UNIVERSITY OF WISCONSIN, LA CROSSE
Graduate Studies

DISRUPTIVE BEHAVIORS IN HEALTHCARE: IMPLICATIONS FOR PATIENTS

A Seminar Paper Submitted in Partial Fulfillment of Requirements for the Degree of Masters of Education and Professional Development

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College of Education
Masters of Education and Professional Development

August, 2009

DISRUPTIVE BEHAVIORS IN HEALTHCARE:
IMPLICATIONS FOR PATIENTS

By Lynn Lenz

We recommend acceptance of this project report in partial fulfillment of the candidate's requirements for the degree of Masters of Education and Professional Development

The candidate has met all of the project completion requirements.

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ABSTRACT

Lenz, L. S. Disruptive behaviors in healthcare: implications for patients. Master of Education-Professional Development, June, 2009, 68 pp. (R. Krajewski)

Disruptive behavior among healthcare workers can have a significant and detrimental effect on the provision of safe and effective patient care. The causes of disruptive behavior are complex but disruptive behavior can occur when staff members turn their anger and frustration toward their coworkers. The consequences of disruptive behavior impede communication and erode teamwork which leads to avoidable medical errors, malpractice risk, and other compromises in quality care. In order to minimize the adverse effects of disruptive behavior, healthcare organizations need to develop zero tolerance policies, provide education to employees and patients, and implement strict standards to effectively deal with this issue. An increased understanding of the causes and consequences of disruptive behavior will help members of the healthcare team effectively deal with frustrations inherent to the high stress environment in which they work and help minimize displaced anger. A better understanding of disruptive behavior will also help organizations and medical schools provide education and training that can lessen the likelihood of disruptive behavior and improve the overall effectiveness of the healthcare team.

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CHAPTER 1

LAYING THE FOUNDATION

Introduction

There are a variety of terms used in the literature to describe negative behaviors that occur in the healthcare environment. These include lateral violence, bullying, relational aggression, intimidation, horizontal hostility, horizontal violence, sabotage, verbal abuse, psychological abuse, and interactive workplace trauma. (Alspach, 2007; Dellasega, 2009; Longo & Sherman, 2007; Lutgen-Sandivk, 2007; Rocker, 2008; Rowell, 2005; Rosenstein & O'Daniel, 2008; Stanley, 2007; The Joint Commission, 2008;). Other workplace abuse issues include sexual harassment and emotional abuse (Lutgen-Sandivk, 2006). The most commonly used terms in recent literature are lateral violence, disruptive behavior (which includes intimidation) and bullying. These are the terms that I will be using throughout this paper.

The Joint Commission (2008) uses the terms disruptive behavior and intimidation as an overarching descriptor of all negative workplace behaviors that may lead to adverse patient events. They go on to describe disruptive behavior and intimidation as overt actions such as verbal outbursts or physical threats as well as covert actions such as refusing to perform assigned tasks or exhibiting uncooperative attitudes. According to Rosenstein and O'Daniel disruptive behavior is any "inappropriate behavior, conflict, or confrontation ranging from verbal abuse to physical or sexual harassment" (Rosenstein & O'Daniel, 2008,

p. 1564). Piper (2003) describes disruptive behavior as any behavior that is offensive and may jeopardize patient care or disrupt the tone of the unit. Piper goes on to state that disruptive behavior refers to any type of interpersonal interaction that can lead to sub-standard patient care and negatively impact the organization's ability to accomplish its mission.

The nursing literature has used the term lateral violence to describe disruptive behaviors between nurses for more than 25 years (Sheridan-Leos, 2008). Sheridan-Leos (2008) describes lateral violence as an act of aggression perpetrated by one nurse against another at the same level within an organizational hierarchy. Both disruptive behavior and acts of lateral violence may be obvious or subtle. Gerald Farrell uses the terms active or passive to categorize aggression (as cited by Leiper, 2005) while other authors use the terms overt or covert. Active or overt actions range from threatening body language (The Joint Commission, 2008) to openly criticizing a colleague in front of others, screaming at others and even physical assault (Leiper, 2005; Longo & Sherman, 2007). Passive, covert aggression is subtle and may take the form of talking behind a colleague's back, withholding information necessary to do the job, or exhibiting uncooperative attitudes during routine activities (The Joint Commission, 2008).

Griffin (2004) found that many seasoned nurses did not have knowledge of the term lateral violence and thought new nurses were making up the term. Likewise, many forms of disruptive behavior may be so subtle that some actions are considered nothing more than a personality conflict between two individuals. Jackson (2002) contends that disruptive behavior is a taken-for-granted phenomenon in healthcare and is accepted by many organizational cultures as a part of doing business. However, when asked specifically about personal experiences with disruptive behavior, most health care

workers admit that they know it when they see it, and many admit to having had some type of experience with it during their career (Alspach, 2007). Due to ongoing concerns about the adverse effects of disruptive behavior on patient outcomes, there has been an increasing amount of attention paid to this topic in the literature. Here is just a sampling of reported instances.

- In 2004 the Institute of Safe Medication Practice surveyed over 2000 healthcare workers including nurses (n=1565), pharmacists (n=354), and others (n=176) and reported that 88% of respondents experienced intimidation by other providers in the form of condescending language or voice intonation. Eighty-seven percent (87%) experienced impatience with questions and 79% encountered reluctance or refusal to answer questions or phone calls.

- In 2006, the *Nursing* journal website asked visitors, "in the past 6 months have you witnessed any nurse treating another inappropriately (horizontal violence)?" Fifty-five percent (55%) of all respondents said yes. This was substantiated in a 2007 by a survey administered to 663 nurses designed to assess perceived vulnerability to lateral violence. Forty-six percent (46%) reported that lateral violence was a "very serious" or "somewhat serious" problem in their hospital and 65% reported frequently observing lateral violence among coworkers (Stanley, 2007).

- Ulrich (as cited by Dellasega, 2009, p. 52) surveyed 4000 critical care nurses and reported that 18% experienced verbal abuse from another nurse and 25% of all respondents rated the quality of communication and collaboration with other nurses as fair or poor.

- A small 2001 study (n=26) of new graduate nurses in Boston reported that 96% of respondents experienced some form of lateral violence as either a victim or a witness during their first year of work. Forty-six percent (46%) said that the act was perpetrated against them. Acts of lateral violence included being set up to fail with an "unreasonable assignment", sabotage, undermining, or not having help available to them (Griffin, 2004).

- According to a 2007 Zogby International survey reported by the Workplace Bullying Institute, an estimated 37% of workers in the United States, or about 54 million people, have been bullied at the office or repeatedly mistreated in a health-harming way. An additional 12% report being a witness to bullying behavior. A combined 40% of targets and witnesses never report the incident.

The Problem

In 2008, the Joint Commission published the results of a survey conducted of 4530 healthcare workers. Seventy seven percent (77%) of respondents reported witnessing disruptive behaviors by physicians and 65% reported disruptive behaviors by

nurses. These behaviors are often manifested by professionals in positions of power and include behaviors such as reluctance or refusal to answer questions; return phone calls or pages; condescending language or voice intonation, and impatience with questions.

As a result of this information, The Joint Commission issued a patient safety alert stating that the presence of intimidating and disruptive behaviors undermines the effectiveness of a team, "erodes professional behaviors, and creates an unhealthy and even hostile work environment" (The Joint Commission, 2008, P 4). This type of work environment leads to medical errors, increased patient complaints, increased cost of care, preventable adverse outcomes, and malpractice risk (The Joint Commission, 2008). Data collected by Rosenstein, et al. (2002, 2006, 2008) produced similar results from which they concluded that disruptive behaviors increased stress levels and frustration which impaired concentration, impeded communication, and adversely affected teamwork and collaboration. These events were perceived by survey respondents to have increased the likelihood of medical errors and compromised patient safety.

Patients are not the only ones to suffer as a result of disruptive behaviors. The Joint Commission also pointed out that toxic work environments cause qualified clinicians, administrators, and managers to seek new positions in more professional environments. Lutgen-Sandvik reported that nurses working in a bullying environment often fear going to work and many face the day with thoughts of "impending doom" (as cited by Rocker, 2005, p. 3). Repeated experiences with bullying cause some nurses to retreat into silence leading to further negative effects on communication and teamwork. If the bullying continues, self doubt takes over and stifles the nurse's initiative and innovation resulting in psychological and occupational impairment (Workplace Bullying

Institute, 2003). All of these factors combine to create potentially devastating effects on the well being of employees, the organization as a whole, and most importantly, the safety of patients.

The Employee

Manifestations of disruptive behavior occur in an almost endless variety, all of which lead to denigration of professional dignity (Alspach, 2007). Disruptive behavior causes stress, anxiety, frustration, and anger (Rosenstein & O'Daniel, 2008). Nurses who are victims of lateral violence have trouble sleeping, develop low self esteem, have poor morale, feel disconnected from other staff, exhibit depression, apathy, and have excessive sick leave from intentional or unintentional work absences (Alspach, 2007; Longo, J., Sherman, R.O., 2007). Some victims of lateral violence have resorted to suicide (Griffin, 2004). According to the Workplace Bullying Institute, 45% of targets had stress-related health problems which include debilitating anxiety, panic attacks, clinical depression (39%), and even post-traumatic stress.

Not surprisingly, the adverse effects of lateral violence are not limited to the target. Co-workers witnessing lateral violence report having a higher degree of stress and greater dissatisfaction with their jobs compared with those who were not exposed (Lutgen-Sandvik, 2007). Employees who witness frequent acts of lateral violence liken the experience to witnessing a mugging and being unable to stop it. Many victims, and witnesses alike, remain silent about the issue and are confused about how to confront their aggressor. Unfortunately this confusion and silence does nothing to resolve the problem which indirectly protects the perpetrator and causes many victims to simply give

up and leave their position.

The Organization

Disruptive behavior injures not only the victim but the business as well. Consequences include increased patient complaints, healthcare costs, unplanned absences, law suits (Rowell, 2005), malpractice risks (The Joint Commission, 2008) and staff turnover (Rosenstein & O'Daniel, 2008). Rocker (2008), states that between one third and one half of all work related absences and illness are a result of workplace bullying. According to a 2008 *Forbes* article (Van Dusen, 2008), companies pay not only in absenteeism but to a small extent, workers' compensation claims as well. Workers compensation benefits vary from state to state, but in some instances benefits may be available for employees suffering from physical or psychological injury resulting from bullying situations. Some victims seek workers' compensation or disability benefits because they can no longer afford to expose themselves to the stress of a bullying workplace (Yamada, 2009).

Faced with the decision of whether to stay in an abusive environment or leave their job, many victims of disruptive behavior simply choose to leave their position. The consequence is a system of adverse employee selection whereby good employees move on, and the company is left with the bullies. And the literature is clear; nurses are leaving the profession due to the frustration and anger brought on by disruptive behavior. In 2003, the Voluntary Hospital Association (VHA) surveyed 2562 healthcare workers consisting of 1615 nurses, 389 physicians, and 104 senior level executives. Nearly thirty -seven percent (37%) of respondents indicated that nurses were leaving their hospital as a

result of disruptive behavior. Of those responding positively, the average number of nurses reported leaving per year was 2.5 (Rosenstein, A. Russell, H. Lauve, R., 2002). According to Rocker (2008) seventy percent (70%) of bullying victims in the United States leave their position. Not only is the organization left with bad employees, but staff turnover is an expensive consequence. According to Childers (2005) the cost to replace just one nurse is estimated at about $50,000.

Estimates based on malpractice claims suggest that only four to six percent of doctors and other healthcare workers actually engage in intimidating practices, but that proportion has a huge impact on organizational costs. According to Gerald Hickson, MD, "any behavior which impairs the health care team's ability to function well creates risk" for the organization (as cited by the Joint Commission, 2008, P 4). Patients and family members recognize hostile work environments (Joint Commission, 2008) and are more likely to sue when they are dealing with arrogant or insensitive behavior by healthcare providers (Aleccia, 2008).

The Patient

Good communication and teamwork are an essential part of safe, effective patient care. The stress, frustration, and anger associated with disruptive behavior impede communication and teamwork resulting in avoidable medical errors, adverse events, and other compromises in quality care (Rosenstein & O'Daniel, 2008). In the 2008 Joint Commission survey 67% of the 4530 respondents reported that disruptive behaviors were linked with adverse patient events.

While most adverse consequences are the result of communication failure, some nurses may carry their bullying behaviors to their patient's while providing care. According to Dunn (2003) some nurses may choose to control patients by delaying their response to the patient's needs – pain medications, toileting, etc. Disgruntled nurses can also strike out at a patient's family by refusing to keep them informed of the patient's condition, or not providing support to them or to the patient when other needs arise. This type of behavior by the nurse causes fear of retribution in both the family and the patient (Dunn, 2003).

Limitations

Disruptive behavior in the workplace is a complex and diverse subject. There are a variety of terms used to describe similar behaviors and despite having unique characteristics the terms are often used interchangeably in the literature. There is also a multitude of other workplace abuse issues that might be classified as disruptive behavior. In this paper I will focus only on psychological and/or verbal abuse and not physical or sexual harassment.

Second, much of the literature related specifically to lateral violence in healthcare is based on the nursing profession. There is a smaller amount of literature suggesting that the same cause and effect relationships should be extended to other care givers. Adding further to this limitation is the fact that the majority of nurses are women. While not all researchers agree, many have drawn conclusions about the cause and effect of gender itself on disruptive behavior in healthcare.

Third, the majority of research on this subject is self reported in the form of survey data. According to Lutgen-Sandivk (2007), self reported data related to workplace

bullying is underreported. Some victims are reluctant to report disruptive behavior for fear of retaliation or because they see it as a sign of personal weakness. Some victims do not perceive their treatment as bullying and consider it nothing more than a personality conflict between two individuals. According to Jackson (2002) workplace violence in healthcare is often trivialized as many consider it "part and parcel of the job" (Jackson, 2002, p. 17).

Purpose

The purpose of my paper is to explore disruptive workplace behavior in the healthcare setting. I will report relevant literature on the subject while specifically addressing the history and causes, the reasons why disruptive behaviors are not reported, and the negative effects of such behaviors on the employee, the organization, and the patient. I will also discuss some of the suggested methods to address disruptive behavior in the workplace.

CHAPTER 2

DEFINITIONS, AGENCIES, AND KEY AUTHORS

Introduction

The variety of terms used to describe disruptive behavior in the workplace is extensive and confusing. Some terms, such as lateral violence, have been used exclusively in the healthcare field to describe behaviors within one workgroup, nurses. Other terms such as workplace bullying are so broad they extend well beyond healthcare to include behaviors found in virtually every work environment. Workplace bullying is so extensively reported that several websites are designed to inform the public about bullying behavior and what can be done about it.

To further complicate research, some authors coin their own phrases to describe similar workplace phenomenon. For example, Cheryl Dellasega (2009) uses the term relational aggression to describe behaviors similar to lateral violence. In this chapter I will provide definitions to terms frequently used in the literature when discussing disruptive behavior. I will also provide a list of prominent agencies and key authors whose work was utilized in my research.

Definitions

Disruptive Behavior

Disruptive behavior is any action that interferes with effective communication and negatively impacts staff performance and patient outcomes.

According to the Joint Commission (2008) these include extreme behaviors such as outbursts, temper tantrums, physical threats, and throwing things as well as subtle behaviors such as rudeness and intimidation. Disruptive behavior was originally used to describe negative behavior among physicians, but is now considered an overarching term that extends to all healthcare workers.

Healthcare Culture

The term culture refers to a set of human characteristics that are not related to genetics. The term was originally used to describe the distinct ways that people living in different parts of the world classified and represented their experiences. The use of the term healthcare culture in the context of my paper refers to a set of shared attitudes, values, goals, and practices that characterize an institution or organization.

Hierarchy

A hierarchy is the arrangement of people or objects such that they are referred to as being "above", "below" or "at the same level with one another". In the literature related to my paper, the term hierarchy refers to the classification of an individual according to their ability or professional standing, each subordinate to the one above it.

Intimidation

Miriam Webster defines intimidation as "intentional behavior that causes others to be timid or fearful and to force into, or deter action by inducing fear". In 2004 The Institute for Safe Medication Practices reported that 88% of over 2000 survey respondents experienced intimidation by providers and almost half (49%) said their past experience with intimidation had altered the way they handled order clarifications. As a result, seven percent reported that they had been involved in a medication error in which intimidation clearly played a role.

Lateral violence

Lateral violence is an "act of aggression that is perpetrated by one nurse against another" (Sheridan-Leos, 2008, p. 399) and can include behaviors ranging from verbal abuse to physical assault. The term lateral violence is typically used to describe negative behaviors directed at equals on the organizational hierarchy. Most of the literature on the subject of lateral violence is devoted to nurse to nurse aggression. The International Council of Nurses (ICN) defines abuse as "behavior that humiliates, degrades, or otherwise indicates a lack of respect for the dignity and worth of an individual" (ICN, 2004). According to Griffin (2004) some of the most common forms of lateral violence include the following:

- Non-verbal innuendo: raising of eyebrows, face making
- Verbal affront: making snide remarks, being less than open
- Undermining activities: turning away, not being available to help
- Withholding information related to policies, practice or to the patient

situation

- Sabotage: deliberately setting up a negative situation
- Infighting: bickering with peers
- Scapegoating: attributing all that goes wrong to one individual
- Backstabbing: complaining about but not speaking directly to an individual

Dellasega (2009) adds the following to her list of behaviors common in nurse to nurse bullying:

- Giving a nurse "the silent treatment"
- Spreading rumors
- Excluding a co-worker from on or off the job socializing
- Making fun of another's appearance, work, or personality trait
- Manipulating or intimidating a co-worker into doing something for you
- Saying something unfavorable, then pretending it was a joke
- Resorting to name calling
- Teasing another nurse about lack of skill or knowledge

Horizontal Violence

Horizontal violence is used by some authors to describe the same type of behavior as lateral violence. Horizontal violence is acts of aggression perpetrated against individuals within the same level of the organizations hierarchy.

Relational Aggression

The term relational aggression is very similar to lateral violence as it refers to the use of psychological and social behaviors rather than physical violence to cause harm (Dellagsaga, 2009). According to Dellasaga, the major difference between lateral violence and relational aggression is that lateral violence is directed at peers on the same level of the hierarchy while relational aggression occurs between different power levels of such as a nurse to a student, or a manager and subordinate. Both lateral violence and relational aggression can manifest itself as bullying.

Bullying

Workplace bullying differs from lateral violence and relational aggression in that these may occur as an isolated incident while bullying is generally defined as persistent and ongoing. Further, lateral violence is by definition directed at co-workers on an equal organizational level while the term bullying is usually used to describe behaviors that occur between individuals with real, or perceived, power differences. There is no standard definition of workplace bullying but commonalities between definitions include the fact that attacks are repeated, and that they usually reflect an actual or perceived imbalance of power. The Washington Department of Labor and Industries (2008) defines bullying as "repeated, unreasonable actions of individuals (or a group) directed towards an employee (or a group of employees), which is intended to intimidate and creates a risk to the health and safety of the employee". Lutgen-Sandivk (2007) defines it as repeated and persistent negative actions towards one or more individual(s), which involve a perceived power imbalance and create a hostile work environment.

According to the Workplace Bullying Institute (WBI, n.d.), the top 10 bullying tactics include:

- Falsely accusing someone of "errors" not actually made (71%)
- Clearly showing hostility (68%) through nonverbal intimidation such as staring or glaring at someone
- Discounting another's thoughts or feelings ("oh, that's silly") in meetings (64%)
- Using the "silent treatment" to "ice out" & separate from others (64%)
- Exhibiting uncontrollable mood swings in front of the group (61%)
- Making up rules on the fly that even she/he did not follow (61%)
- Disregarding satisfactory or exemplary quality of work despite evidence (58%)
- Harshly and constantly criticizing the target with a different set of standards than the rest of the group (57%)
- Starting and/or failing to stop destructive rumors or gossip (56%)
- Encouraging people to turn against the person being tormented (55%).

Oppression

Oppression is considered one of the causes of lateral violence. Oppression is the subjugation of one group by another, carried out under conditions of unequal power, and often enforced by threats of or by actual violence (Miriam Webster). It is contended that because nurses are "dominated (and by implication, oppressed) by a patriarchal system headed by doctors" (Griffin, 2004,

p. 2) they redirect their anger in the form of lateral violence at a safer target, their peers.

Agency Definitions

The Joint Commission (TJC)

TJC is an independent, not-for-profit organization responsible for accreditation of more than 15,000 health care organizations in the United States. Joint Commission accreditation is recognized as a symbol of quality that reflects an organization's commitment to meeting certain performance standards. Joint Commission accreditation is considered voluntary; however, certain Medicare reimbursements are dependent on successful accreditation.

Institute for Safe Medication Practices (ISMP)

The Institute for Safe Medication Practices is a non-profit organization devoted entirely to educating the healthcare community and consumers about medication error prevention and safe medication use. The ISMP is certified as a Patient Safety Organization (PSO) by the Agency for Healthcare Research and Quality.

Agency for Healthcare Research and Quality (AHRQ)

The Agency for Healthcare Research and Quality (**AHRQ**) is the lead Federal agency charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans. Information from AHRQ's research helps

people make more informed decisions and improve the quality of health care services. AHRQ was formerly known as the Agency for Health Care Policy and Research.

Institute of Medicine (IOM)

Established in 1970 under the charter of the National Academy of Sciences, the Institute of Medicine provides independent, objective, evidence-based advice to policymakers, health professionals, the private sector, and the public. The mission of the Institute of Medicine is to serve as adviser to the nation to improve health. The Institute provides unbiased, evidence-based, and authoritative information and advice concerning health and science policy to policy-makers, professionals, leaders in every sector of society, and the public at large.

Federal Communications Commission (FCC)

An independent United States government agency, the FCC was established by the Communications Act of 1934 and is charged with regulating interstate and international communications by radio, television, wire, satellite and cable. The FCC's jurisdiction covers the 50 states, the District of Columbia, and U.S. possessions. The FCC is comprised of 17 bureaus and staff offices organized by function. The Office of Workplace Diversity advises the Commission on all issues related to workforce diversity, affirmative recruitment and equal employment opportunity.

The Institute for Healthcare Improvement (IHI)

The IHI is an independent not-for-profit organization helping to lead the improvement of health care throughout the world. Founded in 1991 and based in Cambridge, Massachusetts, IHI works to accelerate improvement by building the will for change and cultivating promising concepts for improving patient care.

Workplace Bullying Institute (WBI)

Drs. Gary and Ruth Namie established the web based organization in the early 1990's by providing unique pro-employee advice at what was then the WorkDoctor website. In 2002 the name was changed to the Workplace Bullying Institute (WBI) and at the time was the only organization in the United States dedicated to the eradication of workplace bullying through public education, help for individuals, employer solutions and legislative advocacy. In 2008 the Namie's started WBI University to provide education to anyone wishing to learn more about bullying research and materials to address the issue in the workplace.

New Workplace Institute

Founded in June 2007 by David Yamada, the New Workplace Institute is a multidisciplinary, non-profit, research and education center promoting healthy, productive, and socially responsible workplaces. The Institute was founded upon the conviction that employee dignity and responsiveness to the community should be among the core values of any workplace, whether it be in the private, public, or non-profit sector. The New Workplace Institute has targeted workplace bullying

and legal support for victims as two of their initial projects. They plan to work closely with the WBI.

Voluntary Hospital Association (VHA)

The VHA is a not-for-profit health care alliance of over 1400 hospitals and 21,000 non-acute care organizations nationwide. The VHA promotes information sharing between member organizations in clinical practice, financial management, supply chains, and quality improvement.

Key Authors

Alan Rosenstein, MD

Alan Rosenstein is currently Vice President and Medical Director for Voluntary Hospital Association, West Coast, Pleasanton, CA. He graduated from the University of Louisville School of Medicine and earned his M.B.A. in Health Services Management at Golden Gate University in San Francisco, CA. Dr. Rosensteint has extensive experience in the areas of nurse-physician relationships, physician education, physician leadership, performance profiling, hospital report cards, quality improvement and cost-effective care.

Cheryl Dellasaga, Ph.D.

Cheryl Dellasaga is a certified registered nurse practitioner with a Ph.D. in health education. She is currently a professor in the Department of Humanities at

Penn State's College of Medicine and professor of women's studies at Penn State University. After years of working as a nurse and geriatric nurse practitioner, Dellasega authored six books about the needs of adolescent girls and adult female bullying which she terms relational aggression. These include: *Surviving Ophelia: Mothers Share Their Wisdom of the Tumultuous Teenage Years* (Perseus & Ballentine, 2002), *Girl Wars: Twelve Tried and True Strategies for Ending Female Bullying* (Simon & Schuster, 2003) and *Mean Girls Grown Up: Adult Women Who Are Still Queen Bees, Middle Bees, and Afraid-to-Bees* (Wiley Inc., 2005). Dellasage is also the founder of Club and Camp Ophelia designed to teach middle school girls (grades 6–8) about relational aggression (female bullying) and what to do about it.

Pamela Lutgen-Sandivk, Ph.D.

Pamela Lutgen-Sandivk (Ph.D., 2005, Arizona State University) is assistant professor in the Department of Communication and Journalism at University of New Mexico and studies organizational communication, bullying, and injustice in the workplace. Lutgen-Sandvick has authored over 20 publications and 30 conference papers and presentations on effective communication and workplace bullying. Her doctoral dissertation was called *"Water Smoothing Stones: Subordinate Resistance to Workplace Bullying"*.

Gerald Hickson, MD

Dr. Hickson is the Associate Dean for Clinical Affairs and Director of the

Center for Patient and Professional Advocacy at Vanderbilt University Medical Center. He serves as a member of the National Patient Safety Foundation Board of Governors. He has served as Chairperson of the Quality Care Committee for the National Association of Children's Hospitals and Related Institutions (NACHRI) and also was a member of the American Academy of Pediatrics's Committee on Quality Improvement. His research has focused on understanding why families file suit, why certain physicians attract a disproportionate share of malpractice claims, and how to develop strategies for identifying and intervening on high malpractice claims physicians.

Martha Griffin, Ph.D.

Martha Griffin is Program Coordinator, Nursing Professional Development Department, Brigham & Women's Hospital in Boston, Massachusetts. Dr. Griffin has written and presented extensively on lateral violence among nurses as well as having completed research on effectively educating new nurses to deal with lateral violence.

Norma Sheridan-Leos, RN, AOCN, CPHQ

Sheridan-Leos is an advanced oncology board certified nurse practicing in Savannah, Ga., and has been an oncology nurse for 29 years, with 11 of those years at the MSN level. She has worked at the M.D. Anderson Cancer Center in Houston, The University of Texas Health Science at San Antonio and the Veteran's Health Care System. In addition, she has developed, written, and speaks

about her work in devising and implementing an oncology nurse residency program designed to prevent medication errors and enhance collaborative practice.

Marilynn M. Rosenthal Ph.D.

Marilynn Rosenthal was a professor, medical sociologist and director of the Program in Health Policy Studies at the University of Michigan in Dearborn prior to her death in 2007. Her primary research has been done in the field of comparative health care systems and physician self regulation. Her eight books include *The Incompetent Doctor: Behind Closed Doors* (1995), *Healthcare Systems and Their Patients: An International Perspective* (edited with Marcel Frenkel MD, 1992), *Dealing with Medical Malpractice: The British and Swedish Experience* (1988), *The Incompetent Doctor* (1995), and *Medical Mishaps: Pieces of the Puzzle* (edited with Mulcahy and Bostock, 1999).

David Yamada

David Yamada is a Professor of Law at Suffolk University Law School in Boston, where he specializes in employment and labor law. He is a leading authority on workplace bullying and abusive work environments. His articles on workplace bullying have appeared in the Georgetown Law Journal, Employee Rights and Employment Policy Journal, Perspectives on Work, and other publications, and he has been an invited speaker on the topic at conferences and

seminars across the country. Yamada is the author of the Healthy Workplace Act, a bill that bars psychological harassment. In 2009, twelve states and two providences in Canada passed some version of the legislation. In 2007 he launched the New Workplace Institute to provide public education and legal advice for employees suffering from workplace abuse issues.

Gary Namie, Ph. D.

Gary Namie received his Ph. D. in Social Psychology from the University of California in Santa Barbara. Dr. Namie directs a network of State Coordinators acting as citizen lobbyists who work to pass into law the Healthy Workplace Bill. Namie and his wife Ruth founded the Workplace Bullying Institute in 2002 after establishing a consulting firm, The WorkDoctor, in 1985.

Ruth Namie, Ph. D.

Dr. Ruth Namie has a Ph.D. in Clinical Psychology. She was Training Director for Sheraton Hotels before her clinical training led to counseling chemically dependent individuals and families. Dr. Namie's personal experience with workplace bullying was the impetus for the Namie's work devoted to the bullying movement. Together the Namies have authored several books on the topic of workplace bullying including *Bully Proof Yourself At Work!* (1998) and *The Bully At Work* (Sourcebooks, 2009).

CHAPTER 3

LITERATURE REVIEW

The History

Why Now?

The concept of disruptive behavior is not a new phenomenon. In 1985 Horty (as cited by Piper, 2003, p. 337) defined the disruptive physician as "one who is very clinically competent to the point of believing that he or she is more competent that other members of the medical staff. The disruptive physician is by nature a very formidable person to deal with and therefore contentious and potentially litigious". In the 1990s, disruptive physician behavior began to be described in the literature as a form of physician impairment (Piper, 2003). The article, "When Good Doctors Go Bad" (Gawande) gained considerable attention after it appeared in the August 2000 issue of *The New Yorker*. The article revealed how the medical community was poorly prepared to deal with disruptive physician behavior. So why now, after two decades is The Joint Commission requiring action by the medical community? Many authors agree that there were two landmark issues that brought the issue of disruptive behavior to the forefront (Lutgen-Sandivk 2007; Rocker, 2008; Rosenstein & O'Daniel, 2008; Seiden, 2006).

In 1999, the Institute of Medicine (IOM) published *To Err is Human: Building a Safer Health System,* using data gathered from a Harvard and Utah-Colorado Medical Practice Studies. The IOM report concluded that medical errors cause between 44,000

and 98,000 deaths annually– more than result from automobile accidents (43,458), breast cancer (42,297) or AIDS (16, 516) (Baker, 2009). The report called for significant improvements in system design and organizational resources to more effectively monitor patient care and prevent injury. Part of the emphasis in this report was on the need to address human factor and behavioral issues that adversely affected patient care (Rosenstein & O'Daniel, 2008).

The next major influence was the threat of a nursing shortage. In 2001, Aiken et al. published a landmark article on the state of the nursing profession which provided results from a study of staffing, organization, and outcomes in 711 hospitals in five countries. Conducted by the International Hospital Outcomes Research Consortium, the study surveyed 43,329 nurses from the United States (50% of nurses licensed in Pennsylvania, 13,471), Canada (17,450), England (5,006), Scotland (4,721), and Germany (2,681) working in adult acute care hospitals in 1998 and 1999. All nurses sampled received self-administered questionnaires that were anonymously returned by mail. Response rates ranged from 42 to 53% across geographic regions. Survey questions dealt with a variety of issues related to the nurses' perceptions of their working environments and the quality of nursing care being delivered in their hospitals as well as their job satisfaction, career plans, and feelings of job burnout.

The findings indicated that in the United States (Pennsylvania) more than 40% of nurses working in hospitals reported being dissatisfied with their jobs and that the nurses surveyed in Pennsylvania were three to four times more likely than the average U.S. worker to be unhappy with their positions. Many nurses across the five countries were

experiencing considerable job-related strain. A standardized tool, the Maslach Burnout Inventory (MBI), was used to measure emotional exhaustion and the extent to which nurse respondents felt overwhelmed by their work. Significant percentages of nurses, ranging from just under 30% to more than 40% in all countries except Germany, had high scores relative to the norms for medical workers published by the developers of the MBI. Finally, more than three in ten nurses (greater than 30%) in England and Scotland and more than two in ten (greater than 20%) in the United States planned on leaving their jobs within the next year. What was most striking about the data was the percentage of nurses planning on leaving within the next year was much higher for nurses under age thirty than all others nurses in all countries.

In 2005 the notion of a declining nursing work force was confirmed by statistics released by the U.S. Department of Health and Human Services. Their report indicated that the United States had a nursing shortage of nearly 150,000 RNs and that by the year 2020, this number was expected to rise to 800,000 nurses (Childers, 2005). Their conclusion was clear, the nursing workforce is declining and if current trends continue, nurses will be unable to meet the future needs of patients. One cause of nurses leaving the profession is the frustration brought on by disruptive behaviors among co-workers.

According to one author, approximately 60% of newly registered nurses leave their first position within six months because some form of lateral violence by another nurse has been perpetrated against them (Stanley, 2007). In another study, Rosenstein et al. (2002) found that one of the key factors affecting nurse retention is their relationship with physicians. Rosenstein surveyed 2562 participants from 142 hospitals from eleven

VHA regions across the nation. Of the participants, 389 were physicians, 1615 were nurses and 104 were senior level executives. Over ninety percent (90%) of the respondents reported witnessing disruptive physician behavior and more than one third (33%) reported knowledge of a nurse leaving an institution because of disruptive behavior. When asked how important disruptive behavior was to nurse satisfaction and morale, the total group response was 8.01 on a scale of 1 – 10. This was the highest score in the survey. These data suggest that hospitals may face greater staffing issues if the causes of negative recruitment and retention are not addressed. In addition to concerns about nurse retention, the correlation between disruptive behavior and patient safety have prompted many nursing, medical associations, and accreditation organizations to propose zero tolerance initiatives to address lateral violence and bullying in the workplace (Alspach, 2007; Center for American Nurses, 2008; Institute for Safe Medication Practices, 2008; Longo & Sherman, 2007; Rowell, 2005; The Joint Commission, 2008).

Quality Initiatives

Since the IOM report, increasing attention has been paid to medical errors, patient safety, and the development of evidenced-based practices to improve the quality of care. Several government and not-for-profit agencies have followed the IOM report with recommendations to improve patient safety. These agencies include but are not limited to the Agency for Healthcare Research and Quality (AHRQ), the Institute for Healthcare Quality, The Institute for Safe Medication Practices, and the Joint Commission.

At the Federal level, the Agency for Healthcare Research and Quality (AHRQ)

has assumed the lead role in patient safety funding dozens of grants on topics related to error reporting, working conditions, and technology applications. One of AHRQ's first efforts was to commission Evidence Report No. 43, *Making Health Care Safer: A Critical Analysis of Patient Safety Practices*, which was published in July 2001. In preparation for the document AHQA reviewed existing data on practices within and outside of health care that had the potential to improve patient safety. The document itself consists of 59 chapters of which seven are devoted to human errors with specific emphasis on communication and teamwork. One result of this work was the TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety) system that can be adopted to improve communication among healthcare professionals (ISMP, 2008).

In 2006, the IHI published their white paper entitled, *Leadership Guide to Patient Safety,* which included eight steps to achieve high quality patient safety. Step one focused on strategies to change organizational culture and step three focused on improving communication and building awareness among care givers. The IHI also recommended that hospitals provide methods to support staff, patients and families that may be affected by medical errors.

And finally in July 2008 The Joint Commission published a sentinel event alert blaming intimidating and disruptive behaviors for undermining a culture of patient safety. As a result of this report, the Joint Commission developed new leadership standards effective January 1, 2009. The standards address disruptive and inappropriate behaviors and require that organizations adopt a code of conduct that defines acceptable behaviors

and a process for dealing with those who fail to comply. In addition, the standards in the Medical Staff chapter have been organized into six core competencies to be addressed in the credentialing process. These include interpersonal skills and professionalism. How an organization chooses to implement these requirements is left up to the leadership of the institution.

Causes of Disruptive Behavior

Among Physicians

There is a history of tolerance and indifference to disruptive physician behaviors which is thought to occur for a variety of reasons. First, several authors contend that the training a physician receives pre-disposes them to disruptive behavior (Jackson, 2002; Kuhn, 2006; Rosenstein & O'Daniel, 2008,). After a physician completes college, they must attend four years of medical school followed by at least three years of residency. Throughout their medical training physicians are taught to think independently and take responsibility for their actions. This mindset fosters independence, autonomy and an "autocratic, domineering behavior pattern which is the antithesis of team building and collaboration" (Rosenstein et al., 2002, p. 10). According to Kuhn (2006) there is a lack of quality control starting in medical school and it is nearly impossible to be fired from residency. This results in physicians who perceive themselves to be the so-called captain of the ship but potentially lack the skills to keep it up right. This also creates a hierarchal model of health care which establishes subservient roles for nurses and other ancillary staff (Rosenstein & O'Daniel, 2008).

According to Piper (2005) many physicians who exhibit disruptive behavior are

typically excellent clinicians who are well liked and admired by their patients and the community. Because they often have an excellent track record victims may be reluctant to step in thinking the behavior is only an isolated incident. In an environment of increased litigation Piper (2005) states that hospital administrators are faced with the difficult decision of ignoring the behavior, or risk being accused of attempting to destroy a great physician who may simply "show too much passion". A decision to ignore the behavior perpetuates it and may result in adverse consequences on staff such as a decline in morale or a decision to leave the organization. In some cases the victims of disruptive behavior may lash out at their peers in behaviors that the nursing literature terms lateral violence (Sheridan-Leos, 2008).

Because many physicians are not hospital employees, some administrators are reluctant to address the disruptive physician as they voluntarily admit their patients to the hospital and are a major source of hospital revenue (Rosenstein & O'Daniel, 2008). More commonly there is an expectation that disruptive behaviors should be dealt with physician to physician. This system of self regulation was established as early as 1917, when the American College of Surgeons created the Hospital Standardization Program (Reynertson, 2004). Written from a physician's perspective, the program addressed the physicians' demand for self-governance, self-monitoring, and self-discipline. According to Reynertson (2004) the culture within the hospital today evolved from physicians' early demand to be regarded as a separate entity within the contractual relationship with a hospital.

Unfortunately, research by Marilyn Rosenthal at the University of Michigan has revealed that this internal system of self regulation is rarely effective (as cited by

Gawande, 2000). According to Rosenthal it takes an incredible amount of work, and self assurance, to gather enough evidence to suspend a partner's license to practice. Instead, when a respected colleague goes "bad" most other physicians try to quietly help by pulling the colleague aside and having what Rosenthal calls the "Terribly Quiet Chat". Their intentions are good, but the intervention rarely works.

Another cause of disruptive physician behavior is the result of increasing external pressures. According to Rosenstein et al. (2002) these include governmental oversight, demands for greater productivity, managed care restrictions, lower compensation, and increasing liability risk. Practicing physicians are engulfed in paperwork and requirements. Multiple board examinations, recertification processes, and continuing medical education requirements add to the growing sense of intrusion (Kuhn, 2006). As a result, many physicians feel overwhelmed, demoralized, and harbor feelings of resentment which may lead to disruptive behavior.

Another likely cause is the stress inherent in today's medical environment. According to Rosenstein et al. (2002) disruptive behaviors occur most often in high stress areas such as the operating room, medical-surgical units, intensive care, emergency departments, and obstetrics with the potential for greatest patient harm in the surgical setting (Rosenstein & O'Daniel, 2006). This is confirmed by other authors (Kuhn, 2006; Rosenthal et al., 1999) who agree that the physician is more likely to make medical mistakes when burdened with mental fatigue and environmental stressors. The Joint Commission states that the "inherent stress of dealing with high stakes, high emotion situations can contribute to intimidating or disruptive behavior, especially in the presence of factors such as fatigue" (The Joint Commission, 2008, P 5).

These factors are becoming more important as increased demands for productivity

are placed on physicians. Physicians are being encouraged to see more patients in less time while the public continues to demand state of the art technology and best practice medicine. While it may be true that we all face such challenges, the consequences of making a mistake in healthcare is much more intense due to the profound effect on human lives.

Among Other Staff

The causes of disruptive behavior among healthcare workers are complex, but many authors use the theory of oppression to explain lateral violence. According to the theory of oppression, nurses behave aggressively toward peers lateral, or subordinate to them, in order to relive tension that exists because they can't fight back against their true oppressor (Leiper, 2005). According to Sheriden-Leos (2008), oppression exists when a powerful and dominant group controls and exploits a less powerful one. It is contended that because nurses are dominated by a hierarchical system headed by doctors, nurses resort to aggression among themselves (Griffin, 2004).

In a study of 500 operating room nurses, Dunn (2003) found that the majority experienced verbal abuse from physicians which resulted in personal characteristics common among oppressed groups, such as divisiveness and fear of confrontation. The oppressed person often has aggressive feelings toward the oppressor, but is unable to confront these emotional hostilities due to their position in the hierarchy and subsequent fear of retaliation. Unable to resolve these issues, oppressed individuals feel a lack of control over their situation which leads to feelings of powerlessness, low self esteem and self hatred (Griffin, 2004). Believing that alternatives to the status quo do not exist,

oppressed individuals redirect negative behaviors toward other members of their peer group (Dunn, 2003). In other words, hostile emotions are expressed in a way that is felt to be safer, and displaced aggression leads to fighting between peers. Once a colleague becomes a victim, they feel hurt and vulnerable and the cycle of powerlessness is continued. The theory of oppression helps explain that the behaviors of lateral violence are not the result of individual pathology, but are a response to the situation in which a nurse finds herself (Alspach, 2007). Nurses act aggressively toward each other because no other perceived outlet exists.

Several authors contend that gender plays a role in the existence of lateral violence. They contend that women are more prone to lateral violence because they are more likely to internalize their feelings of resentment. Dunn (2003) states that women are often considered a subordinate group within society in general and healthcare in particular. He contends that it is not surprising to observe frequent acts of sabotage in the nursing profession because women comprise 90% of the nursing workforce. Leiper (2005) holds a similar view and states that in general women undervalue their work and have lower self esteem than men. She goes on to state that individuals with low self esteem become angry more easily and have a tendency to lash out at others. This opinion is also reported by Sheridan-Leos (2008) who concluded that lateral violence occurs because women have been socialized to be nurturers and to suppress their anger. Unexpressed anger comes to the forefront when nurses become frustrated, and they tend to vent this frustration laterally, or to those with less power (Sheriden-Leos, 2008). Dellasaga (2009) states that it is generally accepted that boys and men express their aggression more often with physical violence and women express it through character

defamation, humiliation, betrayal of trust and exclusion. Coupled with the fact that only six percent of the three million RNs in the United States are men, relational aggression (lateral violence) is therefore the predominant form of bullying among nurses. This position is not agreed on by all sources.

The Institute for Safe Medication Practices (2004) surveyed 2095 healthcare workers and found only minor differences between female respondents (86% of those surveyed) and males (14% of those surveyed) in regard to the frequency in which they experienced intimidating behaviors. Thomas (2003) agrees with this position and states that "our research has revealed" that horizontal hostility exists equally among female and male nurses.

Not all authors subscribe to the theory of oppression as the mechanism for lateral violence either. Some view the oppression theory as denigrating to nurses, making them appear as the helpless victim. Another viewpoint proposes that organizational cultures are the primary cause of lateral violence. Long standing struggles for power, conflicting work values and leadership styles lead to acts of lateral violence. Additional organizational factors include understaffing, increased workload, lack of supervisory support, poor work group relations, and organizational restructuring (Rocker, C. 2008). Lutgen-Sandivk (2007) says that the American work ethic which stresses competition and individual achievement de-emphasizes collaborative efforts. This competitive environment can lead to disruptive behaviors such as taking credit for another's work and blaming someone else for all that goes wrong (scapegoating). Rowell contends that bullies exaggerate or fabricate weakness in others in order to cover up their own inadequacies (Rowell, 2005).

Still others emphasize that lateral violence is a learned behavior. If lateral violence goes unaddressed by nursing leadership, some staff can begin to think that these behaviors are part of the norm and it becomes a part of a unit's work culture (Sheriden-Leos, 2008). When a new nurse enters a unit she can become the target without realizing the motivation behind it. She then incorporates these behaviors into the norm without questioning it which helps perpetuate the cycle (Longo and Sherman, 2007). Tolerance of some forms of lateral violence have become so institutionalized that they are viewed as a "rite of passage" (Griffin, 2004).

Why Does Disruptive Behavior Go Unreported?

Lateral violence often goes unreported, and therefore unaddressed, for a variety of reasons. Fear of retaliation, the stigma associated with "blowing the whistle" on a colleague, a general reluctance to confront an intimidator (The Joint Commission, 2008), the fact that nothing changes, lack of confidentiality, lack of administrative support, and physician lack of awareness or unwillingness to change all contribute to unaddressed issues in the workplace (Rosenstein et al., 2002). Dr. Mark Chassin, president of the Joint Commission said it's a problem that is underreported and "has become so ingrained in health care that it's rarely talked about" (as cited by Aleccia, 2008 , p. 2).

Like other forms of abuse, workplace violence is often regarded as a private issue and individuals are sometimes reluctant to speak out about it (Gammons, 2006). Many avoid reporting disruptive behavior as that would require identifying themselves as a victim. According to Lutgen-Sandivk (2007) the competitiveness of the U.S. culture may contribute to perceptions that being bullied reflects weakness or passivity.

Many times, disruptive behavior is not reported because it isn't recognized.

Bullying behavior is seldom a "yes or no" experience (Lutgen-Sandivk, 2007). Some clinicians do not believe that intimidation has occurred unless someone yells or uses offensive language (Beyea, 2004). Subtle acts of lateral violence, like not inviting a colleague to lunch, are difficult to recognize and difficult for a manger to address. However, if lateral violence goes unaddressed, some staff can begin to think that these behaviors are part of the norm and victimized staff members perpetuate these behaviors on new victims (Longo & Sherman, 2007).

According to the Workplace Bullying Institute (2007), the mythology surrounding bullying is that targets complain and litigate frequently. The reality however is that 40% of victims never report it, a mere 4% complain to state or federal agencies, and only 3% actually sue.

The Effects of Disruptive Behavior on the Employee

Physical and psychological manifestations of disruptive behavior occur in an almost endless variety. According to Rowell (2005) workplace bullies poison the work environment with low morale, fear, anger, and depression. Nurses who are victims of lateral violence have trouble sleeping, develop low self esteem, have poor morale, feel disconnected from other staff, exhibit depression, apathy, and use excessive sick leave. (Alspach, 2007; Longo & Sherman, 2007).

In a 2007 study by Stanley, 24% of 663 nurses surveyed rated lateral violence as a major cause of stress and tension. An editorial in *Critical Care Nurse* (Alspach, 2007) reported that the stress created by lateral violence can result in a number of physiological and psychological symptoms. These include headache, stomach disorders, weight

changes, hypertension, cardiovascular disease, stress, anxiety, panic, anger, embarrassment, depression, insomnia, and fatigue.

In 2003, Dunn undertook a correlational study to determine if a relationship exists between job satisfaction and the perceived degree of sabotage among operating room nurses. Horizontal violence was measured with the Briles' Sabotage Savvy questionnaire and job satisfaction was measured with the Index of Work Satisfaction (IWS) questionnaire. A sample of 500 nurses was randomly selected from 1523 perioperative nurses living in New Jersey with 145 (29%) completing the survey. Results showed that the most frequent method of being sabotaged was "being expected to do another's work" followed by "being reprimanded in front of others". The perpetrators reported the most frequent form of victimizing others as "ceased talking when they entered" and "complained about others without discussing it with them first." Interestingly there was a positive correlation between sabotage and work satisfaction ($r=.35$, $P < .01$). The author offers the Theory of Cognitive Dissonance as a possible explanation for this unexpected outcome. The cognitive dissonance theory states that individuals strive toward consistency between their opinions and their understanding of a situation. If a difference exists between perceived reality, and a belief about what reality should be, the result is psychological stress. In other words, acknowledging that horizontal violence exists, and that it has a negative effect on job satisfaction, may have been too painful for study participants to admit. This is an example of the limitations related to self reported data related to this topic.

Other responses characteristic of lateral violence are manifested as ineffective, non-productive forms of conflict resolution. Instead of dealing with a problem directly,

group members will talk about each other behind each other's backs, lie, or in some way undermine each other. Regardless of the method used, the purpose of this behavior is to control, humiliate, denigrate or injure the dignity of oppressed colleagues (Dunn, 2003).

Not surprisingly, the adverse effects of lateral violence are not limited to the target. Co-workers witnessing lateral violence report having a higher degree of stress and greater dissatisfaction with their jobs compared with those who were not exposed (Lutgen-Sandivk, 2007). According to Lutgen-Sandivk witnesses describe seeing others being "psychologically terrorized as equivalent to watching a mugging every day and being unable to stop it" (Lutgen-Sandivk, 2007, p. 13). They feel pain for their colleagues and disappointment and anger that little or nothing is done to stop the abuse. Barling (as cited by Lutgen-Sandivk, 2007) uses the terms *primary* and *secondary* victims to describe the target and the witness of disruptive behavior. Secondary victims are those employees "who themselves were not violated but whose perceptions, fears and expectations are changed as a result of being vicariously exposed" to lateral violence (as cited by Lutgen-Sandivk, 2007, p. 14). Alspach (2007) supports this view and contends that post traumatic stress disorder (PTSD) can occur not only as the result of being a recipient of lateral violence, but also secondary to observing aggression being inflicted on others. According to a 2007 Zogby International survey, an estimated 37% of workers in the United States have been bullied at the office or repeatedly mistreated in a health-harming way. The percentage balloons to 49% of workers, or 71.5 million people, when witnesses are included.

Patient Implications

According to the Institute for Safe Medication Practices (2008), many harmful medication errors share a surprisingly common factor: they all had at least one person who felt there was a problem with the order but they failed to speak up. One of the reasons staff don't speak up is due to previous experiences with disruptive behavior. In a 2004 survey of over 2000 healthcare workers, the ISMP reported that 88% of respondents experienced intimidation by providers in the form of condescending language or voice intonation. Eighty seven percent (87%) experienced impatience with questions and 79% encountered reluctance or refusal to answer questions or phone calls. Almost half (49%) said their past experience with intimidation had altered the way they handled order clarifications. As a result, seven percent reported that they had been involved in a medication error in which intimidation clearly played a role.

Results reported by Rosenstein and O'Daniel in 2008 showed similar trends. Rosenstein surveyed 4530 individuals from over 100 different organizations across the United States. The most critical question of the survey was the respondent's perception of the link between disruptive behavior and patient care. Sixty six percent (66%) felt that there was a link between disruptive behavior and adverse events, 71% a link to medical errors, 53% a link to compromises in patient safety, 72% to detrimental effects on quality of care, 25% to patient mortality, and 75% to poor staff satisfaction. Fourteen percent reported that they were aware of a specific event that occurred because of disruptive behavior episode. Nurses reported that the most common event that precipitated disruptive behavior was calling physicians to clarify orders. Physicians indicated that orders not being carried out correctly or in a timely manner were the biggest problems

they encountered.

A study by McKenna et al. (as cited by Longo & Sherman, 2007) reported that more than a third of the 551 newly registered nurses had learning opportunities blocked, felt neglected, and felt they were given too much responsibility without support. Lateral violence stops new nurses from asking questions, which prevents them from acquiring on the job training necessary to become good nurses in clinical practice (Griffin, 2004). Griffin (2004) asserts that one of the reasons new nurses are vulnerable is that once hired to a new department, they are dependent on a clinical peer to expand their knowledge level which opens their work to the scrutiny of others. Because they are unsure of their actions, new nurses can become easy targets for aggressors (Leiper, 2005). The result is a group of new graduate nurses reluctant to ask for help from their co-workers. This increases the possibility of medical errors and adverse patient outcomes (Longo & Sherman, 2007).

Research has demonstrated that nursing students are also adversely affected by acts of lateral violence and disruptive behavior. One study demonstrated that clinical experiences for nursing student were negatively affected because the students were subjected to bullying behavior. Bullying behavior undermined their self-esteem, making them feel powerless; angry, anxious, and stressed (Randle, 2003). Unfortunately these feelings lead to self doubt and reluctance to assert their knowledge and observations when caring for patients (Thomas, 2003). Students may feel hesitant to communicate an observed medical error because of their lack of confidence, fear of a negative evaluation,

and the intimidation they feel from the medical hierarchy. The same type of situation has been reported as occurring with medical students as well as nurses (Seiden, 2006).

Reluctance to speak up about observed behaviors or medical errors is not limited to students. Finding themselves in physician-dominated hierarchies some nurses exert considerable effort to express their displeasure in covert, indirect methods (Lutgen-Sandivk, 2007). Indirect methods of expression are sought over more directly assertive methods because of the fear of being seen as disloyal or the fear of appearing disruptive themselves. The effect is a group of nurses that learn to maintain a code of silence. This silence undermines teamwork and interferes with a potential first-line filter for medical errors (Rosenthal et al., 1999).

According to Rosenstein & O'Daniel (2006) poor communication between surgeons and hospital support staff is the leading cause of avoidable surgical errors. Given the small physical space of the operating room, the strong interdependency on effective teamwork, and the high-stress nature of the work, it is not surprising that disruptive behavior is intensified in the surgical area. The most compelling outcomes of the 2002 Rosenstein study were the impact of disruptive events on stress, frustration levels, lowered ability to concentrate, and impedance of communication and transfer of information. All of which are crucial to good patient care.

In addition to medical errors, distresses from experiences of lateral violence contribute to absenteeism and a desire to leave the profession. As previously discussed, there is clearly a correlation between disruptive behaviors and staff turnover (Aiken, 2001; Griffin, 2004; Rosenstein et al., 2002; Thomas, 2003;). A shortage of nurses directly affects a hospitals ability to provide comprehensive patient care and adversely

affects patient outcomes (Rosenstein & O'Daniel, 2008). For staff members who remain on the unit, trust is eroded if disruptive behaviors are not addressed which results in decreased teamwork and further incidents of lateral violence.

What Can Be Done About Disruptive Behavior?

With increasing accountability and concerns for patient safety, quality and satisfaction, many hospitals are realizing that disruptive behaviors can no longer be tolerated. Recommendations for dealing with disruptive behaviors include developing and enforcing strict zero tolerance policies, multidisciplinary education, skills based training, inter-professional dialogue, processes for conflict resolution and protection for those who report disruptive behavior. Some organizations encourage involving patients and families in identifying and reporting inappropriate behavior (The Joint Commission, 2008).

Policies

The Joint Commission, the American Medical Association, the Institute for Safe Medication Practices, the Agency for Healthcare and Quality, and the Center for American Nurses are just a few of the organizations calling for zero tolerance policies for disruptive behavior regardless of the offenders position in the organization.

The American Medical Association (AMA) Code of Ethics states that "personal conduct, whether verbal or physical, that negatively affects or that potentially may negatively affect patient care constitutes disruptive behavior. This includes, but is not limited to conduct that interferes with one's ability to work with other members of the

health care team". The code creates some flexibility by adding "however, criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior" (AMA, 2009). Rosenstein agrees that although strong policies should be strictly enforced but there also needs to be some degree of flexibility. He contends that the process needs to be consistent, but says that "a single episode from an overworked physician should have a different response than a physician with a long history of unprovoked abusive behavior" (Rosenstein et al., 2002, p. 11). Most other resources agree that the primary objective should be changing the behavior, not ending a physician's career (Lazoritz, 2008; Piper, 2005; Rosenstein, 2008). The AMA addresses this issue by stating that interventions should be "commensurate with the behavior, such as self-correction and structured rehabilitation. Suspension of responsibilities or privileges should be a mechanism of final resort" (AMA, 2009).

Several nursing organizations including The Center for American Nurses (The Center) and the American Association of Critical Care Nurses (AACN) have also issued zero tolerance policy statements. The Center calls for all healthcare organizations to implement a zero tolerance policy including a professional code of conduct and educational and behavioral interventions to assist nurses in addressing disruptive behavior (The Center, 2008). The AACN states that they "condemn acts of abuse perpetrated by or against any person and demands a zero-tolerance stance on any abuse and disrespect in the workplace" (AACN, 2005).

The Joint Commission (2008) implemented leadership standards requiring that all organizations seeking accreditation must have a code of conduct in place by January 1, 2009. The code should define acceptable as well as disruptive and inappropriate

behavior. The standard also requires that leaders create and implement a process for managing disruptive and inappropriate behaviors.

Development of policies and procedures is a start, but disruptive behavior will continue to be a problem if clinicians accept it and fail to support solutions designed to address the issue. The Joint Commission (2008) also suggests that organizations provide skills-based training to give staff the tools they need to respond appropriately to stressful situations.

Education and Training for Healthcare Workers

Most authors agree that recognizing detrimental behavior and naming it is the first step to resolving it (Beyea, 2004; Griffin, 2004; Piper, 2005; Rosenstein & O'Daniel, 2008; Rowell, 2005). Education must be multidisciplinary and must include training for nurses, managers, administrators, physicians, and all other patient care providers. Rowell (2005) recommends developing an evaluation and reporting tool that applies to everyone in the organization. The tool should be described in a written policy and adherence to the policy should be part of annual performance appraisal (Rowell, 2005). In order for nurse managers to enforce a zero tolerance policy, the manager must be provided with the skills to effectively manage lateral violence as well as administrative support for enforcing it (Leiper, 2005). Such training and support are essential since managers with good conflict management skills can mitigate or eliminate laterally violent behaviors. According to Stanley, education and effective leadership was found to lessen negative violence (Stanley, 2007) while ineffective leadership worsened it. As previously discussed, managers who ignore disruptive behavior contribute to perpetuating the cycle

of abuse.

A study by Griffin in 2004 used an exploratory design with an applied intervention to determine if new nurses could more effectively deal with lateral violence following education about its existence and the tools to address it. New nursing graduates were taught about lateral violence and the use of cognitive rehearsal techniques as a shield from the negative effects. Cognitive learning focuses on an individual's understanding of the connection between cause and effect and between actions and the consequences of that action. Cognitive rehearsal is a mental plan that individuals can use to deal with impulse control. The sample (n = 26) participated in a 2 hour education session. The first hour was dedicated to a lecture about lateral violence and it's affects on nursing practice. The second hour was interactive instruction and appropriate responses to the 10 most frequent forms of lateral violence as identified by Griffin. At the conclusion of the session, the nurses were given laminated cue cards with the forms of lateral violence and the aligned response. One year later, during videotaped focus groups, 96% stated that they had witnessed lateral violence and in 46% of the cases lateral violence was directed at them. Of those who had lateral violence directed at them, 100% stated that they confronted the responsible individual. They also stated that the confrontation was difficult, but it resulted in resolution of the offensive behavior. At the conclusion of the study 96% of participants recommended that this type of education should be required of all nurses in the organization as well as physicians and other allied health professionals.

Stephan Lazoritz (2008), Vice President of Medical Affairs in Ohmaha, uses the Birkman Method for providing insight to individual physicians about their usual

behaviors and interactions with others. He contends that while many causes of disruptive behaviors exist, the lack of insight into one's own behavior is one of the most common. Plainly stated, many physicians who display disruptive behavior simply don't know that their actions are disruptive. Cheryl Dellasaga (2009) reports similar experiences with nurses and states that many nurses don't seem to realize how their negative attitude or behavior affects those around them. Dellasaga states that the first step to education is taking an anonymous survey on each unit to assess the emotional state of the department and then using that data to educate staff and develop strategies to change the culture. According to Griffin (2004) many seasoned nurses were unfamiliar with the term lateral violence and baseline data would be useful in a starting point for education and feedback.

Because disruptive behavior is not limited to physicians and nurses, education should be provided to all health care workers. Data collected by Rosenstein (2008) involving 4530 participants included 700 who listed themselves as others (pharmacists, respiratory therapists, laboratory technologists, and physical therapists). The Center for American Nurses (2008) agrees that disruptive behavior is a widespread issue by stating that bullying is an "international phenomenon not limited to the healthcare arena" and that abuse can also occur between professions. This supports the notion that education should be provided for all health care workers and ideally in an interdisciplinary setting.

Pamela S. Dickerson of Healthcare Today (2008) recommends developing interdisciplinary education to enhance trust and respect in the workplace. In response, she has created a free, 1 credit, online training module for all healthcare disciplines to address bullying and intimidation in healthcare. She states that "much of the distrust and disrespect among disciplines is related to the fact that each of us becomes comfortable

within our own sphere of practice. Nurses do nursing, respiratory therapists do respiratory things, physicians practice medicine, social workers do social work things, and so on" (Dickerson, 2008, p. 2). Rowell (2005) supports this position. She contents that discipline specific education creates a situation where each group has little opportunity to develop an appreciation for the contribution each discipline plays in providing the total scope of patient care. Subsequent lack of respect can lead to lateral violence between disciplines (Rowell, 2005).

Education and Training for Students

Education should not wait until individuals are in the hospital setting as employees or as students. Griffin (2004) makes clear the advantages of preparing nursing students for the reality of the clinical setting. The advantage of training in school is twofold. First, students are prepared for the potential of disruptive behavior and will be better prepared to recognize it for what it is. Second, students can be taught some scripted responses designed to defuse a situation while at the same time protecting patients.

According to Seiden (2006) medical students are in a perfect position to identify potentially harmful patient situations as they are typically given a smaller, more manageable workload that staff residents or nurses. "Because they follow fewer patients than house staff, medical students can afford greater attention to details that may avert a medical error" (Seiden, 2006, p. 272). However, recognizing a potential error is useless if the student is hesitant to speak up due to intimidation by the medical staff. Seiden (2006) recommends that medical students should be trained to speak up by providing

them with appropriate medical knowledge of common causes of medical errors. Seiden also recommends that they learn to deflect confrontation by utilizing prefacing phrases such as "I'm probably mistaken but..." or "this might be a ridiculous question, however..."

In addition to scripted communication tools and practice sessions Seiden (2006) also recommends that student education should also include patient safety curriculum and interdisciplinary simulations. The purpose of simulation training is to gain respect for the scope of practice of other disciplines and to practice effective communication.

High Fidelity Simulations

High fidelity simulations is a technique that provides life-like scenarios that are realistic enough that participants experience working in a team setting that may allow them to transfer those skills to clinical practice (Gaba, 2009). Simulation activities can take the form of drills carried out in actual work settings or they can occur in specially designed simulation centers complete with life like teaching mannequins and patient monitors. The problem with the former is that these opportunities are not always available, are not fully controllable, and the drills can be disruptive to (or aborted by) the requirements of actual patient care. By contrast, courses held in dedicated simulation centers can replicate key parts of the clinical environment in a fully controlled environment. Further, they guarantee scheduled time for training that is not interrupted by patient care and the simulations can be recorded and replayed for debriefing. They are however, very expensive.

State of the art high fidelity simulation labs can run into the tens of thousands and

even hundreds of thousands of dollars (Pratt, 2009). Due to this and other factors, Pratt argues that classroom training with low level simulation can be just as effective as high fidelity simulation. His program consists of lectures, instructional vignettes or videos, cases reviews, interactive problem-solving exercises, question-and-answer sessions, and examinations to test knowledge. In either case, the goals of the programs are to teach the skills and knowledge necessary to manage a particular situation and then transfer those skills to the clinical setting.

Team Training

Several team training techniques have been identified in the literature as effective strategies for dealing with disruptive behavior. The Agency for Healthcare Research and Quality (AHRQ) developed TeamSTEPPS (Team Strategies and Tools to Enhance Performance and Patient Safety). TeamSTEPPS is an evidenced training module created by AHRQ which includes power points, video vignettes, attitude questionnaires, and instructor guides available in a free tool kit. AHQA also recommends development of organizational specific training using Crew Resource Management (CRW) techniques borrowed from the aviation industry (AHRQ, 2006).

CRW began in 1979 in response to a NASA workshop examining the role of human error in air crashes. According to McCulloch, P. Mishra, A., Handa, A., Dale, T., 2009) CRM training emphasizes that the three primary components of effective crew management are safety, efficiency, and morale. CRM training develops communication skills, fosters a more cohesive environment among team members, and creates an atmosphere in which junior personnel feel free to speak up when they think the

something is amiss (McCulloch et al., 2009). Team training, simulation, interactive group debriefings, and measurement to improve performance are all part of the CRM training technique. Additionally, participants are educated about the limitations of human performance and how stressors such as fatigue, emergencies, and work overload contribute to the occurrence of errors. Typical CRM training involves simulated crisis scenarios followed by debriefing sessions which require participants to assess their own as well as their peer's behavior. According to Rosenstein & O'Daniel (2008), CRM training fosters an environment of trust and team collaboration which resulted in significant improvements to communication flow in the perioperative setting.

McCulloch et al. (2009) studied the effects of a CRM based training intervention program on error reduction, teamwork, and improved communication in the operating room. The training program incorporated nine hours of mixed didactic and interactive teaching aimed to increase knowledge, change attitudes and improve behavior. There were three, three hour modules devoted to: (a) safety, situation awareness, and error management; (b) self-awareness, communication and assertiveness; and (c) decision-making, briefing and debriefing. In the first module, the theory of organizational error and the value of flat hierarchy, clear impersonal communication and an understanding of situational awareness and "red flags" were explained and demonstrated. In the second module, Myers–Briggs profiles were used to explain personal communication styles, and a tool for graded authority challenge was introduced. In the third module, role-play was used extensively to develop briefing and debriefing skills. A video, role-play scenarios, wall posters and pocket cards containing summaries of the course content were created and distributed. Following the classroom course, teams were supported by twice-weekly

visits from aviation CRM trainers, who provided encouragement, coaching and feedback during a 3-month period. Results documented significant improvements in non-technical skills and attitudes as well as a reduction in errors following the implementation of the program. There were however, some problems with the interpersonal aspects of the study. McCulloch et al. (2009) reported that there was "considerable cultural resistance" existed particularly among medical staff, and that debriefing and challenging authority seemed more difficult to introduce than other parts of the training.

Communication

The Institute for Safe Medication Practices (2008) and The Joint Commission (2008) both recommend the use of the SBAR reporting tool for all patient hand offs. SBAR is an acronym which stands for Situation (describe your concern), Background (provide pertinent information and further explain the basis of your concern), Assessment (offer your assessment of the situation), and Recommendation (suggest the action you believe would improve the situation). The purpose of SBAR is to improve communication between providers whenever a transfer of care occurs (ICU to floor, ward to procedure area, etc.) or when staff contact a physician about a change in patient condition. In the latter, SBAR is useful in promoting dialogue that gets from the problem to a request for action in an efficient method (Rosenstein, 2008). As reported by Rosenstein & O'Daniel (2008) nurses stated that the most common event precipitating disruptive behavior was placing calls to physicians to clarify orders. The education, acceptance, and use of SBAR by both parties should help maximize effective communication by providing structure to the dialogue.

Acknowledging Errors

In many industries all uncertainty about safety is presumed to be a serious problem regardless of who raises the question and they are not put on the defensive to prove he is right. Simply put, if someone thinks it is unsafe, it is considered unsafe (ISMP, 2002) until fully investigated and deemed otherwise. Many hospitals are developing similar models and have some have developed safety "hot lines" whereby staff can report concerns 24 hours a day with immediate intervention. At the University of Illinois, doctors, nurses and medical students now undergo training in how to respond when things go wrong. A tip line has helped drive a 30 % increase in staff reporting of irregularities (Sack, 2008). If an error or disruptive incident does occur, quality improvement committees openly examine cases and errors become teaching opportunities rather than a punitive experience.

The Institute for Safe Medication Practice (ISMP, 2004) recommends establishing a code that staff can use to halt disruptive behavior as soon as it starts. Agreeing to use key words like "red light" to call attention to a problem is a technique that has been described as a technique to ensure safety. Anyone in the organization can use the key word when faced with a safety concern and progress stops until the concern is addressed. The individual does not have to justify their position and they are protected from retaliation. At the Mayo Clinic in Rochester, Minnesota they recently implemented a system called CUSS. The acronym CUSS describes the use of key words to call attention to a situation in which someone feels uncomfortable. In high stress situations, the room should be silent so the team leader, usually a physician, can concentrate. However, staff can use CUSS words if they have something they want the team leader to know. The first

letter stands for concern. Staff can bring a concern forward by saying, "I have a concern..." If their concern is not resolved or continues, they move on to U and say "I am uncomfortable..." Finally, staff is free to say "stop, this is a safety issue" (M. Eickoff, personal communication, April 27, 2009). By using ensuring that all employees are familiar and comfortable with the CUSS terminology a safer culture of collaborative practice is created.

According to Timothy McDonald, chief safety and risk officer for the state of Illinois University Hospital Systems, this is the key to patient safety. If you address errors with a transparent, non-punitive point of view, you're more likely to identify system issues and put processes in place to improve it (Sack, 2008). Rosenthal et al. (1999) agrees and concludes that error prevention is hampered by a system that reacts to mishaps by placing blame on individuals rather than focusing on the possibility that the cause may be out of the individual's control. She goes on to state that much can be learned from root-cause analysis and process improvement.

CHAPTER 4

DISCUSSION AND SUMMARY

Discussion

In today's complex healthcare environment, each discipline brings specific skills to the care of each patient. Whether the clinician is a nurse, a pharmacist, a respiratory therapist, a social worker, a medical assistant, or a physician; each has a special set of skills and knowledge that allows them to see the patient from a unique perspective. Each discipline is most likely seeing the patient at different times of the day or night, and for different frequencies and duration. A respiratory therapist may see a patient four times per day for 20 minutes while the nurse may spend many consecutive hours at the bedside of her patient. The physician may only visit the patient once per day for a brief period. Consequently, changes in patient condition may first be noticed by someone other than the physician. The patient and the effectiveness of the team are reliant on each team member being able to effectively and confidently communicate this perspective. Unfortunately, disruptive behavior interferes with the flow of information and can adversely affect patient outcomes.

Having worked in healthcare for 24 years, first as a staff respiratory therapist and then as a clinical manager, I have had several personal experiences with disruptive behavior and the associated consequences on staff performance. As a staff therapist I can recall a situation where I asked a physician a question and he prefaced his answer

with, "I don't know who the hell you think you are but …". That incident occurred 21 years ago but it had such a profound effect on my psyche that I remember it as if it happened yesterday. Fortunately, the physician and I were able to discuss the incident later and the result was the start of multidisciplinary rounds in the intensive care unit. From that outburst, we realized that we needed to improve communication and the solution was visiting with patients (rounding) together. When we started in 1988, it was just the respiratory therapist, resident doctors, and the pulmonologist. Today, the rounding group has grown to include nurses, pharmacists, nutritionists, surgeons, social workers, and pastoral care and is a model of collaborative practice for other units. The entire group discusses each patient and each discipline has an opportunity to raise their concerns in a safe environment.

When I became a clinical manager in the same department our staff had ongoing problems with one perpetually abusive physician. As I reflect back on that experience, the most compelling concern was the wariness with which staff approached the individual. Despite discussions with the physician and his manager the problem continued and staff eventually admitted they were at a point where they avoided talking to him or contacting him with patient concerns for fear of his outbursts and humiliating behavior. This is clearly not consistent with high quality patient care and was eventually reported to administration.

While these are only anecdotal experiences, there are similar concerns documented in the literature. Rosenstein & O'Daniel (2006) documented and published some of the comments they received in a survey of over 4500 healthcare workers. They included things like, "RN did not call MD about change in patient condition because he

had a history of abusive behavior" and "some surgeons seem to believe that they have the right to be rude and verbally abusive. It is difficult to perform at a high level when constantly afraid of being screamed at" (Rosenstein & O'Daniel, 2006, p. 102).

Unfortunately, disruptive behavior is not limited to physicians and negative behavior by non-physicians is also well documented in the literature. The nursing literature has used the term lateral violence for over 25 years and the phrase "nurses eating their young" became quite well known after it was first used in the literature to describe disruptive behavior among nurses (Sheridan-Leos, 2008). While it hasn't been as well documented, most authors agree that disruptive behaviors extend to other non-physician staff as well. Rosenstein's survey data (2006) supports the premise that disruptive behaviors extend to other non-physician personnel. Comments included; "disruptive behavior from nurses is much more upsetting. I expect it from the surgeons but not from my peers" and "please realize that most stress is from RN managers, not MD's" (Rosenstein & O'Daniel, 2006, p. 102).

According to Rosenstein & O'Daniel (2008), the most common event that precipitated disruptive behavior by physicians, as reported by nurses, was placing calls to physicians. Conversely, the surveyed physicians reported that they were most concerned with the timeliness that their orders were carried out. This illustrates the dependent relationship that providers have with each other yet there may be reluctance to actually talk to one another. This reluctance causes a failure in communication that may have dire effects on the patient. For example, if a nurse is concerned about the appropriateness or accuracy of an order, she may not carry out the order until it is clarified by the physician. If she is nervous about calling the physician due to fear of an angry outburst, she may

delay the call or create a work around by avoiding the physician completely and involving another party. If the medication order is incorrect, this scenario can unfold in several ways, all with dire consequences for the patient.

First, the concern may not be verbalized because the practitioner (or in some cases the patient and/or family) did not want to challenge the stellar reputation of the physician or because they were intimidated by past behavior (ISMP, 2008). So, the wrong medication is delivered. Another possibility is that the concerned party directs their question to a manager, supervisor, or pharmacist to avoid having direct contact with the physician. In this scenario, the person raising the question can be convinced that their concern was unfounded and the medication is delivered as prescribed. In either case the wrong medication is delivered. If the nurse does make the phone call to the physician and experiences an angry outburst, the wrong medication may still be delivered and there are secondary consequences such as becoming less likely to clarify an order in the future. Unfortunately, some staff members must live with the regret of a fatal error because they did not follow through with a suspected problem (ISMP, 2008). The adverse consequences of such an error cause stress and frustration for all parties involved which may perpetuate disruptive behaviors.

Summary

Disruptive behavior is a complex issue that is not easily addressed. The mere definition is difficult to agree on and is so broad it includes everything from facial expressions to physical abuse. The causes are equally broad and range from the stress of long working hours in a critical environment to the steep hierarchy embedded in the

healthcare culture. Regardless of the cause the literature is very clear. Disruptive behavior leads to poor patient outcomes by inhibiting good communication and undermining the effectiveness of collaboration and teamwork.

Recognizing disruptive behavior and providing education is the first step to successfully addressing it. Education should be provided for practitioners already working in the healthcare setting as well as becoming a mandatory part of the curriculum in medical school, nursing programs, and other allied health fields. In both settings, the use of team based scenarios and simulations provide valuable analysis of teamwork and individual performance while improving effective communication across disciplines.

There are multiple causes of disruptive behavior which are also very complex and may vary depending of the position of the individual within the organization. Healthcare workers are human beings working in a constantly stressful environment short on time and high on demands. Failure means a missed diagnosis, disappointment, or even death. This is a tough reality to face day after day and may lead to frustration, disillusionment, and lashing out at peers. The solution requires broad system changes, sympathy and understanding, education and training in an environment that minimizes disciplinary action and promotes trust and teamwork. These should be provided consistently across the organization and not be directed at one or two levels of the hierarchy. These system changes need to stop the cycle and create a healthy work culture based on respect and teamwork in order to ensure good patient care.

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