphericity reached statistical significance, supporting the factorability of the correlation matrix.

Principle components analysis revealed the presence of two factors with eigenvalue exceeding 1. The two-factor solution explained a total of 63.70% of the variance, with factor one contributing 52.41% and factor two contributing 11.28%. Data of the correlation matrix reflected the situation of many coefficients of .4 and above. Factor one includes "ostracism 1, 2, 3, 6, 7, 8, 9, 10". Among them, the loading value of item ostracism 1 is low (i.e .477). Items "ostracism 4 and 5" included in factor two, which is inconsistent with Ferris's one-dimension

theory. Hence, the items of "ostracism 1, 4 and 5" were revised to make it easier for participants to understand.

(2) Emotional labor

The eight items of the emotional labor scale were subjected to principal component analysis (PCA) using SPSS Prior to performing PCA. The suitability of data for factor analysis was assessed. The Kaiser-Meyer-Oklin value was 0.78, exceeding the recommended value of .60 (Kaiser1970, 1974) and Bartlett's (1954) test of Sphericity reached statistical significance, supporting the factorability of the correlation matrix.

Principle components analysis revealed the presence of two factors with eigenvalues exceeding 1. The two-factor solution explained a total of 80.25% of the variance, with factor one contributing 46.65% and factor two contributing 33.60%. Data of the correlation matrix reflected the situation of many coefficients of .7 and above. Factor one includes "surface acting 2, 3, 4, 5, 1" while factor two includes "surface acting 1, 2, 3". The two factors are consistent with constructs and items of the original scale and the factor loadings are also satisfactory.

(3) Nurse-patient relationship

The seven items of the nursing-patient relationship scale were subjected to principal component analysis (PCA) using SPSS Prior to performing PCA. The suitablility of data for factor analysis was assessed. The Kaiser-Meyer-Oklin value was 0.88, exceeding the recommended value of .60 (Kaiser1970, 1974) and Bartlett's (1954) test of Sphericity reached statistical significance, supporting the factorability of the correlation matrix.

The principle components of the analysis revealed the presence of one factor with seven items. The one-factor solution explained a total of 100% of the variance. Data of the correlation matrix reflected the situation of many coefficients of .4 and above. The one factor was consistent with constructs and items of the original scale and the factor loadings are also satisfactory.

After PCA analysis of these three scales, confirmatory factor analysis was conducted in

the formal investigation.

3.7 Confirmatory factor analysis

Based on the pilot test, this study conducted the formal survey. Confirmatory factor analysis (CFA) was performed for the key variable scales.

3.7.1 Workplace ostracism

A CFA with the original factor structure showed poor fit indices (CMIN/df=4.571, p=.000, CFI=.929, RMSEA=.097, SRMR=.0497). Therefore an exploratory factor analysis of all ten items was conducted in this thesis. After removal of three items from the ostracism scale due to low or high factor loading compared with other items, showed a one factor valid solution (KMO=.896, Bartlett x 2 (15) =912.210, p<.001, 53.0% explained variance) with seven items. Contents of the items are shown in Table 3-2.

3.7.2 Emotional labor

A confirmatory factor analysis with the original factor structure showed poor fit indices (CMIN/df=63.283, p=.000, CFI=.483, RMSEA=.406, SRMR=.233). Therefore an exploratory factor analysis of all eight items was conducted in this thesis. After removal of one items from the surface acting due to low factor loading compared with other items, showed a two factor valid solution (KMO=.805, Bartlett x 2 (15)=2148.134, p<.001, 82.40% explained variance). Contents of the items are shown in Table 3-3.

3.7.3 Nursing-patient relationship

A confirmatory factor analysis with the original factor structure showed poor fit indices (CMIN/df=12.663, p=.000, CFI=.900, RMSEA=.176, SRMR=.061). Therefore an exploratory factor analysis of all seven items was conducted in this thesis. After removal of three items from the scale due to low or high factor loading compared with other items, showed one factor valid solution (KMO=.796, Bartlett x 2 (15)=663.650, p<.001, 68.80% explained

variance) with the scale showing acceptable reliability (Cronbach alpha=.847). Contents of the items are shown in Table 3-4.

3.7.4 Turnover intention

A confirmatory factor analysis with the original factor structure showed poor fit indices (CMIN/df=81.88, p=.000, CFI=.758, RMSEA=.460, SRMR=.137). Therefore an exploratory factor analysis of all four items was conducted in this thesis. After removal of one items from the scale due to low factor loading compared with other items, showed a one factor valid solution (KMO=.624, Bartlett x 2 (15) = 423.102, p<.001, 70.17% explained variance). Contents of the items are shown in Table 3-5.

Table 3-2 Factor matrix of workplace ostracism

Items	**Factor** 1
OS1. Others ignored you at work	.803
OS3.Your greetings have gone unanswered at work	.780
OS4.You involuntarily sat alone in a crowded lunchroom at work	.763
OS5. Others avoided you at work	.724
OS7. Others at work shut you out of the conversation	.699
OS9. Others at work treated you as if you weren't there	.680
OS10. Others at work did not invite you or ask you if you wanted anything when they went out for a coffee break	.632

Table 3-3 Rotated factor matrix of emotional labor

Items	Factor	
	1	2
SA2. Fake a good mood	.887	.112
SA3. Put on a “show” or “performance”	.879	.065
SA4. Just pretend to have the emotions I need to display for my job	.869	.141
SA5. Put on a “mask” in order to display the emotions I need for the job	.805	.104
DA1.Try to actually experience the emotions that I must show	.124	.956
DA2. Make an effort to actually feel the emotions that I need to display towards others	.129	.955
DA3. Work hard to feel the emotions that I need to show to others	.096	.944

Note: Extraction Method: Principal Component Analysis.

Rotation Method: Varimax with Kaiser Normalization.

a. Rotation converged in 3 iterations.

Table 3-4 Factor matrix of nurse-patient relationship

Items	Factor
	1
NPR2. I always patiently tell patients or their families of the nursing treatment I have been doing	.881
NPR3. I always take good care of patients	.862
NPR5. I always respond to the questions of patients and their families in a timely and enthusiastic manner.	.833
NPR7. I am very happy to see patients getting better with my nursing work	.734

Note: Extraction Method: Principal Component Analysis.

a. 1 component extracted.

Table 3-5 Factor matrix of turnover intention

Items	Factor
	1
TI1. Basically, I didn't think about leaving this unit	.907
TI2. I plan to have a long-term career development in this unit	.887
TI3. I often get bored with my present job and want to change a new one	.704

Note: Extraction Method: Principal Component Analysis.

a. 1 component extracted.

3.8 Reliability analysis and item analysis

The reliability analysis measures the internal consistency coefficient (Cornbach's α) of the scale. The internal consistency coefficient and the correlation coefficient between the scale and each single item is reported in Table 3-6 which shows that the internal consistency coefficient of each dimension is between .78 and .85, indicating that the reliability is between "good (.70-.80)" and "ideal (.80 or more)" higher than recommended value of social measurement (.70). The internal consistency coefficient after the deletion of the item shows that the internal consistency coefficient has not been obviously improved, which indicates that the homogeneity of all the items is high. The correlation between item and scale is .46-.76 suggesting that the correlation is highly correlated due to the correlation coefficient is all above .4.

Table 3-6 Reliability analysis

Items	Internal consistency coefficient	Internal consistency coefficient after deletion of the item	Correlation between scale and each item
Workplace ostracism	0.84		
Workplace ostracism 1		0.81	0.60
Workplace ostracism 3		0.81	0.58
Workplace ostracism 4		0.82	0.56
Workplace ostracism 5		0.81	0.66
Workplace ostracism 7		0.80	0.69
Workplace ostracism 9		0.81	0.64
Workplace ostracism 10		0.83	0.50
Emotional labor	0.83		
Surface acting	0.89		
Surface acting 2		0.83	0.46
Surface acting 3		0.82	0.53
Surface acting 4		0.82	0.52
Surface acting 5		0.82	0.46
Deep acting	0.96		
Deep acting 1		0.79	0.69
Deep acting 2		0.78	0.74
Deep acting 3		0.78	0.73

Table 3-6 Reliability analysis

Items	Internal consistency coefficient	Internal consistency coefficient after deletion of the item	Correlation between scale and each item
Nurse-patient relationship	0.85		
Nurse-patient relationship 6		0.81	0.69
Nurse-patient relationship 7		0.79	0.73
Nurse-patient relationship 9		0.77	0.76
Nurse-patient relationship 11		0.85	0.57
Turnover intention	0.78		
Turnover intention 1		0.63	0.69
Turnover intention 2		0.57	0.75
Turnover intention 3		0.78	0.46

Chapter 4：Results

This chapter reports the results of descriptive analysis, correlation analysis, variance analysis and structural equation model analysis of the hypotheses.

4.1 Descriptive analysis

As illustrated in Table 4-1, the average age of the sample is 30.41 years, average 8.6 years of nursing experience and 8.37 years of tenure in this hospital. The majority of the gender in the sample is female (98.7%). The majority of the respondents are married (70%).

As for the professional title, senior nurse accounts for 63%, nurse 23% and supervisor nurse is 14%. About the employment form, regular nurse who have permanent employment relationship with hospital accounts for 22% and contract-based nurses is 78%.

As for education, majority of the respondents hold bachelor degrees (67%), followed by junior college (30%) and the rest with secondary specialized school displomas.

According to the survey, 9% of nurses have changed their hospital in the past five years. This indicates the actual turnover behavior among nurses in this study.

4.2 Mean and correlation analysis of key variables

The mean value and correlation analysis of the six variables are reported in Table 4-2. The mean value of workplace ostracism is 1.39 (S.D. = 0.47) with the maximum value of 4.00 and the minimum 1.00. The mean value of surface acting is 1.76 (S.D. = 0.79) with the maximum value of 5.00 and the minimum 1.00. The mean value of deep acting is 2.94 (S.D. = 01.54) with the maximum value of 6.00 and the minimum value of 1.00. The mean value of nurse-patient relationship is 5.38 (S.D. = 0.58) with the maximum value of 6.00 and the minimum 1.00. Lastly, the mean value of turnover intention is 2.53 (S.D. = 1.09) with the maximum value of 6.00 and the minimum 1.00.

Table 4-1 Descriptive analysis (n=379)

Variable	Category	Frequency	Percentage (%)
gender	male	5.0	1.3
	female	374.0	98.7
marital status	married	265.0	69.9
	single	101.0	26.6
	others	11.0	2.9
professional title	nurse	86.0	22.7
	senior nurse	239.0	63.1
	supervisor nurse	53.0	14.0
	co-chief superintendent nurse	1.0	0.3
	chief superintendent nurse	0.0	0.0
education	secondary specialized school	5.0	1.3
	junior college	113.0	29.8
	bachelor	253.0	66.8
department	surgery department	163.0	43.0
	internal medicine department	182.0	48.0
	pediatric department	34.0	9.0
employment form	regular nurse	84.0	22.2
	contract nurse	295.0	77.8

To explore the correlation properties, this research adopted SPSS statistical software to carry out Pearson correlation coefficient analysis. The size of the value of the correlation coefficient follows the guidelines from Cohen (1988, pp.79-81): small(*r=.10 to .29*), medium(*r=.30 to .49*), large(*r=.50 to 1.00*).The results of the correlation analysis of the main variables are shown in Table 4-2.

Bivariate analysis shows that there was a medium, positive correlation between workplace ostracism and emotional labor (*r=.326, p<.01*), surface acting (*r=.430, p<.01*), deep acting(*r=.143, p<.01*). This correlation is in the direction to hypothesis 4a and Hypothesis 4b. There was a small, negative correlation between ostracism and nursing-patient relationship (*r=-.150, p<.01*). This correlation is in the direction to hypothesis 2. There is no significant correlation between workplace ostracism and turnover intention, which is not in the direction to hypothesis 1.

Refers to the emotional labor and two dimensions (surface acting and deep acting), there was a strong, positive correlation between emotional labor and surface acting (*r=.689, p<.01*) and a strong, positive correlation between emotional labor and deep acting (*r=.869, p<.01*). There was a small positive correlation between surface acting and deep acting (*r=.240, p<.01*), indicating that there is a positive correlation between emotional labor and all its dimensions.

As for the relationship between emotional labor and nurse-patient relationship, There was a small, negative correlation between surface acting and nurse-patient relationship (*r=-.189, p<.01*). This correlation is in the direction of hypothesis 5a. However, the correlation between deep acting and nurse-patient relationship is not significant, which is not in the direction to hypothesis 5b.

There was a medium, negative correlation between nursing-patient relationship and turn over intention (*r=-.325, n=379, p<.01*). This correlation is in the direction to theoretical point of hypothesis 3.

Overall, the correlation results provide preliminary supports for the theoretical model.

Table 4-2 Correlations analsysis

Variables	Min-max	Mean	S.D.	Age	Education	Unit	EF	WE	WO	EL	SA	DA	NPR	TI
age	—	—	—	1										
education	—	—	—	-0.01	1									
unit	—	—	—	-0.06	0.08	1								
EF	—	—	—	-0.30**	-0.17**	0.01	1							
WE	—	—	—	0.94**	-0.11*	-0.01	-0.19**	1						
WO	1-3.57	1.39	0.47	0.06	0.18**	0.01	-0.08	0.05	***0.84***					
EL	1-6.00	2.27	0.88	-0.05	0.10*	-0.01	-0.14**	-0.05	0.33**	***0.83***				
SA	1-5.00	1.76	0.79	0.00	0.04	0.02	-0.08	0.01	0.43**	0.69**	***0.89***			
DA	1-6.00	2.94	1.54	-0.06	0.12*	-0.02	-0.14**	-0.07	0.14**	0.87**	0.24**	***0.96***		
NPR	3-6.00	5.38	0.58	0.12*	-0.10*	0.04	0.08	0.14**	-0.15**	-0.11*	-0.19**	-0.01	***0.85***	
TI	1-5.67	2.53	1.09	-0.08	0.09	0.04	-0.05	-0.11*	0.10	0.04	0.05	0.03	-0.33**	***0.78***

Note: EF= employform; WE= workexperence; WO= workplace ostracism; SA= surface acting; DA= deep acting; NPR= nurse-patient relationship; TI= turnover intention. **. Correlation is significant at the 0.01 level (2-tailed). *. Correlation is significant at the 0.05 level (2-tailed). Italicized values on the diagonal represent reliabilities of the scale, i.e. Cronbach's α.

4.3 Variance analysis

For the variance analysis, this study used independent sample t-test to analyze regarding employment forms, and used one-way ANOVA regarding ages, marital status, education, working experence, professional titles and department.

4.3.1 Employment form

An independent sample t-test was conducted to explore the difference on the levels of workplace ostracism, emotional labor, surface acting, deep acting, nurse-patient relationship and turnover intention, concerning different types of employment. Results are showed in Table 4-3.

According to Table 4-3, no significant difference was reported on workplace ostracism, surface acting and nurse-patient relationship, but there existed a significant difference on emotional labor ($p=.00<.01$) and deep acting ($p=.01<.01$). According to the comparison of the mean, emotional labor reported by regular nurses (mean=2.50, SD=.77) is higher than contract nurses (mean=2.20, SD=.91) and deep acting reported by regular (mean= 3.33, SD=.1.48) is higher than that reported by contract nurses (mean=2.83, SD=1.54).

4.3.2 Variance analysis on age groups

One-way ANOVA analysis was conducted to explore the levels of workplace ostracism, emotional labor, surface acting, deep acting, nurse-patient relationship and turnover intention regarding different age groups. Results are showed in Table 4-4 and Table 4-5.

According to Table 4-4 and Table 4-5, the variance result of turnover intention is significant ($p=.03<.01$). LSD testing has been used for Post–hoc comparison. The mean difference (I-J) indicates that turnover intention of nurses aged from 26 to 40 (mean=2.58, S.D. = 1.09) is higher than that of 40 years old or above (mean=1.95, S.D. = 1.03).

Table 4-3 Independent sample t-test of employment form for each variable

Variable	Employment form	N	Mean	S.D.	Levene-test.sig	T-test Sig.(2-tailed)
workplace ostracism	regular nurse	84	1.44	0.53	0.07	0.08
	contract nurse	295	1.35	0.42		0.13
emotional labor	regular nurse	84	2.50	0.77	0.01	0.01
	contract nurse	295	2.20	0.91		0.00
surface acting	regular nurse	84	1.88	0.82	0.54	0.13
	contract nurse	295	1.73	0.78		0.14
deep acting	regular nurse	84	3.33	1.48	0.42	0.01
	contract nurse	295	2.83	1.54		0.01
nurse-patient relationship	regular nurse	84	5.30	0.65	0.10	0.12
	contract nurse	295	5.40	0.55		0.16
turnover intention	regular nurse	84	2.62	1.01	0.35	0.37
	contract nurse	295	2.50	1.11		0.34

Table 4-4 Variance analysis of age groups

Variable	Age group	N	Mean	S.D.	F	.sig
workplace ostracism	≤25	41	1.28	0.34	0.99	0.37
	26～40	317	1.38	0.46		
	>40	21	1.37	0.47		
emotional labor	≤25	41	2.27	0.78	0.02	0.99
	26～40	317	2.27	0.90		
	>40	21	2.30	0.84		
surface acting	≤25	41	1.74	0.75	0.03	0.98
	26～40	317	1.77	0.80		
	>40	21	1.76	0.75		
deep acting	≤25	41	2.97	1.47	0.04	0.96
	26～40	317	2.93	1.56		
	>40	21	3.02	1.50		
nurse-patient relationship	≤25	41	5.40	0.56	1.65	0.19
	26～40	317	5.36	0.58		
	＞40	21	5.60	0.45		
turnover intention	≤25	41	2.43	1.05	3.46	0.03
	26～40	317	2.58	1.09		
	>40	21	1.95	1.03		

Table 4-5 Multiple comparison of age variance analysis LSD

Dependent variable	(I) Age group	(J) Age group	Mean difference (I-J)	S.D.	Significance	95% Confidence interval	
						Lower limit	Upper limit
turnover intention	≤25	26～40	-0.15	0.18	0.41	-0.50	0.21
		>40	0.48	0.29	0.10	-0.09	1.05
	26～40	≤25	0.15	0.18	0.41	-0.21	0.50
		>40	0.63*	0.24	0.01	0.15	1.11
	>40	≤25	-0.48	0.29	0.10	-1.05	0.09
		26～40	-0.63*	0.24	0.01	-1.11	-0.15

Note: *. The significant level of mean difference: 0.05

4.3.3 Variance analysis on education

Results from the ANOVA analysis of education groups are shown in Table 4-6 and Table 4-7.

Subjects were divided into three groups (Group1: secondary specialized school; Group2: Junior college; Group 3: bachelor). According to the Table 4-6 and Table 4-7, there were no significant difference on emotional labor, surface acting, deep acting, nurse-patient relationship and turnover intention, but a significant difference on workplace ostracism ($p=.00<.01$) was reported. LSD testing has been used for Post–hoc comparison. The mean difference (I-J) indicated that workplace ostracism of nurses with bachelors' degree (mean=1.43, S.D. = 0.47) is higher than that of junior college (mean=1.26, S.D. = 0.39).

Despite it was not statistically significant at 0.05 level ($p=.06$), the levels of deep acting reported by nurses with bachelor education (mean=3.03, S.D. = 1.55) is higher than that

reported by nurses with junior college education (mean=2.74, S.D. = 1.49).

Table 4-6 Variance analysis of education groups

Variable	Education	N	Mean	S.D	F	.sig
workplace ostracism	secondary specialized school	5	1.20	0.21	6.14	0.00
	junior college	113	1.26	0.39		
	bachelor	253	1.43	0.47		
emotional labor	secondary specialized school	5	1.60	0.68	2.46	0.09
	junior college	113	2.17	0.94		
	bachelor	253	2.32	0.86		
surface acting	secondary specialized school	5	1.50	0.50	0.38	0.69
	junior college	113	1.75	0.89		
	bachelor	253	1.79	0.75		
deep acting	secondary specialized school	5	1.73	0.96	2.93	0.06
	junior college	113	2.74	1.49		
	bachelor	253	3.03	1.55		
nurse-patient relationship	secondary specialized school	5	5.80	0.27	2.41	0.09
	junior college	113	5.43	0.49		
	bachelor	253	5.34	0.61		
turnover intention	secondary specialized school	5	1.67	0.71	2.12	0.12
	junior college	113	2.46	1.20		
	bachelor	253	2.59	1.04		

Table 4-7 Multiple comparison of education variance analysis LSD

Dependent variable	(I) Education group	(J) Education group	Mean difference (I-J)	S.D.	sig.	95% Confidence interval	
						Lower limit	Upper limit
workplace ostracism	secondary specialized school	junior college	-0.06	0.20	0.77	-0.46	0.34
		bachelor	-0.23	0.20	0.25	-0.62	0.17
	junior college	secondary specialized school	0.06	0.20	0.77	-0.34	0.46
		bachelor	-0.17*	0.05	0.00	-0.27	-0.07
	bachelor	secondary specialized school	0.23	0.20	0.25	-0.17	0.62
		junior college	0.17*	0.05	0.00	0.07	0.27

4.3.4 Variance analysis on departments

Stemming from the analysis of department, the results are shown in Table 4-8 and Table 4-9.

Subjects were divided into three groups (Group1: surgery; Group2: internal medicine; Group 3: pediatrics). According to Table 4-8 and Table 4-9, no significant differences were reported on workplace ostracism, emotional labor, surface acting and nurse-patient relationship, but there were significant differences reported on deep acting ($p=.01<.01$) and turnover intention ($p=.01<.01$). LSD testing has been used for Post–hoc comparison. The mean difference (I-J) indicated that deep acting reported by surgery department nurses (mean=3.14, S.D. = 1.57) is higher than that reported by internal medicine department nurses (mean=2.70, S.D. = 1.50), and turnover intention reported by internal medicine department nurses (mean=2.71, S.D. = 1.14) is higher than that reported by surgery department nurses (mean=2.37, S.D. = 1.02).

Table 4-8 Variance analysis of department

Variable	Department	N	Mean	S.D.	F	sig.
workplace ostracism	surgery	163	1.36	0.42	0.17	0.84
	internal medicine	182	1.38	0.48		
	pediatric	34	1.35	0.37		
emotional labor	surgery	163	2.35	0.90	2.39	0.09
	internal medicine	182	2.17	0.88		
	pediatric	34	2.42	0.77		
surface acting	surgery	163	1.76	0.80	0.05	0.95
	internal medicine	182	1.77	0.80		
	pediatric	34	1.80	0.67		
deep acting	surgery	163	3.14	1.57	4.28	0.01
	internal medicine	182	2.70	1.50		
	pediatric	34	3.25	1.50		
nurse-patient relationship	surgery	163	5.36	0.56	0.36	0.70
	internal medicine	182	5.39	0.60		
	pediatric	34	5.45	0.56		
turnover intention	surgery	163	2.37	1.02	4.82	0.01
	internal medicine	182	2.71	1.14		
	pediatric	34	2.34	1.01		

Table 4-9 Multiple comparison of department variance analysis LSD

Dependent variable	(I) Department	(J) Department	Mean difference (I-J)	S.D.	.sig	95% Confidence interval	
						Lower limit	Upper limit
deep acting	surgery	internal medicine	0.44*	0.17	0.01	0.11	0.76
		pediatrics	-0.11	0.29	0.71	-0.67	0.46
	internal medicine	surgery	-0.44*	0.17	0.01	-0.76	-0.11
		pediatrics	-0.54	0.29	0.06	-1.11	0.02
	pediatrics	surgery	0.11	0.29	0.71	-0.46	0.67
		internal medicine	0.54	0.29	0.06	-0.02	1.11
turnover intention	surgery	internal medicine	-0.34*	0.12	0.00	-0.57	-0.11
		pediatrics	0.02	0.20	0.91	-.38	0.42
	internal medicine	surgery	0.34*	0.12	0.00	0.11	0.57
		pediatrics	0.36	0.20	0.07	-0.03	0.76
	pediatrics	surgery	-0.02	0.20	0.91	-0.42	0.38
		internal medicine	-0.36	0.20	0.07	-0.76	0.03

4.3.5 Variance analysis on nursing working experience

For the analysis of nursing working experience, the results are showed in Table 4-10 and Table 4-11.

According to Table 4-10 and Table 4-11, no significant difference was reported on workplace ostracism, surface acting, nurse-patient relationship and turnover intention, but there were significant differences reported on emotional labor ($p=.05<.01$) and deep acting ($p=.01<.01$). LSD testing has been used for Post–hoc comparison. The mean difference (I-J) indicated that emotional labor reported by nurses of 2 to 5 years' working experience

(mean=2.43, S.D. = 0.88) is higher than that of nurses above 5 years working experience (mean=2.19, S.D. = 0.89). And deep acting reported by nurses of 2 to 5 years' working experience (mean=3.25, S.D. = 1.56) is higher than that of nurses above 5 years working experience (mean=2.75, S.D. = 1.50).

Table 4-10 Variance analysis of working experience

Variable	Nursing age	N	Mean	S.D.	F	.sig
workplace ostracism	≤1	20	1.31	0.41	0.24	0.79
	2～5	117	1.37	0.42		
	>5	240	1.38	0.46		
emotional labor	≤1	20	2.37	0.75	3.12	0.05
	2～5	117	2.43	0.88		
	>5	240	2.19	0.89		
surface acting	≤1	20	1.58	0.63	0.77	0.47
	2～5	117	1.81	0.82		
	>5	240	1.76	0.79		
deep acting	≤1	20	3.43	1.58	5.38	0.01
	2～5	117	3.25	1.56		
	>5	240	2.75	1.50		
nurse-patient relationship	≤1	20	5.16	0.68	2.34	0.10
	2～5	117	5.33	0.58		
	>5	240	5.42	0.56		
turnover intention	≤1	20	2.45	0.87	0.98	0.38
	2～5	117	2.65	1.12		
	>5	240	2.49	1.09		

Table 4-11 Multiple comparison of work experience variance analysis LSD

Dependent variable	(I)Nursing age group	(J) Nursing age group	Mean difference (I-J)	S.D.	.sig	95% Confidence interval	
						Lower limit	Upper limit
emotional labor	≤1	2～5	-0.06	0.21	0.79	-0.47	0.36
		>5	0.19	0.20	0.36	-0.22	0.59
	2～5	≤1	0.06	0.21	0.79	-0.36	0.47
		>5	0.24*	0.10	0.02	0.05	0.44
	>5	≤1	-0.19	0.20	0.36	-0.59	0.23
		2～5	-0.24*	0.10	0.02	-0.44	-0.05
deep acting	≤1	2～5	0.18	0.37	0.62	-0.54	0.91
		>5	0.68	0.35	0.05	-0.01	1.38
	2～5	≤1	-0.18	0.37	0.62	-0.91	0.54
		>5	0.50*	0.17	0.00	0.16	0.84
	>5	≤1	-0.68	0.35	0.05	-1.39	0.01
		2～5	-0.50*	0.17	0.00	-0.84	-0.16

4.3.6 Variance analysis on organizational tenure

For the analysis of nursing organizational tenure, results are shown in Table 4-12 and Table 4-13.

According to Table 4-12 and Table 4-13, there were no significant difference on workplace ostracism, emotional labor, surface acting and turnover intention, but there were significant differences on deep acting ($p=.01<.01$) and nurse-patient relationship ($p=.04<.01$). LSD testing has been used for Post–hoc comparison. The mean difference (I-J) indicated that deep acting of nurses with ≤1 year (mean=3.58, S.D.=1.41) and 2～5 years tenure (mean=3.13, S.D.=1.59) is higher than that of tenure above 5 years (mean=2.77, S.D.=1.51),

while nurse-patient relationship reported by nurses' tenure above 5 years (mean=5.44, S.D.=0.56) is higher than that of 2 to 5 years (mean=5.30, S.D.=0.58).

Table 4-12 Variance analysis of organizational tenure

Variable	Tenure	N	Mean	Standard error	F	.sig
workplace ostracism	≤1	23	1.28	0.39	0.53	0.59
	2～5	128	1.38	0.46		
	>5	227	1.37	0.45		
emotional labor	≤1	23	2.50	0.70	2.30	0.10
	2～5	128	2.36	0.90		
	>5	227	2.19	0.89		
surface acting	≤1	23	1.69	0.66	0.14	0.87
	2～5	128	1.78	0.82		
	＞5	227	1.76	0.79		
deep acting	≤1	23	3.58	1.41	4.44	0.01
	2～5	128	3.13	1.59		
	>5	227	2.77	1.51		
nurse-patient relationship	≤1	23	5.24	0.63	3.35	0.04
	2～5	128	5.30	0.58		
	>5	227	5.44	0.56		
turnover intention	≤1	23	2.44	0.83	2.16	0.12
	2～5	128	2.69	1.13		
	>5	227	2.45	1.09		

Table 4-13 Multiple comparison of organizational tenure variance analysis LSD

Dependent variable	(I) Tenure	(J)Tenure	Mean difference (I-J)	S.D.	.sig	95% Confidence interval Lower limit	Upper limit
deep acting	≤1	2～5	0.45	0.35	0.19	-0.23	1.13
		>5	0.81*	0.33	0.02	0.16	1.47
	2～5	≤1	-0.45	0.35	0.19	-1.13	0.23
		>5	0.37*	0.17	0.03	0.03	0.69
	>5	≤1	-0.81*	0.33	0.02	-1.47	-0.16
		2～5	-0.36*	0.17	0.03	-0.69	-0.03
nurse-patient relationship	≤1	2～5	-0.06	0.13	0.66	-0.31	0.20
		>5	-0.20	0.13	0.11	-0.45	0.04
	2～5	≤1	0.06	0.13	0.66	-0.20	0.31
		>5	-0.14*	0.06	0.02	-0.27	-0.02
	>5	≤1	0.20	0.13	0.11	-0.04	0.45
		2～5	0.14*	0.06	0.02	0.02	0.27

4.3.7 Others

One-way ANOVA also was conducted to analyze on marital status, professional title and age. Results showed that marital status and professional title have no significant differences on the key variables ($p>0.05$). As for variance analysis on gender, research samples include five male and 374 female. This study did not conduct the variance analysis for gender due to the small sample of male.

4.4 Structural equation model analysis

The theoretical model (Figure 2-2) was analyzed by structural equation model. In this process, many models were measured, whereas three models (i.e. model I, II, Ⅲ) revealed good fits. The path diagrams of model I, II and Ⅲ are shown in Figure 4-1, Figure 4-2 and Figure 4-3 respectively. Estimated values of path coefficient are reported in Table 4-14, Table 4-15 and Table 4-16 respectively. Comparison fits of model I, II and Ⅲ are shown in Table 4-17.

The fit indexes (i.e. CMIN/DF=1.54<3, RMSEA=0.04<0.07, SRMR=0.06<0.08, CFI=0.98>0.92, TLI=0.94>0.70, PCFI=0.86>0.50) of model I suggest good and acceptable model fit. According to Table 4-14, the path coefficients of workplace ostracism → deep acting, workplace ostracism → surface acting, surface acting → nurse-patient relationship are statistically significant ($p<0.005$); the path coefficient of deep acting → nurse-patient relationship is statistically insignificant ($p>0.05$).

Table 4-14 SEM path coefficients (model I)

SEM Path	Standardized path coefficient	Non-standardized path coefficient	S.E.	C.R.	P
DA <--- WO	0.17	0.48	0.16	2.92	0.003
SA <--- WO	0.47	0.57	0.08	7.30	***
NPR<---DA	0.03	0.01	0.02	0.60	0.548
NPR<---SA	-0.23	-0.20	0.05	-3.96	***
TI <---NPR	-0.32	-0.36	0.07	-4.91	***

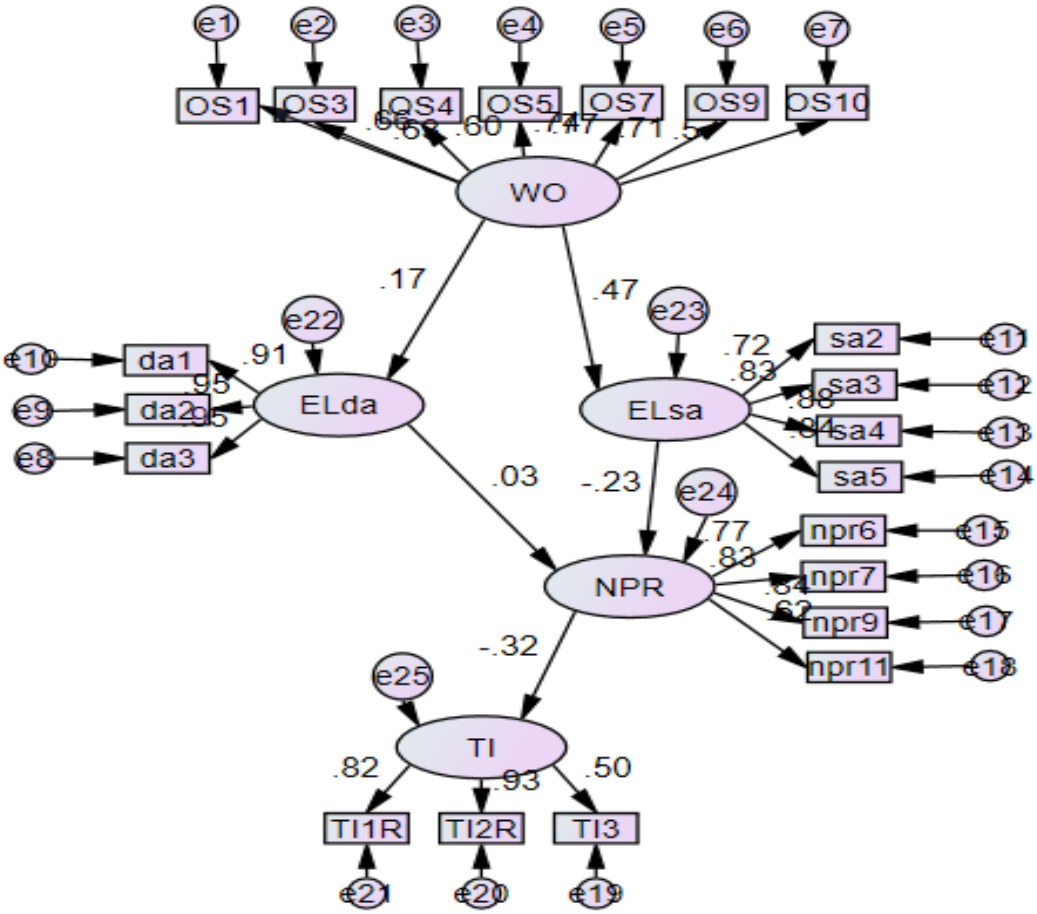

Figure 4-1 Path diagram of SEM (model I)

Table 4-15 SEM path coefficients (model II)

SEM Path	Standardized path coefficient	Non-standardized path coefficient	S.E.	C.R.	P
SA <--- WO	0.47	0.60	0.08	7.24	***
NPR<--- SA	-0.23	-0.15	0.04	-3.81	***
TI <--- SA	0.04	0.07	0.11	0.61	0.541

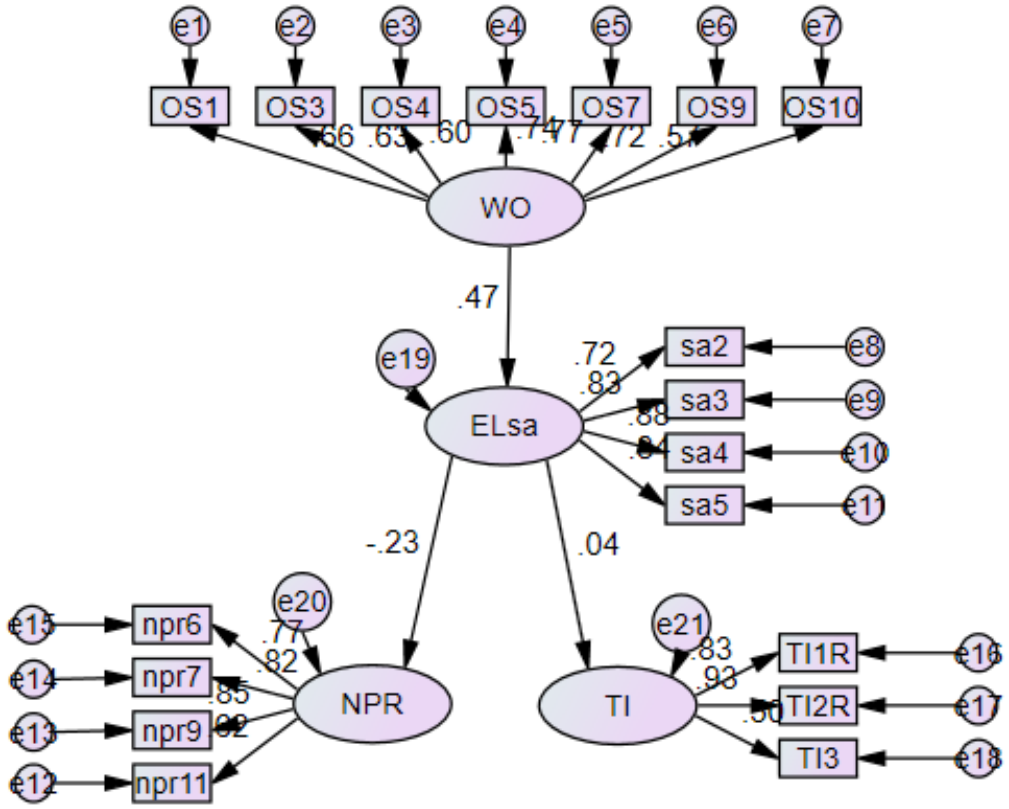

Figure 4-2 Path diagram of SEM (model II)

Fiting indexes (i.e. CMIN/DF=1.62<3, RMSEA=0.04<0.07, SRMR=0.05<0.08, CFI=0.97>0.92, TLI=0.97>0.70, PCFI=0.83>0.50) of model Ⅲ suggest good and acceptable fit. According to Table 4-16, the path coefficients of workplace ostracism → surface acting, surface acting → nurse-patient relationship, nurse-patient relationship → turnover intention are statistically significant ($p<0.001$); the path coefficient of workplace ostracism → turnover intention is statistically insignificant ($p>0.05$).

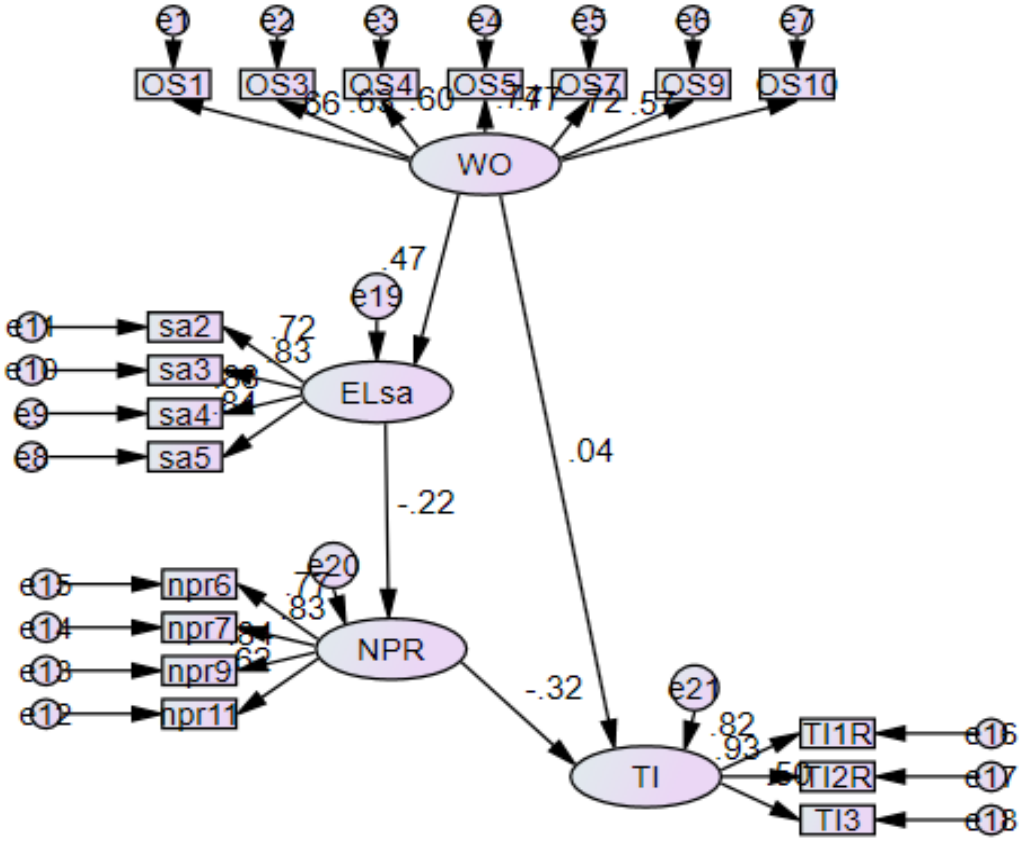

Figure 4-3 Path diagram of SEM (model Ⅲ)

Table 4-16 SEM path coefficients (model Ⅲ)

SEM Path	Standardized path coefficient	Non-standardized path coefficient	S.E.	C.R.	P
SA <--- WO	0.47	0.73	0.10	7.53	***
NPR<---SA	-0.22	-0.12	0.03	-3.78	***
TI <---NPR	-0.32	-0.88	0.17	-5.03	***
TI <--- WO	0.04	0.09	0.13	0.68	0.495

According to Table 4-17, three models all showed good fit. But after comparing the data, model I is the optimal one. Conseqently, model I was chosen as the final model for the base for hypotheses testing and discussion in this study.

Table 4-17 Comparative fits of structural equation model I , II, Ⅲ

Model	CMIN/df	P	CFI	TLI	PCFI	RMSEA	SRMR
Standard parameter	<3.00	<.00	>.92	>.70	>.50	<.07	<.08
SEM_model I	1.54	0.00	0.98	0.97	0.86	0.04	0.06
SEM_model II	1.85	0.00	0.96	0.96	0.83	0.05	0.08
SEM_model Ⅲ	1.62	0.00	0.97	0.97	0.83	0.04	0.05

Findings of the structural equation modeling showed the relationship between workplace ostracism, deep acting and surface acting, nurse-patient relationship, and turnover intention. Based on Figure 4-4 and Table 4-14, the key results are highlighted below.

The path from workplace ostracism to surface acting shows a significant positive coefficient (.47, *p<.001)*, just as the path to deep acting does (.17, *p<.01*). The path from surface acting to nurse-patient relationship shows a significant coefficient (-.23, *p<.001*), but there is an absence of relation between deep acting and nurse-patient relationship. There is a significant negative direct effect between nurse-patient relationship on turnover intention (-.32, *p<.001*). Overall, the results suggest that only surface acting as an emotional regulation strategy mediates the negative relationship between workplace ostracism and nurse-patient relationship that negatively influence turnover intention.

Based on model I, the latent variables and their relations are summarized with standardized coefficients in Figure 4-4.

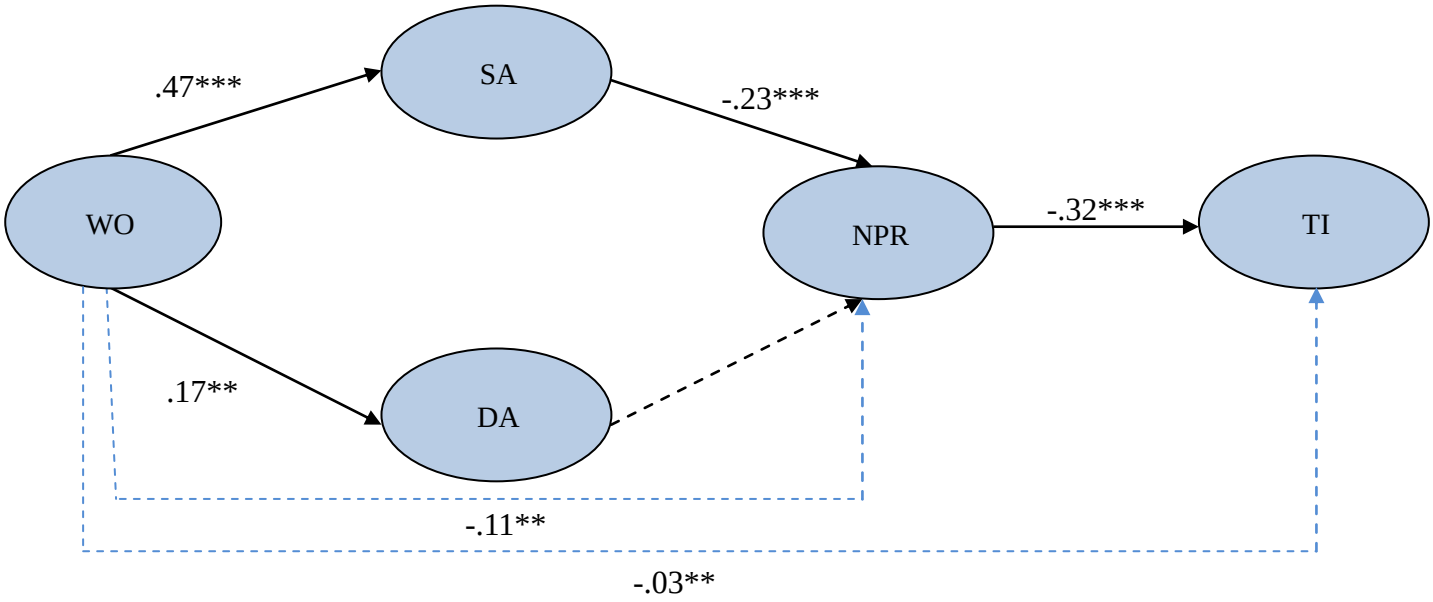

Figure 4-4 Standardized path coefficients (SEM I)

Note: WO= workplace ostracism; SA= surface acting; DA= deep acting; NPR= nurse-patient relationship; TI= turnover intention. ……Indirect effect; ...…Insignificant effect. ***. Coefficient is significant at the 0.001 level (2-tailed). **. Coefficient is significant at the 0.01 level (2-tailed).

According to the results reported in Table 4-14 and Figure 4-4, it can be concluded that:

Hypothesis 2, "*Workplace ostracism is negatively correlated with nurse-patient relationship*" is supported.

Hypothesis 3, "*Nurse-patient relationship is negatively correlated with turnover intention*" is supported.

Hypothesis 4a, "*Workplace ostracism is positively correlated with Surface acting*" is supported.

Hypothesis 4b, "*Workplace ostracism is positively correlated with deep acting*" is supported.

Hypothesis 5a, "*Surface acting is negatively correlated with nurse-patient relationship*" is supported.

Hypothesis 5b, "*Deep acting is positively correlated with nurse-patient relationship"* is not supported.

The direct effects and indirect effects of different paths are shown in Table 4-18. The indirect effect of workplace ostracism on nurse-patient relationship is (β=*-.105, p<.01*). Considering the indirect effect and overall effect of workplace ostracism on nurse-patient relationship are significant, surface acting plays a partial mediating role between workplace ostracism and nurse-patient relationship (workplace ostracism → surface acting, β=*.472, p<.01;* surface acting → nurse-patient relationship, β=*-.233, p<.01*). Therefore H6a "*surface acting partially mediates the relationship between workplace ostracism and nurse-patient relationship*" is supported.

Due to the path deep acting→ nurse-patient relationship (β=*.033, p>.01*), H6b "*deep acting partially mediates the relationship between workplace ostracism and nurse-patient relationship*" is not supported.

The indirect effect and overall effect of workplace ostracism on turnover intention are (β=*.034, p<.01*), whose effect path includes: workplace ostracism → surface acting → nurse-patient relationship → turnover intention, workplace ostracism → nurse-patient relationship → turnover intention. Therefore, H1 "*workplace ostracism is positively correlated with turnover intention*" is supported.

Considering the effect of workplace ostracism on turnover intention, nurse-patient relationship plays a partial mediating role between workplace ostracism and turnover intention (workplace ostracism → nurse-patient relationship, β=*-.105, p<.01*; nurse-patient relationship → turnover intention, β=*-.322, p<.01*). Hence, H7 "*Nurse-patient relationship partially mediates the relationship between workplace ostracism and turnover intention*" is supported.

Table 4-18 Direct and Indirect effects of model I

SEM Path		Direct effects	Indirect effects	Overall effects
WO →	TI	—	0.034**	0.034**
	SA	0.472**	—	0.472**
	DA	0.166**	—	0.166**
	NPR	—	-0.105**	-0.105**
SA →	NPR	-0.233**	—	-0.233**
DA →	NPR	0.033	—	0.033
NPR →	TI	-0.322**	—	-0.322**

Note: **p<.01

4.5 Summary of hypotheses testing

Most of the hypotheses are supported except H5b and H6b, as shown in Table 4-19.

Table 4-19 Summary of validation results of research hypotheses

No.	Research hypothesis	Result
H1	Workplace ostracism is positively correlated with turnover intention	Supported
H2	Workplace ostracism is negatively correlated with nurse-patient relationship	Supported
H3	Nurse-patient relationship is negatively correlated with turnover intention	Supported
H4a	Workplace ostracism is positively correlated with surface acting	Supported
H4b	Workplace ostracism is positively correlated with deep acting	Supported
H5a	Surface acting is negatively correlated with nurse-patient relationship	Supported
H5b	Deep acting is positively correlated with nurse-patient relationship	Not supported
H6a	Surface acting partially mediates the relationship between workplace ostracism and nurse-patient relationship	Supported
H6b	Deep acting partially mediates the relationship between workplace ostracism and nurse-patient relationship	Not supported
H7	Nurse-patient relationship partially mediates the relationship between workplace ostracism and turnover intention	Supported

Chapter 5: Discussion

Taking Chinese nurses as the sample, this study examined the levels of workplace ostracism, emotional labor (surface acting and deep acting), nurse-patient relationship and turnover intention and the hypothesized relationships through structural equation modeling. This chapter first discusses the findings of key variables and the hypotheses testing as well as the research model.

5.1 General

5.1.1 Workplace ostracism

In the study sample, the mean of workplace ostracism perceived by nurses is 1.37, which is higher than that of precious study (Gkorezis & Bellou, 2016), but lower than results from Ferris et al. (2008). Leung et al. (2011) and Chung (2015) argue that the degree of workplace ostracism differs from different groups. The degree of workplace ostracism is not high in this study. This may be because of the influence of the traditional Chinese collectivism values and the belief that “harmony is precious”. Most Chinese employees have a strong tolerance for workplace ostracism than Western employees. In addition, workplace ostracism is a subjective perception of an individual and each individual has different perceptions and responses to ostracism. As a negative and obscure experience, the respondent may have a tendency of hiding as the survey of this study was conducted within one hospital which might make the respondents not comfortable to report their ostracized experience. However, the results do show that 64.1% of the sample reported workplace ostracism which is quite significant. As such, the awareness of workplace ostracism is generalised in nursing profession. In Ferris’s (2008) study, 67% respondents have indicated that they are indifferent to the behavior of others, and 75% of respondents admit to have experienced other people's indifference. Research from Scott et al. (2014) has reported a high level of isolation and ostracism in work place. Therefore, it provides evidence that workplace ostracism is a widespread phenomenon.

There is significant difference on workplace ostracism regarding education. Workplace ostracism reported by bachelor degree nurses is higher than that of nurses of junior college degree, which corroborates the result of Jia's (2013) study in China. The reason may be that the majority of hospital nurses has a bachelor degree and stands for the main force of nursing teams. Nurses with a bachelor's degree may have more tasks than junior college degree nurses. Study has shown that bachelor's degree nurses' work load and pressure is higher than nurses of junior college degree while their job satisfaction is lower than that of junior college degree nurses (Hu, 2015). Work stress leads to employee's counterproductive work behavior, such as quarreling with colleagues (Fox, Spector, & Miles, 2001). Hence, it may lead to conflicts and exclusions among nurses. Moreover, compared with junior college degree nurses, bachelor degree nurses have more opportunities for promotion in career. Therefore, there will be more competition among bachelor degree nurses than junior college degree nurses, which leads to more workplace ostracism among them.

5.1.2 Emotional labor (surface acting & deep acting)

The mean of nurses' emotional labor is 2.27. From the perspective of whether nurses use emotional labor or not, the proportion of nurses using emotional labor accounts for 83.9%, while 16.1% does not resort to emotional labor in this research. This indicates that using emotional labor at work is a common technique that may relate to the professional specialty of nurses labeled as "white angel". Nurses need to get along with patient everyday, a task that requires them to express a good mental state and a good mood at work. Even when nurses believe themselves to have suffered from injustice or dissatisfaction at work, they also need to show positive emotions through surface acting and deep acting. The mean of surface acting and deep acting are 1.76 and 2.94 respectively, suggesting that deep acting is used more frequently than surface acting in this sample. This result is similar to previous research (Mittal & Chhabra, 2011; Gao et al., 2016). As deep acting is a more positive emotional regulation strategy, it may suggest that when nurses in this study see patients threatened by diseases, they will sympathize with them in the patient care delivery process. Hence, by internal

psychological process of positive thinking, imagination and adjustment, they strive to make their own emotions conform to the required performance from heart.

But, the results of this study suggest that there is significant difference on deep acting regarding departments of the same hospital. The result indicates that deep acting reported by nurses in surgery department is higher than that of internal medicine department nurses. This may be because surgical nurses have a better communication with doctors and patients, and they always show a more positive work emotion. In an active working atmosphere, nurses can complete work tasks through inner adjustment and change. Compared with surgery department where patients recover fast, patients in internal medical department tend to take longer time to recover. So, patients and their families may have negative emotions in the long-term disease care, creating negative mood and atmosphere to doctors and nurses which result in a less use of authentical emotional expression (deep acting) by nurses. Therefore, deep acting reported by internal medicine department nurses is lower than that of surgery department nurses.

Moreover, the results show that there is significant difference on emotional labor and deep acting regarding work experience. Emotional labor and deep acting reported by nurses in group with 2 to 5 years work experience are higher than that of nurses with work experience above 5 years. It may have the following reasons. First, because nurses who have 2 to 5 years' work experience will less familiar with the interpersonal relationships than nurses with work experience above 5 years. So, they will use more emotional labor in workplace to cope with the complex situations they encounter in work place. Second, stepping into a career, nurses are full of curiosity and enthusiasm about work and the unit. They seem to be having passion and emotional attachment for their work, hoping to have a good relationship with colleagues. Thus deep acting reported by them is higher than nurses with work experience above 5 years. Similarly, there is a significant difference on deep acting regarding organizational tenure (the time the respondents work in the hospital) in this study. Deep acting reported by nurses with ≤1 and 2 to 5 years tenure is higher than that of tenure above 5 years. This may imply that nurses with less organization tenure tend to show authenticity in emotional regulation when

interact with colleagues.

Lastly there is significant difference on emotional labor regarding employment. This study reveals that emotional labor engaged by regular nurses is higher than that of contract nurses, indicating that regular nurses use more emotional labor than contract nurses. This result is similar to the previous studies (e.g. Li, 2012). The reason might be that some contract nurses foster a belief that they are not a permanent member of the hospital and are more indifferent in the process of interacting with colleagues. Whereas, as a formal employee, regular nurses have more sense of identity and belonging in the hospital, that heighten their activity and sensitivity in interpersonal communication with others at work place. Besides, in terms of promotion, regular nurses usually have more opportunities than contract nurses, which increase the competition in the group of regular nurses. In order to obtain more supports from supervisors and colleagues, regular nurses thus engage emotional labor more often to develop and obtain resources (e.g. Guanxi or networks).

5.1.3 Nurse-patient relationship

In this study, the mean of nurse-patient relationship is 5.38, indicating that nurse-patient relationship in this sampe is quite positive, given the worsening nurse patient relationship in China. The result is similar to that of Ozaras's (2017) and Ross's (2014) researches. Nurse-patient relationship in Ozaras's (2017) study showed that patients' trust degree to nurses is relatively high. However, other researches in China (e.g. Han, Zhang, Lan, & 2011; Wen, 2009) showed poor nurse-patient relationship, which indicates that situations of nurse-patient relationship is different in hospitals and groups. This study shows that nurse-patient relationship is quite good and there are high scores in iterms of "communication", "nursing" and "care". This may be because samples in this study have been drawn from a teitiary hospital that has high requirements for the establishment and maintenance of nurse-patient relationship. Hospitals about this level will have more training courses for nurses, such as nurse-patient communication, interpersonal relationship, nursing operation and nursing etiquette resulting in nurses having a further understanding of the

importance of nurse-patient relationship and skills. They also pay more attention to the process of providing care for patients' health and safety that better implement of the concept of "patient-centered" care to improve nursing quality and promote the rehabilitation of the patients.

In terms of demographic variances on nurse-patient relationship, the nurse-patient relationship reported by nurses of above 5 years tenure - is higher than that of nurses with 2 to 5 years tenure. In China, hospitals often use N0-N4 to define nursing hierarchy. Which normally indicates that the higher the level (i.e. from N0 to N4), the longer tenure and stronger competence of nurses. Study has shown nurse-patient relationship is better among the nurses of level N4 than those at level N1 to N3 (Chen et al., 2015). This further illustrates that nurses with higher tenure may create better nurse-patient relationship. This is understandable because nurses with longer work experience within the sample organization would have more nursing experiences, more resources and supports from supervisors and colleagues and easily gain patients' trust at work. Moreover, long-tenured nurses tend to be engaged in health education work and more emotional communication with patients, which may help to establish a good nurse-patient relationship. Furthermore, study showed that young nurses have higher job pressure but lower satisfaction about interpersonal relationships, promotion and wages and benefits while long tenure of nurses do not (Hua, 2014). Due to nurses' working pressure and santisfaction affected the establishment of nurse-patient relationship (Schoombee, Van, & Kruger, 2014) it may have lower nurse-patient relationship between younger nurses and patients.

5.1.4 Turnover intention

In this study, the mean of turnover intention is 2.53, similar to a nurse research in Canada (Fernet, Tr épanier, Demers, & Austin, 2017). Compared with the relevant research results in China, the result of this study are lower than those of Hua (2014), but higher than that of Liu et al. (2014). This suggests that in different hospitals, nurses' turnover intention is also different. This is related to reasons of hospital with different levels, management style,

working environment, leadership and other factors.

In terms of difference of demographic variables on turnover intention, it showed that turnover intention of nurses aged from 26 to 40 is higher than that of above 40 years old, which is similar to Kim's (2014) and Yang's (2017) research. Because normally the organizational support, job promotion and salaries in group of above 40 years oldare higher than of 26 to 40 age nurses in hospital, the senior group has lower turnover intention than the young group (Mrayyan, 2008). On the other hand, nurses in group of 26 to 40 ages already accumulate a lot of working experience, ability, and then they can have more choice for other work units. Moreover, due to the reasons of marriage and family, a higher turnover intention may relate to nurses aged from 26 to 40. Some studies have shown that when faced with a choice between family and work, many people are willing to quit for the sake of family. Aged above 40 years old, nurse's families are more stable and have more commitment to their recent hospital (Hwang & Chang, 2008) than nurses aged from 26 to 40, the turnover intention is lower. Hence, age is one of the reasons related to nurses' turnover intention (Takase et al., 2016; Mrayyan, 2008).

Lastly, there is significant difference on turnover intention regarding department, that is turnover intention of internal medicine nurses is higher than that of the surgery nurses, which is different from the results of Kim's (2014) research, but similar to Yang's (2017). In this study, turnover intention of internal medicine depertment nurses is higher than that of surgery department nurses, which may relate to the different atmosphere in different departments. With more work pressure and less deep acting expressed by nurses as it decribed before, the working environment of internal medicine department may not be as pleasant as that of surgery department. Studies show that turnover intention of internal medicine doctor is higher than other departments (Hwang & Chang, 2008). Hence, nurses in internal medicine department may have higher turnover intention than other departments.

5.2 Hypothesis testing

5.2.1 Workplace ostracism and turnover intention

From the correlation among variables in this study, the direct correlation between workplace ostracism and turnover intention is not significant. In the optimal structural equation model, the direct effect of workplace ostracism on turnover intention also has not been confirmed. However, the indirect effect of workplace ostracism on turnover intention is significant in this research. Result from previous studies suggests that exclusion behavior directly and indirectly relates to turnover intention (Renn et al., 2013). But only indirect effect is confirmed in this study. The reason may be that, having experienced workplace ostracism, nurses might make various adjustments to solve problems instead of creating turnover intention immediately. In this research, there existed two indirect paths from workplace ostracism to turnover intention (workplace ostracism → surface acting → nurse-patient relationship → turnover intention; workplace ostracism → nurse-patient relationship → turnover intention) in the model, which illustrated the complex process of workplace ostracism's influence on turnover intention.

After being ostracized, nurses need to spend a lot of internal resources to adjust their emotions for meeting work needs, which might cause resource imbalance and problems, such as job stress, emotional exhaustion, feedback avoidance, and insufficient work performance. According to conservation of resources theory, if individual suffered from negative situations but did not get the corresponding compensation, one can take evasive behavior. So, after experiencing workplace ostracism, nurses may engage in surface acting as the result of this study suggests, which consume their resources and further negatively affeact the patient care (nurse-patient relationship), rerulting in turnover intention. In addition, research has shown women are more likely to experience negative affect and to report withdrawing from work on the days when they engaged in surface acting (Scott & Barnes, 2011). Given the majority of nurses are women, they are more likely to have turnover intention when encountered workplace ostracism. Hence, hypothesis 1 (i.e. workplace ostracism is positively correlated

with turnover intention) is supported.

5.2.2 Mediating effect of nurse-patient relationship between workplace ostracism and turnover intention

The direct relationship between workplace ostracism and nurse-patient relationship has not been confirmed in the optimal model of this research, but it showed the significant indirect effect between them. Also, correlation analysis showed a significant negative correlation between workplace ostracism and nurse-patient relationship. The direct effect of nurse-patient relationship on turnover intention and the indirect effect of workplace ostracism on turnover intention are significant. This illustrates the mediating effect of nurse-patient relationship between workplace ostracism and turnover intention. It may be explained as follows. The side effects of workplace ostracism such as sress and pressure cause physical and psychological problems, affecting the quality of nursing work and decreasing nurses' attachment to job. On the other hand, nowadays China's economy and society are developing rapidly and people's demand for health care is increasing, raising the intensity of nursing work. Nurses will bear more burdens in this situation. In that case, side effects from workplace ostracism may lead to nurses' frustrated and exhausted feelings much easier, creating lower work enthusiasm, poor care quality and nurse-patient relationship. Hence, hypothesis 2 (i.e. workplace ostracism is negatively correlated with nurse-patient relationship) is supported.

Different situations of nurse-patient relationship may create different influences on nursing. Good nurse-patient relationship leads to continuity of nursing care (Lotzkar & Bottorff, 2001), bringing win-win outcomes for both nurses and patients at work place, because common goals among nurses and patients will have been developed through the formation of good therapeutic relationships (Peplau, 1952). Trust in nurse-patient relationship is extremely important in professional care relationships and in satisfactory patient outcomes (Ozaras & Abaan, 2017). Good nurse-patient relationship may also lead to a decrease of stress among nurses. For example, patients will use humour during nurse-patient interactions

attempting to help nurses cope with the stress they encounter in clinical practice (Tanay et al., 2014). So, high quality nurse patient relationship will result in improved patient satisfaction, and possibly also the nurses' job satisfaction (Johansson, Oleni, & Fridlund, 2002) which will help to descrease nurses' turnover intention.

However, poor nurse-patient relationship leads to tension and disputes between nurse and patient, which results in many side effects. Nurse-patient relationship underlines the entire process of patient treatment. Improper handling of nurse-patient relationship affects the treatment and rehabilitation of patients. Poor nurse-patient relationship will intensify the conflict between nurses and patient. In nurse-patient disputes, patients may quarrel with nurses or even exhibit violent behavior to nurses. Nowadays, the occurrence of nurse-patient disputes and violences are on the rise in China (Yang, 2015), which causes stress and fear among nurses. On the other hand, the dispute settlement mechanism of hospital medical executive is ineffient presently, creating nurses' job insecurity and dissatisfaction. Moreover, in some stiuations, the hospital may let nurse have the total resiponsibility to the poor nurse-patient relationship, inevitably creating more pressure to nurses. Because establishing of good nurse-patient relationship is a complicated process including factors related to govement policy, hospital management, medicine treatment and nursing (Crowe, 2000). It requires not only nurses' perspective, but the effort of organization and hospitals also calling for a maintainance of this relationship (Bridges et al., 2013). So, based on conservation of resources theory, when nurses lose their specific resources in poor nurse-patient relationship, this not only damages the physical and mental health of nurses, but also affects the enthusiasm of nurses for the profession. They may take evasive behavior to avoid harm including intention to quit.

Therefore, hypothesis 3 (i.e. nurse-patient relationship is negatively correlated with turnover intention), H7 (i.e. nurse-patient relationship partially mediates the relationship between workplace ostracism and turnover intention) are supported.

5.2.3 Mediating effect of surface acting between workplace ostracism and nurse-patient relationship

From the correlation among variables, there is a significant positive correlation between workplace ostracism and surface acting, indicating that the higher degree of workplace ostracism felt by nurses, the more use of surface acting. Result of this study also confirms the mediation role of surface acting between workplace ostracism and nurse-patient relationship. This result provides evidence for the emotional regulation process between workplace ostracism and its consequence as expected. Based on emotional regulation theory, as a negative event, workplace ostracism will result in emotional adjustment, then affects individual's behavior outcomes. When encountering workplace ostracism, nurses will use surface acting such as faking a smile or putting a mask to others to adjust of the interpersonal relationship demand. Hence, hypothesis 4a (i.e. workplace ostracism is positively correlated with surface acting is supported),

However, through engaging surface acting, nurses suffer from the negative effects of surface acting (e.g. stress, emotional exhaustion). For example, surface acting has a positive relationship with stress (Kammeyer-Mueller et al., 2013b). Study indicates that a long period of surface acting results in physical discomfort, which will create sleeplessness and health problems of individual (Berkeley, 1983; Liu & Eacute, 2004). On the other hand, the inconsistency with the expression behavior, the cognitive evaluation and the emotional experience requires more psychological resources, using surface acting means engaging in emotional camouflage at work, which may result in pressure and burnout (Delgado et al., 2017; Carlson et al., 2012; Yang, 2015). The superficial emotion inharmonious with inner actual emotion causes more psychological efforts leading to emotional exhaustion.

In addition, surface acting would create the detachment to job, due to the reduced role identity (Brotheridge & Lee, 2003) and job satisfaction (Kammeyer-Mueller et al., 2013b). Surface acting will cause less engagement in role identity. Role identity is the perception of self-identity in different situations, and is synchronous with role definition related to work. If employees' sense of identity is lower in their work, their work performance and job

satisfaction are reduced, which is not helpful to the maintenance good nurse-patient relationship (Li, 2014).

Lastly, by employing surface acting, nurses do not display the true and authentical emotions at work, which may hinder the nurses to develop trust working relationship with colleagues and patients. As a result, the more surface acting a nurse uses at work, the worse nurse-patient relationship may exsit. Therefore, hypothesis 5a (i.e. surface acting is negatively correlated with nurse-patient relationship), hypothesis 6a (i.e. surface acting partially mediates the relationship between workplace ostracism and nurse-patient relationship) are supported.

5.2.4 Effect of deep acting between workplace ostracism and nurse-patient relationship

From the correlation among variables, there is a significant positive correlation between workplace ostracism and deep acting, indicating that the higher degree of workplace ostracism felt by nurses, the more use of deep acting. But there is an absence correlation between deep acting and nurse-patient relationship. In the analysis of structural equation model, the effect of deep acting on nurse-patient relationship was also not significant. This process can be discussed as bellow.

From the nature of nursing professional, the service target of nursing work is to care for the patient suffering from the disease that require physical and emotional care. The concept of professional ethics of saving the dying and sympathizing for patients make nurses' emotional situation consistent with the actual behavior (Halldorsdottir, 2008). This study suggests that even in the situation of encoutering workplace ostracism, the respondent nurses also engage deep acting in dealing with situation in work place to meet the job needs. Hence, hypothesis 4b (i.e. workplace ostracism is positively correlated with deep acting) is supported.

Many researches indicated the positive effectes of deep acting, such as less stress and burnout (Zhang & Zhu, 2008), higher job satisfaction and job performance (Kammeyer-Mueller et al., 2013a). However, if deep acting and surface acting are used combined, that may weaken the positive effect of deep acting or even make it become

negative, because emotional regulation strategy will have different effect when it is in different emotional labor contexts. Reseash has shown that high levels of deep acting were harmful for employee's well-being when individual also engage in high surface acting but that it can be beneficial for employee when engaging in low levels of surface acting (Gabriel et al., 2015). That means high level of surface acting will make the effect of deep acting become negative if they are used together. It might because deep acting may be performed without cost to employees, while surface acting requires individuals to consume a lot of internal resources. In this case, the negative effects of surface acting may cover or even exceed the positive effects of deep acting. So, the result of this research showed that deep acting did not lead to better nurse-patient relationship, due to surface acting and deep acting both engaged by nurses at the same time. Therefore, hypothesis 5b (i.e. deep acting is positively correlated with nurse-patient relationship) and hypothesis 6b (i.e. Deep acting partially mediates the relationship between workplace ostracism and nurse-patient relationship) are not supported.

5.3 The hypothesized research model

Overall, the hypothesized research model is supported by the structural equation model analysis, showing that workplace ostracism weaken nurse-patient relationship through surface acting, thus increasing turnover intention. But of the two emotional regulation strategies, only surface acting mediated the relationship between workplace ostracism and nurse-patient relationship. The mediating role of deep acting between workplace ostracism and nurse-patient relationship has not been found. The indirect effect of workplace ostracism on turnover intention has been confirmed, indicating that the process between workplace ostracism and turnover intention influenced by other variables. In this research, it can be influenced by two paths: workplace ostracism → surface acting → nurse-patient relationship → turnover intention, workplace ostracism → nurse-patient relationship → turnover intention. The indirect effect of workplace ostracism on nurse-patient relationship has been confirmed due to the mediation role of surface acting.

Chapter 6: Conclusion

6.1 Conclusion

Workplace ostracism is wide spread in nursing professional, creating many negative effects on the nurse's working environment, but the knowledge on the process of workplace ostracism's impact on turnover intention is limited in nursing professional. Based on emotional regulation theory and conservation of resource theory, this study uses two-wave survey to fill the research gap with 379 samples from a Chinese public hospital. The structural equation model has been used to test the relationships between workplace ostracism, surface acting, deep acting and nurse-patient relationship. Results reveal that: 1) workplace ostracism is positively correlated with emotional labor (both surface acting and deep acting); 2) surface acting plays a mediating role in the process of workplace ostracism and nurse-patient relationship; 3) nurse-patient relationship is negatively correlated with turnover intention.

Contributions from this study are concluded the following. First of all, this study introduces emotional labor in the process of workplace ostracism and its consequences, which better explains how workplace ostracism impacts on employee's behavior and work-related outcome, thus enriching the literature in both workplace ostracism and emotional labor.

Second, this study narrows our knowledge gap about the process between workplace ostracism and turnover intention with empirical support from a nurse sample in an under-researched setting – Chinese public hospital. This study suggests that workplace ostracism's influence on turnover intention is not direct, but rather a sophisticated process involving emotional regulation, and nurse-patient relationship in the case of nursing professional.

The practical value of this study lies in the implication for hospitals, nursing school and nurses per se to better prevent and manage workplace ostracism for nursing care quality and nurse retention, as discussed next.

6.2 Practical implications

In this study, majority of nurses reported experience of workplace ostracism in work place and workplace ostracism leads to surface acting which in turn to weaken nurse-patient relationship. And the condition of nurse-patient relationship has a significant negative impact on turnover intention. This result suggests the negative consequences of workplace ostracism, direct and indirect on nurses' wellbeing (e.g. surface acting), patient care (e.g. nurse-patient relationship) and organizational performance (e.g. turnover intention of nurses), thus posing a threat to the management of nursing human resources and patient care. To cope with such challenge, hospitals and their managers, nursing schools and nurses should work together to prevent and manage when it occurs. Next, the implications for the stakeholders are discussed.

6.2.1 Managerial implications for hospitals and managers

6.2.1.1 Prevent and manage workplace ostracism

The number one implication for hospitals and their managers is to prevent workplace ostracism in the first place. Although this study did not examine the antecedents that can give direct implication to prevent workplace ostracism, the results of this study do imply ways to reduce or minimize the occurence of workplace ostracism. For example, this study revealed that nurses with bachelor degree reported higher workplace ostracism than those with lower education. A possible reason lies in the intense competition among this group of nurses. Therefore, setting open, transparent and fair promotion rules may help to prevent and reduce the likehood of workplace ostracism in this regard.

In addition, managers should know that workplace ostracism is a subjective feeling that the targets sometimes hard to recognize it. In particular, Chinese people value the concept of "harmony" and avoid confrontation in public. As a result, the ostracized individuals often endure the rejection behavior but not express the dissatisfaction and discomfort emotion publically. This may cause physical and mental damage to the ostracized individual without others' notice. Although employees are more tolerant of workplace ostracism in the context of

Chinese collectivist cultural values, this should not be the reason for ignoring the negative effects of workplace ostracism by authority. Hence, managers should take effective measures to intervene and actively respond to workplace ostracism in nursing.

Hospitals should establish openning communication and complaint channels for employees, and provide a standardized supervision and complaint mechanism guidance, encouraging nurses to put forward valuable opinions and suggestions to their superiors. Meanwhile, managers should give reasonable feedback to the opinions, suggestions and complaints of nurses, and encouraging nurses to actively adopt the right approach when they experience workplace ostracism, and seek help and support through correct channels to deal with it. This will not only solve the problem reasonably, but also reduce the negative impact of workplace ostracism and avoid causing more damage.

Lastly, education and training should be provided to increase nurses' knowledge on the harms of workplace ostracism and skills to respond to it. For example, this study suggests that the use of deep acting might "stop" workplace ostracism's negative influence on nurse-patient relationship. Therefore, revelant training on emotional intelligence and emotional management may help nurses better manage workplace ostracism when it takes place. On the other hand, given the role of surface acting which consumes resources, based on conservation of resource theory, it is of importance for giving support and helping to those who are ostracized to minimize workplace ostracism's negative impacts on employees and organization.

6.2.1.2 Cope with emotional labor engaged by nurses

In this study, we find that emotional labor is prevalent in nurses' work. Nursing as a high-intensity and fatigued working group, invest in lots of emotional labor in the process of caring for patients. So, extra stress resulted from workplace ostracism will lead to more pressure to nurses. Therefore, managers should pay more attention to the importance of nurses' psychological well-being and help them to adjust the requirements in job. Nurses often engage emotional work to show empathy and compassion to patients. Therefore, it called for the attention to emotional connections in nurse training, practice, and research (Clinton &

Hazelton, 2000). So, it is important to have different training of emotional management courses in hospital, such as emotional intelligence and emotional management skills. Among these courses, nurses also should be given an opportunity to learn how to develop positive attitude and skills for stress coping and how to use emotional regulation properly in daily work.

This research has shown the negative effect of surface acting. Hence, nurses should be encouraged to use more deep acting and minimize the use of surface acting. In particular, from the result of this research, regular nurses and nurses within 5 years' working experience tend to use more emotional labor, so nurses with these two groups need to get more focus on the emotional management training.

6.2.1.3 Manage nurse-patient relationship

In nurse patient relationship, patient as the bearers of a diseases, are often in a state of discomfort and helpless by themselves. They also lack professional knowledge about the disease. So, they hope to obtain supports and care from the professionals, resorting to technology, knowledge and emotion. Nursing staff, as the main role of nurse-patient relationship, should view patients as a synthesis of psychological, physical, social characteristics rather than an independent organism. This research showed that nurse-patient relationship negatively correlated with turnover intention. Therefore, establishing a good nurse-patient relationship is not only beneficial to patient care, but also could help reduce the loss of nurses.

In this study, nurses with 2 to 5 years organization tenure reported a lower nurse-patient relationship comparing with nurses above 5-years tenure. Hence, in designing and arranging different levels of nurses for training, managers should formulate training courses based on the relevant level of nurses and related factors that affect nurse-patient relationship to meet the needs of nurses for their professional development and improvement of nurse-patient relationship. Training can be varied from discussion, scenario simulation, quality improvement projects and so on. In addition, e-learning is also an effective educational approach in educating nursing staff (Brunero & Lamont, 2014).

Establishing and maintaining a good nurse-patient relationship should not only be the concern of nurses, but also the joint efforts of the society, the government, hospitals and other entities. Therefore, it should consider many factors jointly to create a good nurse-patient relationship. The society should give publicity to the positive power of health industry, avoid spreading unreal and negative gossip news and respect healthcare professional. Government departments should increase investment in medical and healthcare services, balance health resources, increase the spread of medical insurance, further improve nursing laws and regulations to promote the benefits of both patients and nurses. Hospitals should strengthen the construction of the hospital culture, build a good medical environment for patients, pay more attention to the nursing work and provide more physical and mental health training of nursing staff. Nursing managers should treat the harmony between nurses and patients as an important research topic and the key issue for the future development of the hospital.

6.2.2 Implications for nurse

Nurses should strengthen learning and training for emotional management through participating in psychological workshops and other activities. Such traings are helpful for two ways. On the one hand, it helps nurses to cope with workplace ostracism with the right emotional regulation strategy. For example, the use of deep acting is more desirable than the use of surface acting, as the result of this study suggests. On the other hand, the nature of nursing engages with lots of emotional labor, as reported in this study. Therefore, good emotional management knowledge helps to develop positive and healthy nurse patient relationship and improve patient care.

In case of encountering workplace ostracism, nurses should use deep acting rather than surface acting to deal with the situation, as this study suggests. When nurses can not solve the problem of workplace exclusion, they need to seek appropriate helps and supports from the organization and supervisor to minimize the negative consequences brought by workplace ostracism.

6.2.3 Implications for nursing school

At present, nursing school curriculum pays more attention to technical skills of diagnostics and treatment for nursing education (Kelc ĸova, Skodova, & Straka, 2012), while insufficient attention has been given to emotional education and interpersonal relationship education of nursing students. This research reveals that nurses engage in lots of emotional labor in their work on daily basis and emotional regulation strategy (deep acting vs surface acting) influence patent care (e.g. nurse-patient relationship) in different way. Therefore, nursing school should set up relevant courses, such as emotional management to better nurses to cope with challenges in work place.

6.3 Limitations and suggestions for future research

The following limitations are acknowledged.

First of all, this study only investigated the nurses from one tertiary hospital in Sichuan Province in China. In the process of collecting the data, only the nurses of the hosptial's three subbranches of were selected as the survey participants. The sample was limited. Therefore, the results of this study can not be generalized for nurses in different regions and other countries. In the follow-up study, the representativeness of the research objects may be increased, so that the results of the study will be more generalized.

Secondly, measures for turnover intention of this study only adopted subjective indicators in survey, but not objective data of actual turnover rate. In future research, more objective data on relevant variables should be collected to examine the consequence of workplace ostracism via emotional regulation.

Lastly, this study measured the emotional labor with colleagues and did not include nurses' emotional labor engaged with patients. In the future, it would be worthwhile to study the relationship between workplace ostracism, emotional labor with patients and nurses' work attitudes and behaviors like turnover and occupational comments.

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Appendix 1：Questionnaire cover letter

Dear nurses!

Thanks for your cooperation! This questionnaire is about nurse working conditions. It can be finished within 10 minutes.

There is no right or wrong in this questionnaire, and the investigation is anonymous.

Only for research use, you can fill out the form honestly.

After finishing, please hand in the questionnaire to the nurse in the department office.

Any question, please contact Xiao (Tel: **********)

Thanks again!

2017

Appendix 2：Questionnaire on nurse working conditions (first-round questionnaire)

Dear nurses,

Thank you very much for participating in this questionnaire! This questionnaire is about nurse working conditions. Please answer the questions according to the actual situation, and click "√" on the corresponding options. There is no right or wrong in the questionnaire. Your truthful answer is of vital importance to this research!

Declaration: The survey is conducted in an anonymous way. The questionnaire will be kept strictly confidential and only for research purposes. Please feel free to fill in the questionnaire. Thanks again!

1. working conditions

When getting along with colleagues, please judge how well the description fits your situation and type (√) in the appropriate number of options.

Items	never	seldom	occasionally	sometimes	often	always
1. Others ignored you at work	1	2	3	4	5	6
2. Others left the area when you entered	1	2	3	4	5	6
3. Your greetings have gone unanswered at work	1	2	3	4	5	6
4.You involuntarily sat alone in a crowded lunchroom at work	1	2	3	4	5	6
5. Others avoided you at work	1	2	3	4	5	6
6. You noticed others would not look at you at work	1	2	3	4	5	6
7. Others at work shut you out of the conversation	1	2	3	4	5	6
8. Others refused to talk to you at work	1	2	3	4	5	6
9. Others at work treated you as if you weren't there	1	2	3	4	5	6
10. Others at work did not invite you or ask you if you wanted anything when they went out for a coffee break	1	2	3	4	5	6

1. Emotional management with colleagues

When associating with your colleagues (leaders or colleagues), in order to effectively carry out your work, how well you will expose the behaviors as bellow, please type (√) in the appropriate number of options.

Emotional expression management

description	never	seldom	occasionally	sometimes	often	always
1. Put on an act in order to deal with customers in an appropriate way	1	2	3	4	5	6
2. Fake a good mood	1	2	3	4	5	6
3. Put on a “show” or “performance”	1	2	3	4	5	6
4. Just pretend to have the emotions I need to display for my job	1	2	3	4	5	6
5. Put on a “mask” in order to display the emotions I need for the job	1	2	3	4	5	6

Inner emotion management

description	never	seldom	occasionally	sometimes	often	always
1. Try to actually experience the emotions that I must show	1	2	3	4	5	6
2. Make an effort to actually feel the emotions that I need to display towards others	1	2	3	4	5	6
3. Work hard to feel the emotions that I need to show to others	1	2	3	4	5	6

Personal information：Please put "√" on the appropriate option, or fill in the corresponding number on “_____”.

1. Gender: (1) male (2) female

2. Age: _____ years old

3. Marital status: (1) married (2) single (3) others (divorce, etc.)

4. Professional title: (1) nurse (2) senior nurse (3) supervisor nurse (4) co-chief superintendent nurse (5) chief superintendent nurse

5. Education: (1) secondary specialized school (2) junior college (3) bachelor (4) master and above

6. Department: (1) surgery department (2) internal medicine department (3) pediatric department

7. Nursing experence: _____ years

8. Organizational tenure in this hospital: _____ years

9. Employment form: (1) regular (2) contract

10. The number of your hospital beds:

(1)≤500 (2) 501-1000 (3) 1001-1500 (4) 1501-2000 (5)>2000

11. Have you changed your work unit in the past 5 years: (1) yes (2) no

12. If you have changed your work unit, how many: _____

Appendix 3：Second-round questionnaire

Dear nurses,

Thank you very much for participating in this questionnaire! There is no right or wrong in the questionnaire and the questionnaire will be kept strictly confidential and only for research purposes. Your truthful answer is of vital importance to this research! Declaration: The survey is conducted in an anonymous way. The questionnaire will be kept strictly confidential and only for research purposes. Please feel free to fill in the questionnaire. Please answer the questions according to the actual situation, and click "√" on the corresponding options.

description	completely disagree	relatively disagree	a little disagree	a little agree	relatively agree	completely agree
1. I always patiently communicate with patients on their health condition, treatment and cost	1	2	3	4	5	6
2. I always patiently tell patients or their families of the nursing treatment I have been doing	1	2	3	4	5	6
3. I always take good care of patients	1	2	3	4	5	6
4. I do my best to care for patients in nursing (e.g. reducing pain)	1	2	3	4	5	6
5. I always respond to the questions of patients and their families in a timely and enthusiastic manner	1	2	3	4	5	6
6. I am proud to have nursing skills to help patients effectively	1	2	3	4	5	6
7. I am very happy to see patients getting	1	2	3	4	5	6

better with my nursing work						
8. Basically, I didn't think about leaving this unit	1	2	3	4	5	6
9. I plan to have a long-term career development in this unit	1	2	3	4	5	6
10. I often get bored with my present job and want to change a new one	1	2	3	4	5	6
11. I will probably leave the present unit within half a year	1	2	3	4	5	6

Thank you for supporting this research!