Constructive Deviance: Striving Toward Organizational Change

Dana L. Robbins
Bella L. Galperin
The University of Tampa
John H. Sykes College of Business

Abstract

Constructive deviance is becoming increasingly important in businesses today because constructive deviants can bring about positive changes. Unlike much of the literature on workplace deviance which focuses on dysfunctional behavior such as antisocial behavior and workplace aggression, constructive deviants are employees who break the rules and norms but intend to benefit the organization. These individuals can play a key role in creating an organizational change and serve as future change agents. Given the increasing discussion on health care reforms, our paper explores the factors that relate to constructive deviance among physicians. Finally, practical implications and future research directions are discussed.

Introduction

Workplace deviance has generally been used to describe the following behaviors: antisocial behavior (Giacalone & Greenberg, 1997), workplace aggression (O'Leary-Kelly, Griffin & Glew, 1996), organizational retaliation (Skarlicki & Folger, 1997), and employee deviance (Robinson & Bennett, 1995). Although previous research has increased our understanding of the harmful effects of deviance within organizations, little research has examined the positive aspects of deviance. Constructive workplace deviance encompasses behaviors that violate significant organizational norms in order to contribute to the well-being of the organization (Galperin, 2003).

Constructive deviance is becoming increasingly important in businesses today because constructive deviants can bring about positive changes. Unlike much of the field of organizational behavior which focuses on managerial dysfunctions, such as resistance to change (Luthans, 2002), constructive deviants can play a central role in facilitating organizational

change. Given the increased interest in healthcare reforms in the United States, we chose to examine constructive deviance in the healthcare setting. Our paper explores the factors that relate to constructive deviance among physicians. Specifically, we propose that physician emotional intelligence, empathy, extroversion and trust are central characteristics in facilitating constructive deviance. Finally, practical implications and future research directions are discussed.

Constructive Deviance

While the concept of deviance can be found in the psychological and criminology literature and typically refers to people who do not obey or conform to the social norms (Cohen, 1966), the management literature has generally conceptualized deviance as harmful to the organization. More recently, researchers (Galperin, 2003; Morrison, 1006; Warren, 2003) have based their definition on the literal definition of deviance and viewed deviance as constructive or positive. Constructive deviance is defined as behaviors that violate the organizational norms with the intent of helping the organization (Galperin, 2003). Constructive deviance can include behaviors that are unauthorized yet facilitate the organizational goals. For example, an employee may intentionally depart from dysfunctional organizational policies or procedures to solve a problem. Similarly, a manager will violate company procedures in order to solve a customer's problem.

Constructive deviance is related to organizational citizenship behavior (OCB), whistle-blowing, and voice. OCB is defined as "individual behavior that is discretionary, not directly or explicitly recognized by the formal reward system, and that in the aggregate promotes the effective functioning of the organization" (Organ, 1988, p. 4). OCB is similar to constructive

deviance since both promote the effective functioning of the organization. OCB differs from constructive deviance because OCB may not depart from the organizational norms.

Whistle-blowing is defined as "disclosure by organizational members (current or former) of illegal, immoral, or illegitimate practices under the control of their employers to persons or organizations who may be able to effect action" (Near & Miceli, 1985, p.4). Since external whistle-blowing can be conducted with the intent of retaliation rather than protecting the public, employees or investors (Dozier & Miceli, 1985), whistle-blowing differs from constructive deviance. However, a whistle-blower can also use internal channels to save the organization in the long-run and act in the society's best interest. Consequently, internal whistle-blowing (not external) is similar to constructive deviance.

Finally, voice emphasizes verbal expressions of improving rather than merely criticizing the organization (LePine & Van Dyne, 1998). Contrary to the concept of voice which focuses on making verbal constructive suggestions that may challenge the system, constructive deviance includes behaviors that more strongly violate the organizational norms.

Despite the importance of workplace constructive deviance in facilitating change and innovation, the literature on constructive deviance is limited. Studies on workplace constructive deviance in the area of healthcare are even more limited. Research on constructive deviance can contribute to the implementation of changes in the healthcare setting. In a survey by the American College of Healthcare Executives (2007), hospital chief executive officers cited that financial challenges and patient safety and quality were the most important factors which confronted their organizations. Nevertheless, the literature suggests that hospitals have generally been unable to improve their current situation due to the inability to realize organizational changes (Erwin, 2009; Griffith, Pattullo, Alexander, Jelinek & Foster, 2006; Langabeer, 2008).

Constructive deviants can benefit hospitals by improving processes and creating institutional innovations. Below, the norms in the heathcare setting are discussed.

Organizational Norms in the Healthcare Setting

As noted earlier, deviance requires the departure from social norms of a referent group. Since norms and rules are in place to guide behavior, people generally do not depart from the expectations that guide behavior within a certain group context. Individuals do not deviate from what is considered acceptable by a group even though they may behave in another manner in a different setting (Cialdini & Trost, 1998). For example, a doctor may act in a reserved manner in the hospital but may be a comedian in a non-work setting.

Norms can be visible in two types of individual behavior. First, norms shape individuals behaviors by providing people with the felt obligation to behave according to the norm. Second, norms involve the individuals as sanctioning agents whereby others are obligated to behave according to the norm (Opp & Jasso, 1997). Specifically, organizational norms can be adaptive and facilitate group functioning. Norms are often developed around behaviors that are important for the completion tasks and facilitates social functioning (Shaw, 1981). However, norms can be adaptive since the modifications of norms ensure group survival (Feldman, 1984). Norms help task-related behaviors and social interaction by providing the individual with information on the appropriateness of behaviors which provides group members' actions with more predictability and facilitates other members to respond rapidly with a range of appropriate behaviors (Hackman, 1976; Levine & Higgins, 2001).

In general, organizational norms can largely vary based on the work context. For example, one will expect that the organizational norms in hospitals will be different from construction companies. Based on the literature, there are three common norms within the hospital environment: (1) emotional distance, (2) professionalism, and, (3) adherence to protocol. First, the norm of emotional distance facilitates the functioning of the physician-patient relationship. Physicians are expected to display emotional distance from their patients in order to provide quality care for their patients. Physicians who have a greater emotional involvement and show a high degree of caring toward their patients may be limited in their objectivity and effectiveness of intervention. While emotional reactions are largely frowned upon and widely discouraged within the healthcare setting, some physicians recognize the role of emotions in the workplace. For example, Dr. Paul Rousseau states, "…I now realize that as a physician I am merely a shepherd guiding others through this convoluted, confusing, and forever changing thing called life" (Marnocha, 2009).

Second, physicians are expected to display a degree of professionalism when interacting with their patients. Patients expect a level of professionalism and expertise from their physicians at all times which includes thinking logically and maintaining a demure exterior posture. Finally, there is the norm within hospital cultures that dictates that employees must strictly comply with all policies and procedures due to patient safety and patient quality assurance. It is largely frowned upon in this environment to break the "red tape," since it was instituted for patient care.

While these norms facilitate group functioning in hospitals and increase predictability, *sometimes* these norms do not contribute to the overall productivity of hospitals. Given today's dynamic environment, hospitals must change and adapt to the needs of the current context (Erwin, 2009). Hospitals generally possess a stagnant culture which implements new policies in

order to discourage deviance. Pascale and Stenin (2005) note that some hidden obstacles include the fear of "seemingly" exotic procedures, concerns about time consuming insurance approvals and worries that patients would be exposed to unnecessary risk. There is a need to alter the doctors' mind-sets.

It is evident from the healthcare literature that organizational changes are needed to enhance the effectiveness in the healthcare setting. We argue that constructive deviants may be the change agents needed to facilitate this change. Which factors may contribute to constructive deviance in hospitals? In the section below, we propose several individual factors that facilitate constructive deviance among physicians.

A Theoretical Framework for Understanding Constructive Deviance among Physicians

We propose that emotional intelligence, empathy, extroversion, and trust are central factors that can increase constructive deviance among physicians.

Emotional Intelligence

Emotional intelligence (EI) refers to the ability to do such things as understand one's feelings and regulate one's emotions to increase the quality of life. This form of intelligence emphasizes the ability to connect with people and understand their emotions. Goleman (1988) argues that a person can be most effective when he or she has a high degree of emotional intelligence, cognitive intelligence (general mental ability), and technical skills. A person can have excellent training, higher analytical skills, however, the person will not reach his or her full potential without emotional intelligence.

Researchers have viewed emotional intelligence as the ability to perceive emotion, integrate emotion to facilitate thought, understand emotions, and to regulate emotions to promote

personal growth (Weng, Chen, Chen, Lu, & Hung, 2008). An emotionally intelligent person can harness emotions, even negative ones, and manage them to achieve intended goals (Salovey & Grewal, 2005). Salovey and Mayer propose the four branch model of emotional intelligence which characterizes emotional intelligence as a set of four related abilities: perceiving, using, understanding, and managing emotions (Salovey & and Grewal, 2005). These abilities enable an individual to build stronger bonds with others in both their personal and professional lives.

The literature on healthcare management suggests that the ability to recognize and respond to nonverbal and emotional information, EI- related abilities, are a central factor related to patient satisfaction. EI must be included in a doctor's lifelong learning effort to be informed and aware of patient needs (Weng, Chen, Chen, Lu, & Hung, 2008). A physician with a high level of emotional intelligence can use it to benefit the organization as a whole by keeping patient satisfaction ratings high.

It is expected that physicians high on emotional intelligence will be effective at perceiving and understanding when it is effective to break the norm of emotional distance. While physicians may be expected to generally behave with emotional distance, some situations may require a greater management of emotions. For example, a patient recently diagnosed with cancer may expect his physicians to understand his stress and anxiety. Consequently, we expect that,

Proposition 1: Physicians who are high in emotionally intelligence are more likely to engage in constructive deviance with patients.

Empathy

Empathy is largely a cognitive attribute that involves an understanding of experiences, concerns and perspectives of another person, combined with a capacity to communicate this understanding. Empathy in the context of clinical care can lead to positive patient outcomes including greater patient satisfaction and compliance, lower rates of malpractice litigation, lower cost of medical care, and lower rate of medical errors (Hojat, 2009). Furthermore the act of being empathetic has been proven to aid in patient's recovery. Reassurance can reduce stress, enhance positive expectation, reduce negative emotions and positively influence the body's ability to self-heal (Prarties, 2008). Previous studies have shown that patients whose doctors show empathy are more satisfied with their medical encounters, which leads to a better understanding of their condition and lower anxiety (Rubin, 2008).

While emotional distance still remains to be norm in hospitals, more recently some a minority in the medical humanities have promoted the importance of empathy. The "practice of empathy" has become an icon among the medical humanities movement in the United States and the United Kingdom. American physicians have even gone so far as to adopt empathy as one of the accredited "skills" required by the American Council for Graduate Education (Macnaughton, 2009).

Therefore, the question remains: if there are positive outcomes associated with empathic behavior then why are majority of physicians not engaging in this constructive behavior? In a recent study published in the Archives of Internal Medicine, it was found that physicians overwhelmingly miss opportunities to express empathy to their patients. Physicians missed 90

percent of opportunities to respond empathetically to their patients (Chen, 2008). Overall, the most common response cited by physicians was the "lack of time", it was noted that physicians may believe that there is no time for empathetic responses in a busy clinic (Chen, 2008). This study supports the overwhelming norm of emotional distance in the healthcare industry. While the value of empathy has been recognized, generally physicians choose not to engage in empathetic behavior.

The findings of the above study lead us to examine the remaining 10 percent of physicians who are engaging in empathetic behavior. What motivates these physicians to break the norm of emotional distance? Scholars have argued that empathy evokes a motivation to help meet another person's needs. Consequently, the concern for others promotes interpersonal helping behavior (Morrison, 2006). It is expected that when physicians are highly empathetic, they focus on the needs of their patients and therefore are more likely behave in constructive deviance. It follows,

> Proposition 2: Physicians who are highly empathic are more likely to engage in constructive deviance with patients.

Extroversion

Extroversion, is one of the "Big Five" dimensions of personality. Extroversion is the extent to which a person is outgoing versus shy. High extroverts enjoy social situations; while those low on this dimension (introverts) avoid them (Barrick & Mount, 1991). An extrovert is generally most content when surrounded by people. Within the medical profession there are several personality traits that can be identified as facilitating patient-oriented physicians.

However, one of the most significant traits is extroversion. Extraversion is generally regarded as consistent with good medical practice (Maron, Fein, Maron, Hillel, El Baghdadi & Rodenhauser, 2007). General sociability with a cheerful disposition, as well as warmth, gregariousness, assertiveness, activity excitement-seeking, positive emotions are usually characteristics that are important for physicians to possess when dealing with patients (Maron et al., 2007).

According to a recent study conducted by BMC Health Serve Research, a review of the literature on patient's priorities found "humaneness" to be the most highly rated aspect of care, followed by clinical competence and patient's participation in decisions (Schattner, Rudin, & Jellin, 2004). In addition, 38% of respondents stated patience and friendliness as important attributes in physicians (Schattner, Rudin, & Jellin, 2004).

Based on the above, it appears that characteristics associated with extroversion are highly valued from the patient care perspective and are good general medical practices. While there is a norm of professionalism, which dictates that all physicians are to remain composed and in control of their emotions at all times, patients may prefer physicians to display warmth and emotion. For example, a patient has recently received a diagnosis that he has a curable cancer, yet chooses *not* to undergo radiation treatment. The hospital norm would dictate that the doctor should present the facts in a logical manner and remain composed during the situation. What if that doctor breaks the norm of professionalism and displays an emotion of anger because the patient has the chance to live if treatment was accepted? The deviation from the hospital norm of professionalism could cause the patient to undergo the treatment and eventually save his life. It is expected that physicians who are high on extroversion (e.g. show deep connections with their patients and enjoy social situations) will more likely engage in constructive deviance and not follow the norms of professionalism. It follows,

Proposition 3: Physicians with a high degree of extroversion are more likely to engage in constructive deviance.

Trust

The relationship between a physician and patient has been viewed as the essence of medicine (Rosseau & Blackburn, 2008). However, the physician-patient bond can be easily broken if the physician or patient breaks the one unifying connection--trust. Patient trust in the physician has been proposed as a key feature of this relationship. There are several potential benefits to patient trust, including increased patient satisfaction, adherence to treatment, and continuity of care (Thom, 2001). In the hospital setting, patient satisfaction is one of the key indicators of a functioning healthcare setting. When the relationship between a patient and physician has a strong degree of trust and patient satisfaction is increased, hospital ratings will improve in the long run. For effective treatment, physicians need to elicit trust almost instantaneously with new patients who know virtually nothing about them (Axelrod and Goold 2000). The ability to do so depends critically on patients' views of physicians in general, and on the symbolic or archetypal features of being a doctor (Hall, Camacho, Dugan, & Balkrishnan, 2002).

Trust is seen as important in its own right because it is the attribute that gives medical relationships intrinsic value (e.g. makes the interaction more enjoyable) but also trust is critical in a more instrumental fashion (e.g. proper diagnosis). Trust is central to patients' willingness to seek care, reveal sensitive information, submit to treatment, and follow physicians'

recommendations (Hall, Camacho, Dugan, & Balkrishnan, 2002). In a research study on the 'patient-doctor relationship' or PDR, the findings show the patient views health care services in terms of the people who deliver them. In line with this reasoning, trust can make the exchange in the PDR more enjoyable and improve psychological transactions between two individuals (Weng, Chen, Chen, Lu, & Hung, 2008). In addition, trust was found to be positively associated with a doctor's experience, the patient follow-up ratio, and PDR (Weng et al., 2008).

When there is trust between the physician and the patient, the degree of risk decreases because there is honesty between the two parties. Research has shown that risk-taking propensity is positively associated with the tendency to deviate from organizational norms (Morrison, 2006). In addition, when companies empower their employees, they are more likely to engage in risk-taking behaviors that depart from the organizational norms in a way that is beneficial to the organization (Applebaum, Iaconi, & Matousek, 2007).

Based on the research, it is expected that physicians who have a high level of trust with their patients will more likely engage in risk-taking behavior and deviate from the key hospital norms which stresses the adherence to policies and procedures. By engaging is greater risk-taking behavior, the physician will more likely deviate from the hospital norms but may be able to provide superior patient care in the long run. For example, a physician is confronted with the situation when a urine test comes back positive for some type of illegal substance. When the doctor confronts that the patient, the patient assures the physician that no drugs were taken. In a patient-doctor relationship that has low levels of trust, the doctor would not likely believe the patient, where as in a relationship with high levels of trust the physician will more likely search for a reason why the patient tested positive for the drug substance. The physician may disobey an

organizational policy or procedure in order to prove that the patient is indeed being honest and there was a confusion in the urine samples.

Proposition 4: Physicians who have a high level of trust with their patients are more likely to engage in constructive deviance.

Discussion

In conclusion, our paper examines the factors related to constructive deviance among physicians. Specifically, we suggest that physicians who are high in emotional intelligence, empathy, extroversion, and trust will more likely engage in constructive deviance. It is expected that physicians who engage in constructive deviance have the capability of bringing about change within their hospitals. When physicians deviate from the hospital norms, an innovative procedure or process may be discovered and a new era of medicine may emerge--one that increases patient safety and quality while decreasing costs.

Hospital administrators may want to pay closer attention to emotional intelligence and enhancing physicians' capacity for emotional intelligence (Weng, Chen, Chen, Lu, & Hung, 2008). Researchers estimate that emotional intelligence accounts for more than 60% of performance ability and matters twice as much as technical proficiency or intelligence in some positions (Robbins, 2007). In addition, any kind of serious weakness in emotional intelligence will predict failure (Robbins, 2007). It is apparent that emotional intelligence can benefit hospitals.

Similarly, we suggest that empathy is also important in enhancing constructive deviance. Unfortunately, research has shown a decline in medical students' "empathetic concern" which describes their feelings of warmth, concern and sympathy towards others (Stratton, Terry, Saunders, 2008). Therefore, it is expected that empathy training which teaches physicians how to engage in empathetic behavior towards patients in order to increase overall patient satisfaction is greatly needed since physicians are not currently being trained in this skills. A more humanistic approach to the patient-doctor relationship could create a new breed of physicians in the future who are highly sensitive to their patients needs.

While we discussed three central hospital norms, future research should examine how hospital size and location influences constructive deviance. In addition, studies should examine additional actors which facilitate constructive deviance in physicians, as well as other stakeholder in the hospitals, such as nurses.

References

American College of Healthcare Executives (ACHE). (2007). *Top issues confronting hospitals: 2007*. Chicago: American College of Healthcare Executives. http://www.ache.org/PUBS/research/ceoissues.cfm (accessed August 19, 2009).

Applebaum, S., Iaconi, G. D., & Matousek, A. (2007). Positive and negative deviant workplace behaviors: causes, impacts and solutions. *Corporate Governance*, 586-598.

Axelrod, D. A. & Goold, S.D. (2000). Maintaining Trust in the Surgeon-Patient Relationship: Challenges for the New Millennium. *Archives of Surgery 135*, 55-61.

Barrick, M.R. & Mount, M.K. (1991). The big five personality dimensions and job performance: A meta-analysis. *Personnel Psychology, 44*, 1-26.

Chen, P. W. (2008). Taking time for empathy. *The New York Times*, Column 0; Science Desk; Doctor and Patient.

Cialdini, R.B. & Trost, M.R. (1998). Social influence: Social norms, conformity and compliance. In D.T. Gilbret, S.T., Fiske & G. Lindzey (Eds.), *The handbook of social psychology* (4th ed., pp. 151-192). New York: McGraw –Hill.

Cohen, A.K. (1966). *Deviance and control*. Englewood Cliffs, NJ: Prentice Hall.

Columbia Encyclopedia. (2009, January 1). *Extroversion and introversion.* Retrieved July 25, 2009, from Columbia Electronic Encyclopedia, 6th Edition: https://search.ebscohost.com/login.aspx?direct=true&db=a9h&AN=39005745&site=ehost-live.

Dozier, J.B. & Miceli, M.P. (1985). Potential predictors of whistle-blowing-a prosocial behavior perspective. *Academy of Management Review, 10*, 823-836.

Erwin, D. (2009). Changing Organizational Performance: Examining the change process. *Hospital Topics: Research and Perspectives on Healthcare, 87*, 28-40.

Feldman, D.C. (1984). The development and enforcement of group norms. *Academy of Management Review, 9*, 47-53.

Galperin, B.L. (2003). Can workplace deviance be constructive? In A. Sagie, S. Stashevsky & M. Koslowsky (Eds.), *Misbehavior and dysfunctional attitudes in organizations* (pp. 154-170). Palgrave Macmillan.

Giacalone, R.A. & Greenberg, J. (1997). *Antisocial behavior in organizations.* Thousand Oaks, CA: Sage.

Goleman, D. 1988 What makes a leader? *Harvard Business Review, Nov-Dec*, p.94.

Griffith, J.A., Pattullo, A., Alexander, R., Jelinek, J.A. and Foster, D.A. (2006). Is anybody managing the store? National trends in hospital performance. *Journal of Healthcare Management, 51*, 392-406.

Hackman, J.R. (1976). Group influences on individuals. In M. Dunnette (Eds.), Handbook of industrial and organizational psychology (pp. 1455-1525). Chicago: Rand McNally.

Hall, M., Camacho, F., Dugan, E., & Balkrishnan, R. (2002). Trust in the Medical Profession: Conceptual and Measurement Issues. *Health Services Research, 37*, 1419-1439.

Hojat, M. (2009). Ten approaches for enhancing empathy in health and human service cultures. *Journal of Health & Human Services Administration, 31*, 412-450.

Langabeer, J., II. (2008). Hospital turnaround strategies. *Hospital Topics, 86*, 3-10.

Le Pine, J.A. & Van Dyne, L. 1998. Predicting voice behavior in work groups. *Journal of Applied Psychology, 83*, 853-868.

Levine, J.M. & Higgins, E.T. (2001). Shared reality and social influence in groups and organizations. In F. Butera & G. Mugny (Eds.), Social influence in social reality: Promoting individual and social change (pp. 33-52). Ashland, OH: Hogrefe & Huber Publishers.

Luthans, F. (2002). Positive organizational behavior: Developing and managing psychological strengths. *Academy of Management Executive, 16*, 57-72.

Macnaughton, J. (2009). Dangerous Practice of empathy. *The Lancet* , 373, 1940-9679.

Marnocha, M. (2009). What truly matters: Relationships and Primary Care. *Annals of Family Medicine, 7,* 196-197.

Maron, B. A., Fein, S., Maron, B. J., Hillel, A. T., El Baghdadi, M. M., & Rodenhauser, P. (2007, January). Ability of prospective assessment of personality profiles to. *Baylor University Medical Center Proceedings* . United States of America: Baylor University Medical Center.

Morrison, E. W. (2006). Doing the Job Well: An Investigation of Pro-Social rule breaking. *Journal of Management, 32, 5-28.*

Near, J.P. & Miceli, M.P. (1985). Organizational dissidence: The case of the whistle-blowing. *Journal of Business Ethics, 4*, 1-16.

O'Leary-Kelly, A.M., Griffin, R.W. & Glew, D.J. (1996). Organization-motivated aggression: A research framework. *Academy of Management Review, 21,* 225-253.

Opp, K.-D., & Jasso, G. (1997). Probing the character of norms: A factorial survey analysis of the norms of poliical action. *American Sociological Review, 62*, 947-964.

Organ, D.W. (1988). *Organizational citizenship behavior: The good soldier syndrome*. Lexington, MA: Lexington Books.

Pascale, R. T., & Sternin, J. (2005). Your company's secret change agents. *Harvard Business Review* , 73-81.

Prarties, N. (2008). Empathy with patients aids recovery. *Pulse, 68*, 1-6.

Robbins, M. (2007, November 1). Getting in touch with your emotions: Emotional intelligence: What is it, and how can employers apply it to the workplace? *Employee Benefit News and SourceMedia, Inc*.

Robinson, S.L. & Bennett, R.J. (1997). Workplace deviance: Its definition, its nature and its causes. In R.J. Lewicki, B.H. Sheppard & R.J. Bies (Eds.), *Research on negotiation in organization: Vol. 6* (pp. 3-28). Greenwich, CT: JAI.

Rosseau, P., & Blackburn, G. (2008). The Touch of Emapthy. *Journal of Palliative Medicine, 11*, 1299-1300.

Rubin, R. (2008, September 23). Study: Physicians show little empathy. *USA Today* .

Salovey, P., & and Grewal, D. (2005). Current directions in psychological science. In P. Salovey, & D. and Grewal, *The Science of Emotional Intelligence* (pp. 281-285). New Haven: American Psychological Society.

Schattner, A., Rudin, D., & Jellin, N. (2004, April 26). Good physicians from the perspective of their patients. *BMC Health Serv Res* . Jerusalem, Israel: BioMed Central Ltd.

Shaw, M.E. (1981). *Group dynamics* (3rd ed.). New York: McGraw Hill.

Skarlicki, D.P. & Folger, R. (1997). Retaliation in the workplace: The roles of distributive, procedural and interactional justice. *Journal of Applied Psychology, 82,* 416-425.

Stratton, T.D., Saunders, J.A. and Elam, C.L. (2008). Changes in Medical Students' Emotional Intelligence: An Exploratory Study, *Teaching & Learning in Medicine 20*, 279-84.

Thom, D. H. (2001). Physician Behaviors that Predict Patient Trust. *Journal of Family Practice, 50*, 323-328.

Warren, D. 2003. Constructive and destructive deviance in organizations. *Academy of Management Review, 28*, 622-632.

Weng, H.-C., Chen, H.-C., Chen, H.-J., Lu, K., & Hung, S.-Y. (2008). Doctors' emotional intelligence and the patient–doctor relationship. *Medical Education;, 42*, 703-711.