

RURAL NURSES' PERCEPTIONS OF DISRUPTIVE  
BEHAVIOR AND CLINICAL OUTCOMES:  
A REPLICATION-EXTENSION STUDY

by

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## ABSTRACT

Disruptive behavior in the healthcare setting is considered a major threat to patient safety, patient outcomes, patient satisfaction, and interdisciplinary relationships. The Institution of Medicine estimated that over 44,000 to 98,000 people die related to medical errors (2000). The Joint Commission suggests that disruptive behavior is one of the leading causes of adverse events in the healthcare setting (2008). The purpose of this study was to evaluate Montana nurses perceptions of disruptive behavior and its impacts on interdisciplinary relationships, patient safety, and patient outcomes while working in rural hospitals.

This study was a replication-extension study based on Rosenstein & O'Daniel's research in 2008. Rosenstein's survey was used to assess perceptions of disruptive behavior in the healthcare environment. This survey was sent out to 120 rural nurses in Montana. Fifty-nine participants completed the survey resulting in a 49% response rate. One hundred percent of nurses indicated that disruptive behavior could have a potential negative effect on patient outcomes. Over 45% of nurses indicated that they were personally aware of an adverse event that occurred from disruptive behavior and 82.2% of nurses indicated this event could have been prevented. Nurse indicated that both nurse and physician disruptive behavior was prevalent in the rural healthcare setting. Also, participants indicated that disruptive behavior could be linked to increased stress, frustration, loss of concentration, reduced team collaboration, frustration, reduced information transfer, reduced communication, and impaired RN/MD relationships.

Results from this survey demonstrated that disruptive behavior can lead to adverse events, compromises in patient safety and quality, and finally decrease overall interdisciplinary relationships. These findings have important implications for patient safety and effective interdisciplinary relationships and support the development of effective policy implementation to address and manage such behavior.

## CHAPTER ONE

## DISRUPTIVE BEHAVIOR

Disruptive behavior is a frequently occurring threat to patient safety, patient outcomes, and effective interdisciplinary relationships. Disruptive behavior can be defined as “any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical and sexual harassment” (Rosenstein & O’Daniel, 2005). The history of disruptive behavior lies deep within the medical profession and such a threat of disruptive behavior is not new to the health care setting. In the past, disruptive behaviors have been excused and normalized being accepted as a status of the profession (Evans, 2007). Although its roots lie deep, health care organizations have begun recognizing disruptive behavior as an endangerment to patient safety, staff satisfaction, and staff retention in the last ten years (Rosenstein & O’Daniel, 2005). Emerging evidence indicates that disruptive behavior in the workplace has significant implications for healthcare organizations, healthcare personnel, and patients (Rosenstein & O’Daniel, 2005, 2008).

Background and Significance

Mounting evidence suggests that disruptive behavior is a threat to patient safety, causing irreversible errors and sometimes death (Evans, 2007; JC, 2008; Rosenstein & O’Daniel 2005, 2008; Saxton, Hines, & Enriquez, 2009). These implications of patient harm have forced healthcare institutions to address disruptive behavior. For example, in the Joint Commission’s (JC) Sentinel Event Statement of 2008, the JC wrote,

“intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction and to preventable adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments” (JC, 2008, p. 1). The Joint Commission (JC) defines disruptive behavior as any behavior that undermines patient care, patient safety, team performance, and communication (Joint Commission, 2008). According to the JC, “Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities” (Joint Commission, 2008, p. 1). Disruptive behavior has been described and defined in many studies by multiple authors and health care organizations. For example, disruptive behaviors such as interruption, rushing, rude phone calls, or negative attitudes have been found to negatively impact patient care, safety, and overall outcomes (Tjia et al., 2009). Specifically, when physicians refuse to repeat orders, curtail clinical information through interruptions, and use demeaning tone when information is given, patient safety as well as staff retention remains at stake (Tjia et al. 2009).

“Sentinel events for year 2010,” (SEA 40) published by the JC, indicated that 57% of root causes pertained to failures in the interdisciplinary team and miscommunication, which includes disruptive behavior (JC, 2010). A sentinel event is “an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof” (JC, 2011). These data illustrate that an alarming reality exists; over half of healthcare mistakes leading to sentinel events were related to a break down in the interdisciplinary team through communication, disruptive behavior, or lack of leadership,

which could ultimately be avoided. Rosenstein and O'Daniel conducted a study assessing the occurrence of disruptive behavior and found that 86% of respondents witnessed disruptive behavior within the healthcare setting and over 60% felt that potentially adverse events occurred directly from disruptive behavior (2005). Such evidence suggests that disruptive behavior contributes to adverse events and is a threat to patient safety. Growing evidence continues to produce correlations between disruptive behavior and decreased patient safety and quality of care (Rosenstein & O'Daniel, 2005, 2008; Veltman, 2007; Saxton, Hines, & Enriquez, 2009; Springer, 2008).

Not only does disruptive behavior cross the bounds of patient safety, it also affects health care personnel retention, satisfaction, and relationships. Multiple studies have found that workplace stress, violence, and incivility can lead to low retention rates and unsafe working environments (Rosenstein, 2002). In a study conducted by Rosenstein examining nursing retention rates and satisfaction, researches found that 30% of nurses were perceived as leaving their job related to disruptive behavior (Rosenstein, 2002). Also, researches found that nurses didn't always leave their hospital but they transferred departments, shifts, or revised their schedules to avoid certain physicians or nurses inflicting disruptive behavior (Rosenstein, 2002). In another study examining nurse satisfaction, researchers found that 85% of pediatric nurses who had experienced verbal abuse reported a drastic decrease in overall job satisfaction and 66% of the respondents reported reluctance to return to work (Saxton, Hines, & Enriquez, 2009).

Health care organizations are trying to improve the culture of safety by addressing disruptive behavior in the interdisciplinary team. However, limited research has been performed that specifically examines the negative effects of disruptive behavior in the

clinical setting. In addition, research regarding disruptive behavior within the rural health care setting is lacking. Lastly, appropriate methods for defining and managing disruptive behaviors have not been fully established. A crucial step in addressing disruptive behavior requires understanding how it affects clinicians, patients, and the work environment.

### Purpose

The purpose of this replication-extension study was to evaluate Montana nurses' perceptions of disruptive behavior and its impacts on interdisciplinary relationships, patient safety, and patient outcomes while working in rural hospitals (<125 beds).

The research question(s) addressed by the study were:

1. What is the occurrence of disruptive behaviors among nurses in rural hospitals in Montana?
2. Is there a perceived link between disruptive behavior and adverse events, patient safety, and medical errors?
3. Do nurses perceived a negative link between disruptive behavior and psychological or behavioral variables such as stress, frustration, communication, and team collaboration?

### Conceptual Framework

Disruptive behavior in the clinical setting provides for a complex understanding of communication, interaction, behavior, and environment. The conceptual framework used for this study is based on Johns Hopkins Conceptual Framework for Disruptive

Behavior (Walrath, Dang, & Nyberg, 2010). This model adapted Pearson and colleagues' Workplace Incivility framework to help define and structure disruptive behavior in the workplace (Walrath, Dang, & Nyberg, 2010). The Johns Hopkins model attempts to describe a foundation for the causes and impacts of disruptive behavior through four main concepts: triggers, disruptive behaviors, responses, and impacts (Walrath, Dang, & Nyberg, 2010). According to this model, triggers are anything that initiate, generate, contribute, or precede disruptive behavior (Walrath, Dang, & Nyberg, 2010). Disruptive behaviors for this model are defined as "personal conduct, whether verbal or physical, that negatively affects or potentially may affect patient care and interfere with one's ability to work with the other members of the healthcare team" (Walrath, Dang, & Nyberg, 2010, p.106). Responses can be defined as any reaction or reply, verbal or non-verbal, elicited from disruptive behavior. Impacts related to the conceptual framework for disruptive behavior include any effect, direct or indirect, resulting from the act or ramifications of disruptive behavior on the patient, interdisciplinary team, or organization (Walrath, Dang, & Nyberg, 2010).

The first step to understanding disruptive behaviors is to identify the trigger(s). For many individuals these triggers may range from emotional stress to personality conflict. Once the trigger is identified, the next step of the model may be approached, acknowledging the disruptive behavior(s). This may not be a simple task; disruptive behavior can be blatantly obvious such as yelling or swearing at a coworker or less subtle such as passive aggressive behavior. Unfortunately, in many cases, multiple types of disruptive behavior may be displayed and identified.

The third step of the John Hopkin's model involves identifying how individuals respond to these behaviors (Walrath, Dang, & Nyberg, 2010). Responses can be positive, negative, and none (Walrath, Dang, & Nyberg, 2010). Most of the time responses are negative or none due to the nature of disruptive behaviors (Rosenstein & O'Daniel, 2008). Individuals may argue back, say nothing at all, report the behavior, not report the behavior, or ignore the behavior (Walrath, Dang, & Nyber, 2010). The last step is assessing impacts of the disruptive behavior. Examples of impacts include but are not limited to: decreased ability to concentrate, error, fear, anger, decrease in work satisfaction and retention, decrease in patient safety, and an alteration in interdisciplinary teams (JC, 2008; Tjia et al., 2009; Veltman, 2007). For example, nurses in previous research studies reported psychological ramification and readily recalled lasting memories of abusive behaviors from angry physicians causing public humiliation and emotional distress (Walrath, Dang, & Nyberg, 2010). Using these four components in a stepwise approach to assess disruptive behavior can lead to the identification and impact of the behavior, ultimately leading to a possible resolution.

This specific model was chosen as a conceptual framework to help understand the multiple and broad causes and effects of disruptive behavior in the healthcare setting. The use of this model within a rural healthcare setting was helpful because it closely examined the process of disruptive behavior within a small population. Also, this study helped to emphasize the impacts of disruptive behavior and highlighted the cycle of disruptive behavior that the John Hopkin's model presents. Through understanding the triggers, behaviors, responses, and impacts associated with disruptive behavior, organizations can address and ultimately eliminate the occurrence of disruptive behavior.

With this study examining the impacts of disruptive behavior it may add to the knowledge and understanding aspects of this framework.

### Rural Population

Montana has a population of 989,415 and is the eight largest state in the United States (U.S. Census Bureau, 2011). In many counties three or fewer persons live per square mile and in some counties one person per square mile (Long & Weinert, 2010). One Metropolitan city exists in Montana and has a population over 100,000 including the surrounding area (U.S. Census Bureau, 2011). For the purpose of this study, rural will be defined as territories with a population less than 50,000 (U.S. Census Bureau, 2010). Therefore, specific territories of Montana will be included based on their specific population from the U.S. Census Bureau.

### Definition of Terms

Adverse event: “an injury resulting from a medical intervention” and “is not due to the underlying condition of the patient” (Institute of Medicine, 2000, p. 2).

Disruptive behavior: “any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse to physical and sexual harassment” (Rosenstein & O’Daniel, 2005).

Error: “The failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim” (Institute of Medicine, 2000, p. 2).

Patient Safety: Freedom from accidental injury (IOM, 2000, p. 2).

Rural and Urban: The Census Bureau's classification of rural consists of : all territory, population, and housing units located outside of urbanized areas and urban clusters. Urbanized areas include populations of at least 50,000, and urban clusters include populations between 2,500 and 50,000. The core areas of both urbanized areas and urban clusters are defined based on population density of 1,000 per square mile and then certain blocks adjacent to them are added that have at least 500 persons per square mile (U.S. Census Bureau, 2010).

Rural hospital: A hospital within a rural territory with less than 125 beds.

Sentinel Event: “An unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof” (JC, 2011, p. 1).

### Summary

Disruptive behavior occurs in all settings of the healthcare environment. In the last decade, multiple organizations such as the Joint Commission have taken initiative to research the deleterious effects of disruptive behavior. The ramifications of disruptive behavior extend to all facets of healthcare including patient care, healthcare personnel retention and satisfaction, and interdisciplinary relationships. Using the John Hopkins disruptive behavior conceptual framework model, the effects of disruptive behavior in the rural healthcare setting may be understood and more thoroughly examined.

## CHAPTER TWO

## REVIEW OF LITERATURE

The goal of this review of literature is to elicit a greater understanding of disruptive behavior within the health care setting. This review of literature was performed by accessing database sites containing academic books and articles such as Cumulative Index to Nursing and Allied Literature (CINAHL), PubMed.gov, and Medline. Inclusion criteria were set as full text articles within the time frame of 2000-2011. Search terms used include: *disruptive behavior, patient outcomes, patient safety, and nursing retention* in accordance with other key words including: *physicians, nurses, safety, and the Joint Commission*. The literature review is organized into nine sections including: (a) history of disruptive behavior, (b) defining disruptive behavior, (c) the occurrence of disruptive behavior, (d) factors affecting disruptive behavior, (e) Impacts on patient outcomes/safety, (f) impacts on healthcare personnel, (g) Horizontal violence, (h) managing disruptive behavior, and (i) research gaps.

History of Disruptive Behavior

In the past, disruptive behaviors have often been accepted as status quo and ignored due to possible economic effects of confronting high generating revenue clinicians. Therefore, such behavior has been deemed acceptable and has gone underreported, causing its prevalence to continue (Springer, 2008). Many staff are fearful of the whistle blower stigma associated with reporting such behavior and fear the possibility of retaliation from the reported individual (Springer, 2008). In many cases, the

issue of disruptive behavior may be acknowledged, but the organization does not have any reporting process or solution to intervene in the situation.

Evans, a masters-prepared registered nurse, addresses the issue of patient safety within a “culture of silence.” For decades, the medical profession has created an environment, which discourages the voluntary acknowledgment of errors and upholds a hierarchical structure in approaching errors (Evans, 2007). Additionally, in the past, healthcare workers have been punished for reporting, committing, or whistle blowing about medical errors. Over the past decade, measures have been taken to offset this fear through the Assurance Disclosure Acts. Such acts are set into place to create a safe environment for reporting disruptive behavior (Evans, 2007). However, though efforts have been made to offset the aforementioned fear, health care workers still avoid conflict or reporting errors in fear of retaliation (Evans, 2007). Although nurses may identify an error or disagree with a doctor, silence is usually the pattern followed and confrontation is avoided (Evans, 2007; Springer, 2008). In such cases, a nurse may have administered a medication dosage she/he disagreed with, ultimately causing an adverse event that could have been prevented. In one study, 75% of 17,000 healthcare staff reported difficulty confronting or reporting disruptive behaviors (Evans, 2007). Reasons staff did not report these behaviors include fear of retaliation, lack of confidence, or lack of time (Evans, 2007).

Although disruptive behavior has been underreported in the clinical setting, health care workers are trying to make a change. The first step to acknowledging disruptive behavior is defining it within the health care setting.

### Defining Disruptive Behavior

In July of 2008, the Joint Commission (JC) declared disruptive behavior within the health care setting a threat to patient and staff safety as well as one of the leading causes of sentinel events (Joint Commission, 2008). Disruptive behavior in the health care setting has been linked to adverse patient outcomes, medication errors, decreased patient safety, and decreased staff retention over the past twenty years (Evans, 2007; JC, 2008; Rosenstein & O'Daniel 2005, 2008; Saxton, Hines, & Enriquez, 2009). The institution of health care has been very lenient regarding disruptive behavior (Springer, 2008). Many clinicians experiencing or witnessing disruptive behavior do not report these incidences related to fear of retaliation or the whistle blower stigma. In some organization, such tolerance to disruptive behavior continues, but with the JC's new regulations addressing disruptive behavior, some efforts are being made to curb this behavior. The JC defines disruptive behavior as any behavior that undermines patient care, patient safety, team performance, and communication (Joint Commission, 2008). According to the JC (2008):

Intimidating and disruptive behaviors include overt actions such as verbal outbursts and physical threats, as well as passive activities such as verbal outbursts and physical threats, as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities. (p. 1)

On January 1, 2009, the JC established a new Leadership Standard addressing management of disruptive behavior. The standard requires two criteria: the organization must establish a code of conduct defining acceptable behavior codes addressing disruptive behavior and secondly, a protocol must be established by administrators for

managing disruptive behavior (Joint Commission, 2008). Some organizations have responded to the Leadership Standard. For example, the American Association of Critical-Care Nurses developed standards defining a healthy working environment with skilled communication, collaboration, and leadership (Luparell, 2011). Although healthcare institutions have made an effort to implement a change, the occurrence of disruptive behavior continues (Rosenstein, 2011).

In many research studies and reviews of literature, disruptive behavior has been acknowledged in most healthcare professionals, such as physicians, nurses, respiratory therapists, and hospital administrators (Springer, 2008). Many different factors have been examined to explain the occurrence of such behavior.

### Occurrence

In a survey conducted by The Institute for Safe Medication Practices, researchers found that out of 2000 American health care workers surveyed, 80% revealed that within the last year they had personally experienced intimidation from a physician (Evans, 2007). In 2005, researcher and VHA chief of medical affairs, Dr. Alan Rosenstein, reported from a recent survey that 44% of nurses felt pressured into giving a drug they disagreed with and felt threatened the patient's safety (2005). Out of these nurses, 7% of such actions resulted in medication error (Rosenstein & O'Daniel, 2005)

Rosenstein and O'Daniel, who reported on health care perceptions of disruptive behavior, performed a recent follow up survey. Both yes and no questions were rated on a Likert scale and open-ended questions for individual comments were categorized and listed (Rosenstein & O'Daniel, 2008). Overall, 77% of nurses, physicians, and health care

administrators reported that they had observed physician disruptive behavior (Rosenstein & O'Daniel, 2008). Specifically, participants were asked about the type of physician specialties most often associated with disruptive behavior, in which they rated obstetrics the lowest and general surgery the highest (Rosenstein & O'Daniel, 2008). Of the participants, 65% witnessed nurse-to-nurse disruptive behavior within the health care setting (Rosenstein & O'Daniel, 2008).

The concept that disruptive behavior occurs is fairly well established, but the documented impact of such occurrences is lacking. Therefore, the participants were asked about their perception regarding the impacts of disruptive behavior on patients, staff, and relationships. Respondents were asked to rate their answers as never, rarely, sometimes, frequently, or constantly (Rosenstein & O'Daniel, 2008). When combining the latter three responses, 99% of participants indicated that disruptive behavior within the health care setting led to impaired nurse-physician relationships, 94% specified that disruptive behavior directly led to frustration, and 67% of respondents directly correlated disruptive behavior to adverse events and medical errors (Rosenstein & O'Daniel, 2008).

Open comments were available for respondents to expound upon specific events related to disruptive behavior (Rosenstein & O'Daniel, 2008). In this section an individual commented, "disruptive behavior results in medication errors, slow response times, and treatment errors" (Rosenstein & O'Daniel, 2008, p. 467

Rosenstein and O'Daniel's research illustrates the ramifications of disruptive behavior on collaboration, communication, relationships, and patient outcomes. Such disturbances lead to preventable errors, errors, lack of patient safety, and possibly sentinel events leading to mortality (Rosenstein & O'Daniel, 2008).

### Factors Affecting Disruptive Behavior

Many different factors affect the ability of a medical team to work together to provide patient care. In the healthcare setting, disruptive behavior undermines factors essential for team-work, such as effective communication and collaboration which are fundamental for patient safety (Veltman, 2007).

Disruptive behavior is too frequently excused, and in many cases, the offending practitioner excuses his or her behavior by denying such actions (Veltman, 2007). Also, when disruptive behavior is addressed, such clinicians use legal threats when privileges are challenged or restricted for inappropriate behaviors (Veltman, 2007).

One theory suggests that the health care profession is one with high intensity and emotional stress. Health care professionals are constantly dealing with life and death issues, thus creating an environment of high emotional tension (Springer, 2008). Such factors can culminate into outbursts, disruptive behavior, ineffective coping, and increased fatigue or burnout rates (Springer, 2008). Another theory suggests that the basis for disruptive behavior stems from medical school and residency in which such behavior is portrayed and accepted (Springer, 2008). In some cases, disruptive behavior may indicate pathologic concerns, such as mental illness, narcissism, bipolar disorder, or personality disorders (Springer, 2008). Common factors identified in all these theory pertains to stress, increased workload, and burnout.

#### Communication

In a study examining nurse-physician relationships, one nurse stated that good doctor-nurse relationships “could mean anything from the doctor doesn’t yell at me to he

responds when he is called” (Schmalenber & Kramer, 2009, p. 75). Understanding the factors that form an appropriate nurse-physician relationship is an important aspect of patient care. If a nurse does not feel comfortable to call a physician when a patient is decompensating, related to fear of degradation or yelling, patient safety may be at risk. How a team of healthcare professionals work together, defines the quality and safety of care for patients and staff. According to Schmalenber & Kramer (2009) collaborative relationships are “marked by mutual trust, power, respect, and cooperation are based on mutuality rather than equality” (p. 77). Multiple research studies illustrate that teams who work collaboratively with open communication to care for patients, had decreased mortality rates and positive outcomes (Schmalenber & Kramer, 2009). Also, collaborative healthcare relationships have been shown to decrease length of stay and ultimately decrease net patient cost (Schmalenber & Kramer, 2009). However, disruptive behavior inhibits collaboration and can lead to decreased satisfaction of staff, increased length of stay, and decreased patient outcomes (Schmalenber & Kramer, 2009).

In addition to the nurse physician survey, other studies have demonstrated a connection between poor communication and collaboration with disruptive behavior (Rosenstein, 2002). In a nationwide study examining disruptive behavior, 96% of nurses stated that they had either experienced or witnessed a hostile work environment, and 36% indicated that they worked in a hostile work environment without team collaboration (Schmalenber & Kramer, 2009). Nurses indicated that a hostile work environment was “marked with by anger, verbal abuse, real or implied threats, or resignation” (Schmalenber & Kramer, 2009, p. 77). Nurses stated that in such disruptive environments, physicians were sharp, verbally abusive, and disregarded many requests

(Schmalenber & Kramer, 2009). In another study examining collaboration, nurses who were fearful of calling the doctor indicated that patient care and patient outcomes suffered (Rosenstein, 2002). Ultimately, such studies illustrate the need to address and eliminate disruptive behavior in the healthcare setting.

### Fear

Fear is most commonly reported as a factor directly related to disruptive behavior (Springer, 2008). In one study evaluating the relationship between nurse satisfaction and disruptive behavior, participants identified fear of retribution as the most common reason for not reporting disruptive behavior (Evans, 2007; Springer, 2008). Other rationale for not reporting disruptive behavior identified, include: “fear of retribution, the belief that nothing ever changes, lack of confidentiality, lack of administrative support, and physician lack of awareness or unwillingness to change” (Rosenstein, 2002, p. 29). In association with fear of retribution, nurses specified that possible threats and legal ramifications inhibited them from reporting the behavior (Rosenstein, 2002). Lastly, some nurses indicated that the administration was permissive and accepting of such behavior (Rosenstein, 2002).

As discussed above, many factors affect how disruptive behavior is perceived and reported. Many of these factors have a lasting impact and affect both patient care and safety.

### Impacts on Patient Care

Adverse events occur globally within the health care system much more frequently than one would guess. In the U.S. alone, the number of deaths related to adverse events could be compared to “two jumbo jets crashing every three days” (Evans, 2007, p. 16). Not only are lives taken, but the cost of such medical errors is estimated between, 17 and 29 billion dollars each year for hospitals (IOM, 2000). In New Zealand, a retrospective chart review study performed on thirteen hospitals found 1 in 8 patients experienced an adverse affect before discharge (Evans, 2007). Of these patients, researchers estimated that 1500 deaths occurred related to preventable adverse outcomes (Evans, 2007). A study in New Zealand reported that 6.3% of patients visiting ER and urgent care settings were admitted to the hospital related to adverse events in these locations. In this population, 40% were admitted with adverse events that were identified as preventable (Evans, 2007).

Veltman found in a research based study evaluating disruptive behavior in obstetrics that over 50% of both doctors and nurses stated they witnessed near errors or adverse outcomes, which had occurred related to disruptive behavior (Veltman, 2007). Additionally, 41% of respondents reported specific adverse events directly correlated with disruptive behavior (Velman, 2007). Veltman’s study illustrates the negative impacts disruptive behavior has on both patient safety and outcomes. Such behavior can directly contribute to adverse patient outcomes in addition to decreasing staff retention and satisfaction.

According to the Institute of Medicine (2000), preventable medical errors are estimated to kill between 48,000 and 98,000 hospitalized Americans each year. This number may seem overwhelming and unrealistic, however, this estimate has not decreased within the past 8 years (IOM, 2000; Saxton, Hines, & Enriquez, 2009). Research continues to identify factors causing such high numbers of deaths related to errors that should normally be prevented. Many health care organizations have taken a look at teamwork and collaboration and have deemed factors that negatively affect appropriate collaboration as a risk to patient care. Although the JC has made efforts to address disruptive behavior through the Leadership Standard, institutions continue to struggle to decrease occurrence of adverse errors (Saxton, Hines, & Enriquez, 2009). Disruptive behavior continues to be researched and addressed in such organizations. Although ten years have passed, many organizations are at a standstill for the appropriate way to define and eliminate disruptive behavior. In a research review of literature from 2000 to 2008, only ten research articles were identified that contained the key words, nurse-physician, disruptive behavior, and relationships (Saxton, Hines, & Enriquez, 2009). The idea that a possible 98,000 people die each year and limited research has been performed to address disruptive behavior is a frightening concept. According to Saxton's review of literature, verbal abuse was the most common type of disruptive behavior identified in all ten articles (2009). Of the ten articles, seven identified a clear link between disruptive behavior and patient safety (Saxton, Hines, & Enriquez, 2009).

In one study assessing the effects of verbal abuse on patient outcomes, researchers found that over 50% of respondents reported decreased patient safety and increased error related to the abuse (Saxton, Hines, & Enriquez, 2009). In a similar study of nurses, both

concentration and critical thinking skills were negatively impacted by over 57% of respondents (Saxton, Hines, & Enriquez, 2009). In a study surveying perioperative personnel, more than 80% of respondents “reported loss of concentration, reduced communication/collaboration, and impaired relationships with other team members as a result of disruptive behavior” (Saxton, Hines, & Enriquez, 2009, p. 181). In multiple studies addressing medical errors, intimidation played a significant role in medication practices in which 49% of respondents reported medical errors related to such behavior and 75% stated that they would rather have a colleague interpret orders than call the offending clinician (Saxton, Hines, & Enriquez, 2009).

In the year 2000, the Federation of State Medical Boards (FSMB) reported on professional conduct and ethics stating:

While disruptive behavior may not, in and of itself, constitute a clear violation of the medical practice act, the effects of this behavior have serious implications on the quality of patient care and patient safety. Patterns of disruptive behavior can have a deleterious impact on patient care and can result in error in clinical judgment and performance. Additionally the increased anxiety and intimidation associated with a disruptive physician’s behavior may severely compromise the effectiveness of the health care team providing patient care by increasing the level of workplace stress and creating an environment in which error are more likely to occur (Federation of State Medical Boards, 2000, p. 4).

Although back in 2000, the FSMB acknowledged the harmful consequences that disruptive behavior can have on both patient safety and staff effectiveness, no new regulations or punishments have been enforced. Eleven years later, disruptive behavior has become the forefront of major discussions within the health care setting.

Organizations continue to acknowledge the risks of disruptive behavior but do not implement or address the issue within the organization. Organizations need to keep in

mind that the impact affects not only patients but also healthcare personnel and medical costs.

### Impact on Healthcare Personnel

Four major studies have established a relationship between disruptive behavior and decreased nurse retention rate and satisfaction. In a pediatric nurse study examining the effects of verbal abuse, “84.9 % reported a decrease in job satisfaction and 66.7% reported a reluctance to go to work as result of verbal abuse” (Saxton, Hines, & Enriquez, 2009p. 181). In addition, over 25% of nurses stated they had either switched shifts, changed jobs, or changed their work schedules to avoid disruptive behavior (Saxton, Hines, & Enriquez, 2009). When examining physician perspectives of nurse-physician relationship, respondents rated such relationships more positively than nurses and denied any changes in practice related to disruptive behavior (Saxton, Hines, & Enriquez, 2009). These findings suggest that disruptive behavior has a significant impact on nurse-physician relationships and practice. Not only do these studies illustrate the decrease in nurse retention rates related to disruptive behavior they also demonstrate the potential adverse effects on patient care.

In many research articles, researchers have identified numerous factors affected nurse retention and satisfaction, including: verbal abuse, concerns of quality care, physician disruptive behavior, and staffing and monetary cutbacks. In 2002, Rosenstein established a connection between the influence of nurse-physician relationships and nurse retention rates. In a survey of 1200 nurse, physician, and administration participants, 92.5% of respondents they had witnessed disruptive behavior by physicians within the

hospital setting (Rosenstein, 2002). Twenty-eight percent of respondents stated they had witnessed disruptive behavior one or two times per month and 26% stated weekly (Rosenstein, 2002). Respondents were asked if they knew of any nurses leaving their jobs related to disruptive behavior, in which 30% of participants answered affirmatively (Rosenstein, 2002).

In this study both physician and nurses overwhelmingly agreed that disruptive behavior affected the overall work environment, collaboration, communication, safety, and morale. Veltman found in a research based study evaluating disruptive behavior in obstetrics, that 60% of respondents reported disruptive behavior within their organization (2007). The survey indicated that specific fields of health care professionals are more prone to display disruptive behavior such as pediatricians, obstetricians, neonatologist, and anesthesiologists (Veltman, 2007). Thirty-nine percent of nurses reported changing or transferring out of their unit to avoid disruptive behavior (Veltman, 2007). Lastly, the Nurse Physician Survey in addition to other related studies illustrates the ramification of disruptive behavior on the working environment, staff retention, and productivity (Rosenstein, 2002).

### Horizontal Violence

Interpersonal conflict between nurses is a significant issue and is associated with negative nursing and patient outcomes. In the last decade, multiple research studies have focused on the occurrence and impacts of horizontal violence. Horizontal violence in the nursing practice is an ironic paradox. Nurses are characterized as compassionate, caring,

and giving individuals to patients; on the contrary, nurses have a high rate of interpersonal conflicts with staff members.

Horizontal violence also referred to as bullying can be defined as any disruptive or aggressive behavior of nurses against each other (Woelfle & McCaffrey, 2007). Such behavior and interactions can cause toxic work environments in which nurses feel undermined and abused. Multiple studies have established that horizontal violence can cause increased stress levels, decreased job satisfaction, and a decreased rate of staff retention (Jones, 2011). Nursing has a long hierarchical traditional history of victimizing the less experienced nurses. Some individuals refer to this as “nurses eating their young” (Woelfle, & McCaffrey, 2007). Woelfle and McCaffrey performed a literature review regarding the effect of disruptive behavior. In one study assessing horizontal violence in the perioperative setting, researchers found that horizontal violence was prevalent in such a setting (Dunn, 2003; Woelfle & McCaffrey, 2007). Participants identified that the stressful work environment may trigger aggression, which is then taken out on co-workers ultimately creating a trend of horizontal violence (Dunn, 2003). The most common forms of horizontal violence in this setting included: the expectation of doing another’s work through intimidation, passive aggressive behavior, and undermining co-workers work ethic (Woelfle, & McCaffrey, 2007).

According to another study analyzing the occurrence of horizontal violence, researchers found that “horizontal violence most commonly takes the form of psychological harassment, which creates hostility as opposed to physical aggression” (Mckenna, Smith, Poole, & Coverdale, p. 91, 2003). Interpersonal conflict was present in over 50% of participants. Specifically 17% of participants felt that learning opportunities

were blocked due to ongoing conflict (Mckenna, Smith, Poole, & Coverdale, 2003). According to researchers 23% of new graduate nurses felt that they had too much responsibility without support due to conflict with more experienced nurses (Mckenna, Smith, Poole, & Coverdale, 2003). New graduate nurses also expressed psychological consequences related to horizontal violence including fear, anxiety, depression, sadness, frustration, and mistrust of co-workers (Mckenna, Smith, Poole, & Coverdale, 2003). Researchers concluded that horizontal violence results in absenteeism from work, decreased staff retention, and psychological impacts from being exposed to horizontal violence. Also, researchers suggested that in order to create a patient-centered environment, working relationships, open communication, and respectful teamwork are all necessary. Horizontal violence can degrade and destroy such components.

Another study analyzed the effects of horizontal violence on student nurses. Results illustrated that the students' self-esteem was greatly affected by the way they were treated in the clinical environment. Students reported a common occurrence of bullying while being a student and observed qualified nurses exhibiting such behavior. Also, students in this study observed professional nurses humiliate, isolate, and belittle other nurses and patients (Randle, 2003). After observing such inappropriate behaviors, students personally evaluated whether they wanted to continue in nursing. In addition, students' belief of nurses as being supportive and caring individuals was challenged with their negative clinical experiences. In some students, the only way to survive was to participate in the bullying (Randle, 2003). Such exposure and socialization to horizontal violence only continues the cycle from generation to generation of nurses. When students observe other nurses participating in horizontal violence it can become a learned

behavior, which is established even before the student becomes a registered nurse. This study implies that the cycle of horizontal violence should be addressed early on in student nursing programs to prevent further bullying. Ultimately horizontal violence undermines self-confidence, confidence in the nursing profession, and overall dissatisfaction of the victim.

The occurrence of horizontal violence has been well documented in the literature for over two decades. Horizontal violence creates unsafe work environments and decreased staff satisfaction and retention. Nursing professionals must learn to protect their profession and support each other on a daily basis. They must recognize the destructive nature of horizontal violence and eliminate it before the cycle continues through generations. Addressing disruptive behavior and horizontal violence is key for future success of RNs in addition to positive work environment and teamwork.

### Managing Disruptive Behavior

Since the JC's, new mandate, many hospitals have acknowledged and defined disruptive behavior within their institution and attempted to manage such behaviors. Through both policy implementation and education, facilities have approached the issue of disruptive behavior.

### Policies

The FSMB, American Medical Association, and the JC have all acknowledged the serious threat of disruptive behavior and suggest different ways of addressing and defining such behavior. All of these institutions have defined disruptive behavior

differently and have made individual programs for addressing such behavior. Although, these efforts are a step forward, a universal code of conduct needs to be established in all healthcare organizations addressing disruptive behavior (Springer, 2008). Lastly, reporting, reviewing, and intervention process needs to be implemented to follow up on concerns and monitor improvements after interventions (Springer, 2008).

Rosenstein & O'Daniel suggest that a zero-tolerance culture is essential in addressing and stopping disruptive behavior (2008). Some suggestions include organization recognition and awareness, cultural and leadership commitment, establishing policies and procedures, incident reporting, education, training, and lastly strategic intervention implementation (Rosenstein & O'Daniel, 2008). Establishing a disruptive behavioral survey within each institution will help to create a level of awareness and recognition for staff and administration. A commitment from board members, administration, and clinical leadership to address and intervene with disruptive behavior is critical to combat such behavior (Rosenstein & O'Daniel, 2008). Policies must be established in health organizations, defining clear and absolute conduct for behavior standards. A zero-tolerance policy for disruptive behavior will help create awareness and stop the behavior (Rosenstein & O'Daniel, 2008). Policies need to be established throughout all levels of the organization to be thorough and maintain adherence (Rosenstein & O'Daniel, 2008). Creating a uniform incident reporting system will help avoid inconsistencies in the reporting process. In many institutions the reporting process is very time consuming, difficult, ineffective, breaches confidentiality, and raises fear for retaliation of the reporter (Rosenstein & O'Daniel, 2008). A committee representing administration, human resources, and staff needs to be formed to address

behaviors, follow up on complaints, and provide appropriate education. Education and training for all staff can play a critical role in addressing disruptive behavior (Rosenstein & O'Daniel, 2008). Education regarding behavior, implemented policies, and how to recognize and address disruptive behavior will help create a culture of awareness. Lastly, interventions for addressing disruptive behavior can help mediate situations and stop conflicts (Rosenstein & O'Daniel, 2008). Disruptive behavior, although a sensitive subject to discuss, must be addressed to prevent further disturbance and harm.

Organizations need to commit to a culture of safety and establish a zero tolerance policy for disruptive behavior to guarantee patient safety (Rosenstein & O'Daniel, 2008).

### Education

Healthcare organizations should take steps to initiate education and training to increase awareness of disruptive behavior and take initiative to eliminate behavior that could be the culprit of adverse patient and staff outcomes (Veltman, 2007). According to the JC Sentinel Event Alert, education and policy establishment are critical in managing disruptive behavior (Beyea, 2008). The Leadership standard suggests to educate all staff members of the definition, prevalence, and ramifications of disruptive behavior.

Establishing policies that define disruptive behavior, hold perpetrators responsible, and promote zero tolerance of such behavior is fundamental (Beyea, 2008; JC, 2008). A zero tolerance approach will help to reduce if not eliminate such behavior in the health care setting (Beyea, 2008). If all team members have such an understanding, disruptive behavior is likely to be unaccepted and reported.

Also, educating employees about effective communication and teamwork are necessary in establishing competent patient care and safety (Evans, 2007). An essential ingredient in addressing disruptive behavior stems from promoting a no-blame culture (Evans, 2007). Through appropriate communication and teamwork, errors can be prevented and an environment of safety established. If disruptive behavior occurs, such incidences must be thoroughly and objectively documented and addressed (Evans, 2007). With the JC's new mandates for addressing disruptive behavior, some organizations have made an effort to create a "culture of safety" to prevent such deleterious effects on patient care and team work (Springer, 2008). A culture of safety emphasizes open communication, collaboration, and positive patient outcomes (Springer, 2008). For a culture of safety to truly thrive, disruptive behavior cannot be tolerated and must be addressed. The first step many organizations are taking to approach disruptive behavior is defining disruptive behavior within in policies in the institution and educating their staff.

### Research Gaps

A significant issue regarding disruptive behavior pertains to the lack of a universal definition of disruptive behavior. In this review of literature, many different definitions were presented and used to define disruptive behavior. The Joint Commission has a definition, however, they mandates all healthcare organizations to select or formulate their own definition. Without a universal definition for disruptive behavior, a valid measurement of such behavior is statistically impossible (Saxton, Hines, & Enriquez, 2009). For an effective reporting and surveillance process to be implemented for addressing disruptive behavior, a single definition must be employed for all

institutions. Multiple studies suggest, “the development of effective definitions and measures will provide impetus for appropriate intervention programs to address the important health care problem of disruptive behavior to reduce its negative impact on patient safety and nurse retention” (Saxton, Hines, & Enriquez, 2009, p. 182).

Although the JC mandated in 2009, that health care organizations must follow the Leadership standard LD.03.01.01 and establish “a code of conduct that defines both acceptable and disruptive behavior and create and implement a process for managing disruptive and inappropriate behaviors,” (Beyea, 2008, p. 637) a problem exists: no universal definition of disruptive behavior has been established. Thus, a true code of conduct cannot be established. Not only do institutions lack a universal definition of disruptive behavior, in many cases, a lack of knowledge exists regarding what interventions are most effective to eradicate disruptive behavior and how to effectively implement such interventions.

Furthermore, most major studies assessing incidence, perceptions, and ramifications of disruptive behavior have taken place in large metropolitan studies. Little or no research exists examining rural perspective on disruptive behavior and how rural health care facilities approach or manage disruptive behavior.

### Conclusion

This review of literature illustrates the significant impacts disruptive behavior has on the healthcare system. Multiple definitions of disruptive behavior were employed to exemplify the many ways it can be demonstrated. The topic of disruptive behavior is not new to the healthcare profession; however, the method in which it has been addressed has

changed. With increasing research illustrating the mal effects on patient and staff outcomes, many organizations are acknowledging such behavior as a threat healthcare. Emerging implications of disruptive behavior suggest significant implications for healthcare workers, healthcare administrators, and patients. A closer look at research and ways of identifying and addressing disruptive behavior is essential to curtail the ramifications of disruptive behavior.

## CHAPTER THREE

## METHODS

The purpose of this descriptive cross-sectional, replication-extension study was to examine nurses' perception of disruptive behavior in the health care setting and its effects on patient care, patient outcomes, and interdisciplinary relationships. Drawing on Rosenstein's study of VHA-employed nurses, this study examined perceptions of nurses who work in rural (<125 beds) hospitals in Montana.

Design

A cross-sectional, descriptive design was used to assess such perceptions in Montana. Five hospitals located in rural territories with less than or equal to 125 beds were invited to participate in this survey. Specifically, the study addressed the following research questions:

1. What is the occurrence of disruptive behaviors among nurses in small hospitals in Montana?
2. Is there a perceived link between disruptive behavior and adverse events, patient safety, and medical errors?
3. Do nurses perceived a negative link between disruptive behavior and psychological or behavioral variables such as stress, frustration, communication, and team collaboration?

### Sample

A convenience sample of nurses with any educational preparation who were holding any FTE in the selected small hospitals were used. Five Montana hospitals within Rural territories and less than 125 beds were sent e-mails inviting them to participate in the survey.

### Instrument

Alan Rosenstein's survey assessing disruptive behavior was obtained with permission to use in this study (Appendix B). The VHA survey consisted of 21 questions including multiple choice, yes-no answers, 5 and 10 point scales, and lastly open ended questions (Rosenstein & O'Daniel, 2008) (Appendix C). Example of these questions include:

1. Have you ever witnessed disruptive behavior from a physician at your hospital?
2. Have you ever witnessed disruptive behavior from a physician at your hospital?
3. How often do you think there is a link between disruptive behavior and adverse events, patient safety, and medical errors?

For the purpose of this study, the questionnaire was put into electronic format using Survey Monkey. Survey Monkey provides online survey software and questionnaire tools.

Rosenstein reports face validity of the instrument, but no psychometric data was available upon request (Rosenstein & O'Daniel, 2008). Face validity was determined using a VHA subgroup of doctors and nurses (Rosenstein & O'Daniel, 2008). The RN-MD survey was field tested at the Mayo Clinic Hospital in Scottsdale, Arizona, and Barnes-Jewish-Christian hospitals in St. Louis (Rosenstein & O'Daniel, 2008). Changes were identified and applied. Surveys were also used in three previous large-scale studies performed by Rosenstein. The questions were applicable to all nurses of any background. The questions within this survey did not need to be altered to apply to the Montana nurses population. A copy of the questionnaire is included in Appendix C.

#### Data Collection

The Montana State University Investigational Review Board reviewed this study (Appendix A). Permission was obtained from Alan Rosenstein for use of his survey through e-mail confirmation (Appendix B). Five hospitals falling within the decided criteria were selected; Montana hospitals with 125 bed or less. Introduction e-mails inviting the institutions to participate in the survey were sent to the director of nursing (Appendix D). Once institutions agreed to participate in the study, an email with the survey was sent to the director of nursing to distribute to all nurses e-mails in the hospital. E-mails were sent out to these nurses, inviting them to participate in a survey regarding disruptive behavior.

A prompting e-mail was sent initially to alert the person that they would be receiving a study invitation within one week. A brief overview of the study was included and this contact was made in order to give nurses time to reflect upon the topic

(Appendix E). Within the following week, the formal invitation to participate with an electronic link to the questionnaire was sent (Appendix F). This e-mail contained an attached cover letter explaining the purpose of the study, an ethical statement regarding confidentiality, and finally the risks and benefits of participation. The e-mail also included a link to the survey, using Survey Monkey, a survey program which de-identifies personal information. A reminder e-mail with survey links was sent out at day fifteen after the initial survey (Appendix G). This time period was used to increase response rates with frequent reminders. Surveys were available up to twenty days after the initial e-mail was sent. Returning the survey indicated participant consent.

In the survey, participants were required to answer questions with sometimes, frequently, constantly, or never. Also, an optional open section was provided for any addition comments or personal examples of disruptive behavior. A variety of demographic information was collected including: years of nursing education, years of nursing practice, area of employment, and gender.

After surveys were submitted, participant identifiers were removed through Survey Monkey software and sent to researcher. Therefore, information sent to the researcher had no connecting information to the recipient of the study. For safety precautions, information was stored on a secured flash drive, which was locked in an office file cabinet at all times. Once the data analysis was finished the flash drive was destroyed.

### Data Analysis

Data were analyzed using Survey Monkey analysis software. All answers to questions, “sometimes”, “frequently”, “constantly”, and “never” were subtotaled and categorized to determine percentages of perceived disruptive behavior. Simple frequencies were calculated to create averages. Answers to optional open-ended questions were categorized according to themes.

### Ethics and Protection of Human Subjects

Montana State University Institutional Review board reviewed this study in fall of 2011. All information provided by the participant was de-identified immediately using Survey Monkey Software upon submission. Lastly, there is no software mechanism by which to trace the de-identified data back to the participant.

The purpose of the study was communicated to all participants in addition to the right to refuse participation. The anticipated risk of emotional integrity was noted and conveyed to all participants. Recalling emotionally challenging events related to disruptive behavior may disrupt the individual’s emotional integrity. In this case, the benefits of this study were determined to outweigh any harm associated to participants. Submission of the questionnaire implied participant consent.

## CHAPTER FOUR

## RESULTS

The purpose of this study was to evaluate Montana nurses' perceptions of disruptive behavior and its impacts on patients and the healthcare environment. There were 120 surveys sent out to Montana nurses in two Central Montana hospitals via the hospital intranet. The survey was available for 30 days. One reminder email was sent at day 15. A total of 57 surveys were completed resulting in a 47.5 response rate.

The majority (94.5%) of nurses taking this survey were female. Over 67% of participants worked in an Acute care hospital and 26.8% of nurses worked in a Critical access facility. A total of 23.6% nurses taking the survey worked in an 11-20 bed hospital and 63.6% worked in a hospital with 51-100 beds. Lastly, the majority of nurses taking this survey ranged between the ages of 20-39 years old. Specifically, 26.8% identified themselves in the age group of 20-29 years, 33.9% indicated they were between 30-39, 14.3% were 40-49 years old, 17.9% were 50-59 years old, and finally, 7.1% of nurses were 60 years or older. Finally, the overall experience of nurses ranged from less than one year to greater than 21 years. In particular, 29.6% of nurses had practiced between one to five years, 24.1% practiced between 6-10 years, 18.5% answered 11-15 years of practice, and 16.7% responded 16-20 years.

#### The Occurrence of Disruptive Behavior

Of the 57 respondents who answered the question *Have you ever witnessed disruptive behavior from a physician at your hospital?* 98.2% of respondents selected

yes. Of the 57 respondents who answered the question *Have you ever witnessed disruptive behavior from a nurse at your hospital?* 87.8% of respondents answered yes, and 12.3% selected no. When asked *what percentage of physicians would you say exhibit disruptive behavior at your hospital?* 33.3% of participants selected 2-3% of physicians. Also, 31.6% selected 4-5% of physicians at their facility. A total of 12.3% of participants selected 6-10%, and 3.5% of respondents selected more than 10% of physicians displaying disruptive behavior (See Figure #1). When asked the question, *what percentage of nurses would you say exhibit disruptive behavior at your hospital?* Participants indicated that disruptive behavior occurs in more nurses than physicians. In fact, 42.8% of nurses selected that more than 6-10 % of nurses at their facility displayed DB. Also, other participants, 17.9%, felt that 2-3% of nurses exhibited DB, and lastly 17.9% indicated that only 1% of nurses displayed such behavior (See Figure #1).

When asked the question, *How often does physician disruptive behavior occur at your hospital?* 18.2% of respondents answered “Weekly”, 52.8% answered “1-2 Times/Month,” and 3.6% of individuals indicated that physician disruptive behavior never occurs (See Figure #2). While zero percent of participants indicated that daily disruptive behavior occurs, 25.5% indicated such behavior occurred up to “1-5 Times/Year.” Of the 53 respondents who answered the question, *How often do you think nurse disruptive behavior occurs at your hospital?* 28.3% answered “Weekly,” 30.9% answered “1-2 Times/Month,” and 18.2% answered “1-5 Times/Year.” Although 5.5% of nurses indicated that nurse disruptive behavior never occurs, 18.2% specified that DB occurs on a daily basis (See Figure #2).

Of the 44 respondents who answered the question, *Are there any particular setting where disruptive behavior is most prevalent (ICU, OR, ED, OB, Medical unit, Surgical units, or other)?* 73.3% answered the ED, 37.8% indicated the ICU, and over 35% answered the medical and surgical units. When asked, *Are there any particular specialties where disruptive events occur most often (General surgery, Cardiac surgery, Cardiology, Orthopedics, Neurosurgery, Anesthesia, OB/GYN, or Other)?* The majority of nurses, 79.1% answered that Cardiology is the specialty where disruptive events occur most often. Also, 25.5% of nurses felt that Anesthesia was a specialty with frequently occurring disruptive events. Finally, 2.3% indicated general and cardiac surgery, 16.3% answered OB/GYN, 0% selected Neurosurgery, and 14.0% selected other. (See Figure # 3).

Figure 1. Respondents' Estimates of the Percentage of Physicians and Nurses Who Exhibit Disruptive Behavior.

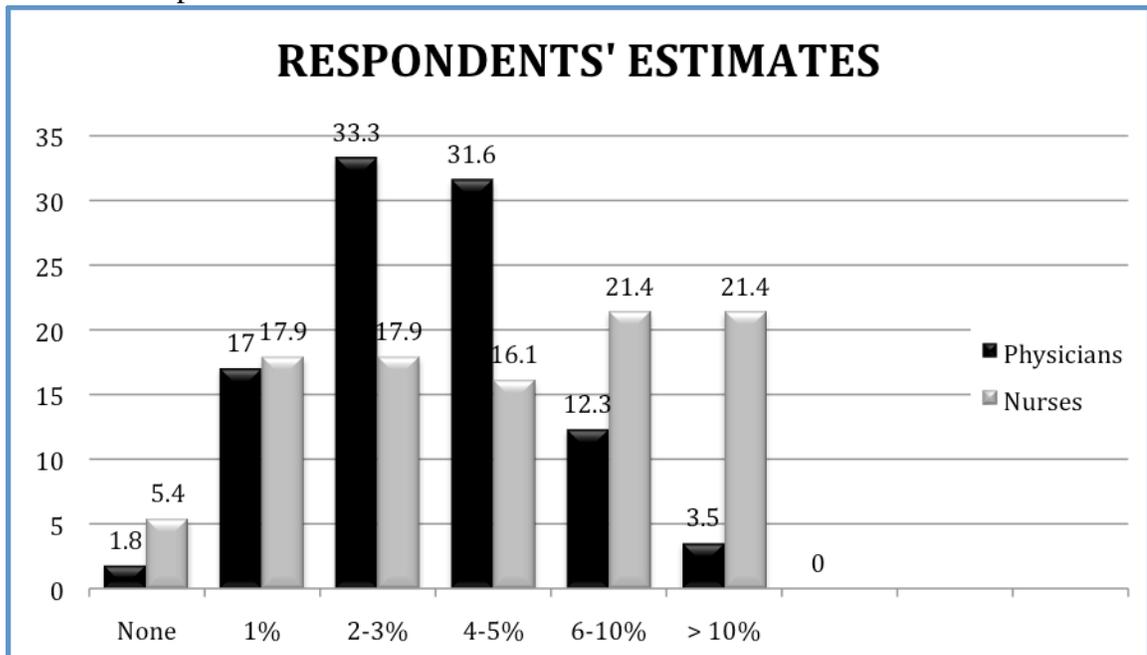


Figure 2. Respondents' Estimates of the Frequency of Occurrence of Disruptive Behavior Exhibited by Physicians and Nurses.

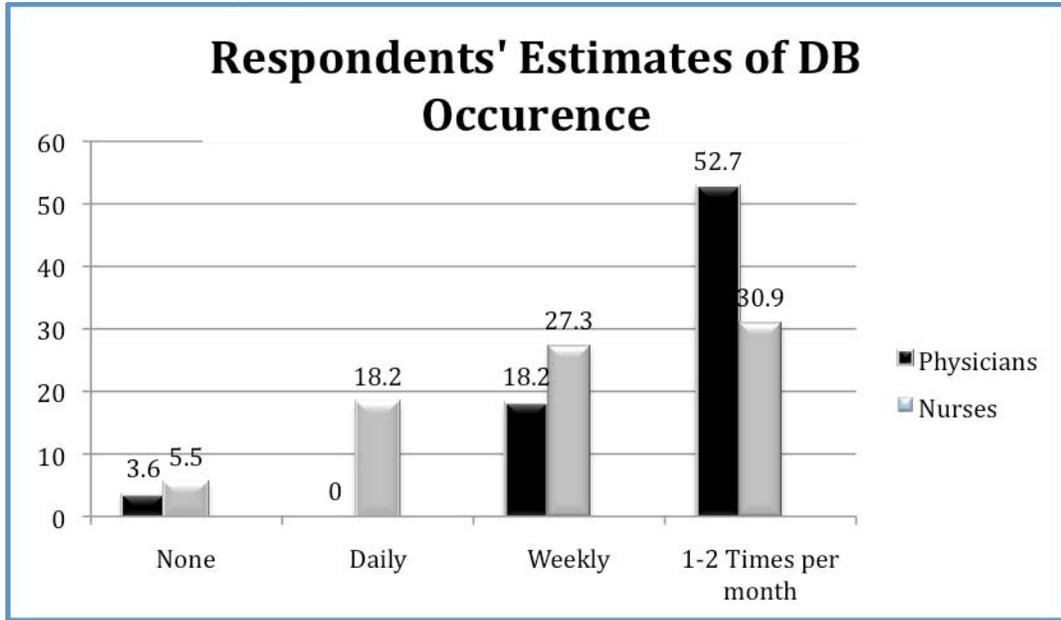
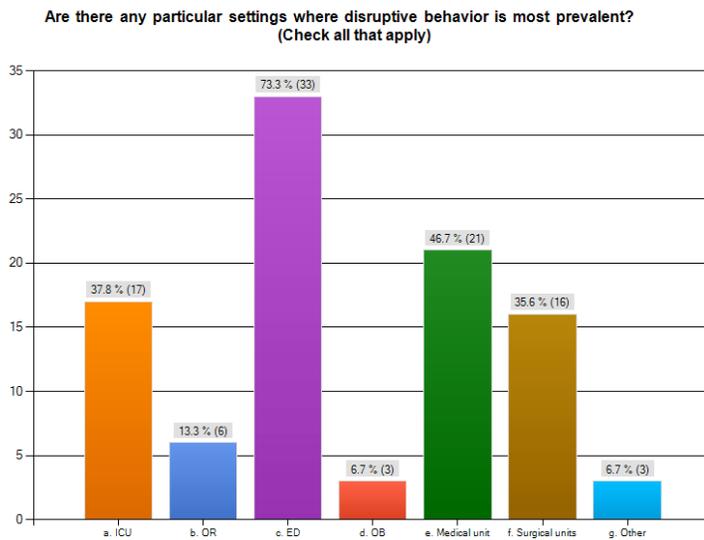


Figure 3. Particular Settings Where Disruptive Behavior is Most Prevalent.



### Disruptive Behavior and Adverse Events

When asked, *Are you aware of any potential adverse events that could have occurred from disruptive behavior?* 61.8% of respondents answered yes. Of the 37 participants who answered the question follow-up, *If yes, how serious an impact do you think this could have had on patient outcomes?* 43.2% answered a “very serious impact.” Also, 86.4% of respondents indicated that disruptive behavior can have a “serious,” “very serious,” and “extremely serious effect” on patient outcome. When participants were asked, *Are you aware of any specific adverse events that did occur as a result of disruptive behavior?* 45.5% responded affirmatively. Ten participants provided examples of such events, described in the discussion. Twenty-nine participants who answered yes to the aforementioned question also answered the follow up question, *Could this have been prevented?* 82.8% of nurses answered that this adverse event could have been prevented. (See Figure # 4)

When asked, *Is there a code of conduct or policy for handling of disruptive behavior/abusive behavior at your hospital that you are aware of?* 52.7% of respondents answered “Yes” and 47.3% answered “No”. As a follow-up question participants were asked, *Is the plan effective?* 72.1% of participants answered “No”. However, when asked, *Is there a non-punitive reporting environment for those who witness/experience disruptive behavior?* 68.5% answered “Yes”. When asked, *Are there any barriers or resistance to the reporting of disruptive behavior?* 94.3% selected the barrier “The feeling that nothing ever changes.” Also, greater than 56% of participants identified both “Fear of retaliation” and “lack of confidentiality” as common barriers.

Respondents were invited to participate in or explain their reasoning for some of the above questions. These responses will be referred to in the discussion section.

Participants were asked, *If you know of physicians who have been counseled about his or her behavior, on a scale of 1-10 with 10 being completely satisfied, rate the success of this process*, 81.8% of participants indicated that their satisfaction with the results of counseling was minimal. Respondents were then asked, *If you know of nurses who have been counseled about his or her behavior, on a scale of 1-10 with 10 being completely satisfied, rate the success of this process*. The majority of participants, 58.2%, indicated that they did not believe the counseling process was successful.

Figure 4. Respondents' Answers to Selected Survey Questions

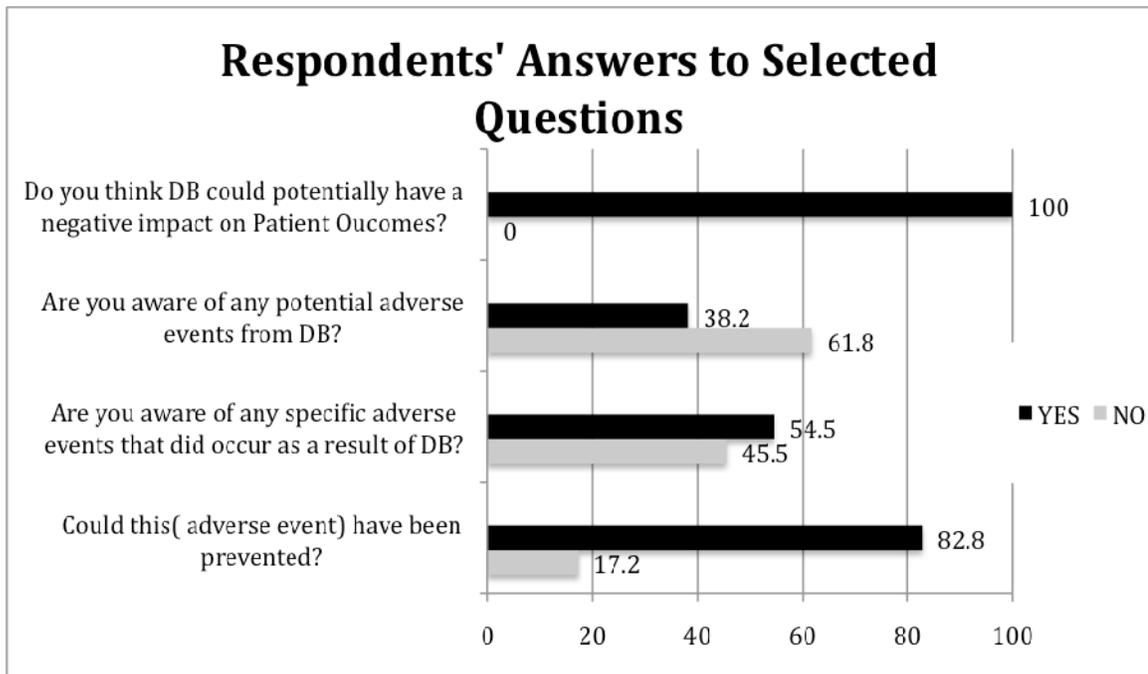
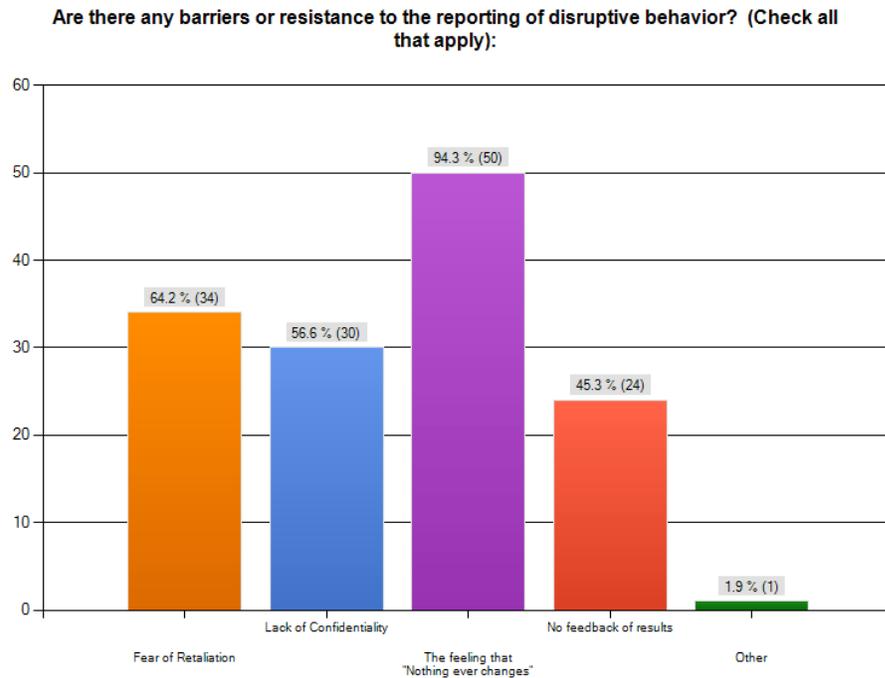


Figure 5. Barriers or Resistance to Reporting Disruptive Behaviors



### Psychological and Behavioral Effects of Disruptive Behavior

When asked, *From your perspective, do you think that disruptive behavior can potentially have a negative effect on patient outcomes?* 100% of participants responded affirmatively to this question. Respondents were then asked, *How often does disruptive behavior result in the following: stress, frustration, loss of concentration, reduced team collaboration, reduced information transfer, reduced communication, and lastly impaired physician-nurse relationships?* For each variable, the respondents checked a box on a 5-point scale that ranged from “never, rarely, sometimes, frequently, or constantly.” Over 50% of all participants felt that all the aforementioned variables were “constantly” associated with disruptive behavior. To see exact effects of disruptive behavior on

psychological and behavior factors see Figure # 6. To assess the nurses perception of the link between clinical outcomes and disruptive behavior, participants were asked, *How often do you think there is a link between disruptive behavior and the following clinical outcomes? (adverse events, errors, patient safety, the quality of care, patient mortality, and patient satisfaction)* Responses were made according to the same 5-point scale in which individuals could select “never, rarely, sometimes, frequently, or constantly” as DB was related to each outcome. Over 50% of nurses indicated that adverse events occurred “sometimes” related to DB, 42% indicated that errors “sometimes” occurred because of DB, and 48% stated that patient mortality “sometimes” occurred due to DB. Over 38% of respondents stated that patient satisfaction was “constantly” linked to DB, 35.1% answered that quality of care was “constantly” affected by DB, and lastly 43.9% of nurses indicated that DB constantly affected patient satisfaction. Subtotals of the “sometimes, frequently, and constantly” were combined to determine the percentage of respondents who perceived such disturbances as common occurrence. Regarding adverse events, 90% of respondents indicated a strong link between disruptive behavior and adverse events. Also, when assessing percentages related to patient safety, 87% of nurses saw a strong link between disruptive behavior and patient safety. To see specific percentages of participants responses please see Figure # 7.

Figure 6. Percent of Respondents Answering to the Question, *How often does disruptive behavior result in the following (psychological or behavioral effects)?*

**How often to you think DB results in the following?**

	Never	Rarely	Sometimes	Frequently	Constantly
Stress	0%	0%	9.3%	40.7%	50.0%
Frustration	0%	0%	10.9%	40.0%	49.1%
Loss of Concentration	0%	3.7%	16.7%	27.8%	51.9%
Reduced team collaboration	0%	1.9%	18.5%	27.8%	51.9%
Reduced information transfer	0%	1.9%	16.7%	38.9%	44.4%
Reduced Communication	0%	1.8%	14.5%	32.7%	50.9%
Impaired RN/MD relations	0%	1.9%	20.4%	27.8%	51.9%

Figure 7. Percentage of Respondents Answering the Question, *How often do you think there is a link between disruptive behavior and the following (clinical outcomes)?*

**How often do you think there is a link between disruptive behavior and the following?**

	Never	Rarely	Sometimes	Frequently	Constantly
Adverse Events	0%	11.1%	51.9	14.8	22.2
Errors	0	9.3	40.7	18.5	31.5
Patient Safety	0%	13.0%	33.3%	14.8%	38.9%
Quality of Care	0%	9.1%	29.1%	25.5%	36.4%
Patient Mortality	7.4%	27.8%	48.1%	3.7%	14.8%
Nurse Satisfaction	0%	0%	14.5%	38.2%	47.3%
Physician Satisfaction	0%	1.9%	32.2%	37.7%	28.3%
Patient Satisfaction	0%	5.5%	27.3%	21.8%	45.5%

Summary

The results of this study suggest that the occurrence of disruptive behavior is common in the rural healthcare setting. Participants indicated that DB might be linked to adverse events, ultimately, decreasing patient safety and satisfaction. In addition, participants perceived a link between disruptive behavior and psychological and behavioral variables. Finally, the majority of respondents indicated that their facility lacked appropriate reporting and counseling policies for addressing disruptive behavior.

## CHAPTER FIVE

## DISCUSSION

Disruptive behavior continues to be a persistent force in the healthcare setting and can severely affect the safety of both patients and staff in the healthcare setting. The main focus of this study was to evaluate Montana nurses' perceptions of disruptive behavior and its impacts on interdisciplinary relationships, patient safety, and patient outcomes while working in rural hospitals. The findings from this study suggest that DB negatively affects rural hospitals within Montana and is responsible for decreasing patient safety and negatively impacting staff environment and relationships.

Limitations

There were several limitations to this study. The first and most difficult limitation in this study was access to Montana state nurses' emails. Although the State Board of Nursing (SBON) maintains some contact information on all licensees and shares it for the sake of research, they do not keep email contacts. The Montana Nurses Association (MNA) does keep email information, but does not share it (Personal communication with MNA, 2011). With no email access, an alternative and less direct route of reaching Montana nurses was employed. This approach entailed sending the survey to the Director of Nurses at five different rural hospitals. If the DON agreed to permit participation in the survey, the DON forwarded the survey cover letter and link to all the nurses in the facility. Having an intermediary involved in sending the survey out may have resulted in a decrease in nurse participation. With three of the hospitals, direct

contact was made with the DON via telephone and e-mail. The DONs agreed to send out the survey, but unfortunately, the survey was never sent out and contact could not be made again despite three separate attempts. Therefore, only two out of the five hospitals participated in the survey. Also, in one participating hospital, the DON sent the survey out to nursing directors of each unit, and the nursing directors then had control of whether the survey was then sent out to the unit nurses. Finally, the Nursing Managers were responsible for forwarding the email to their nurses. Some of these managers did not forward the e-mail to their nurses until one week before the survey closed. In many cases, this only gave nurses one week to complete the survey. Therefore, such late delivery may have also caused a decrease in overall response rate. With the survey link being juggled between multiple people, it had the potential for being lost or forgotten.

Another limitation was using the email route for distribution of surveys. The participation was largely dependent on nurses checking their hospital email. Many nurses do not check their hospital emails on a regular basis or at all, causing a potential for decrease in response rate. Also, some nurses stated that they chose not to take the survey due to fear of the hospital monitoring the emails and input of the survey. Nurses also stated that many times they received multiple emails a day, so they frequently deleted them without reading the content. Lastly, nurses stated that they rarely had time to check email or respond to a survey at work. One nurse stated that if the survey had been mailed or emailed to her home, she would have taken the time to participate in the survey (Personal communication, 2012). According to Shih and Fan (2008), postal mail surveys continue to have a better response rate with professionals than email surveys. Although, email surveys tend to be quicker, easier, and more accessible, their overall response rates

are decreased in comparison to the postal route (Shih & Fan, 2008). The aspect of postal surveys brings up the lack of finances involved in this study. The overall cost to send out email surveys was very minimal in comparison to sending out surveys via the post service. The study was not backed by any financial support and the financial burden was thus placed on the researcher.

As a result of the above, an additional limitation of the study was the small sample size collected. The survey was originally supposed to be sent out to five rural hospitals at all different geographic locations of Montana. These hospitals were chosen due to their increased patient population, rural setting, bed availability, and staffing ratios. With three of the five hospitals not participating, this unexpectedly created a smaller sample size than projected. Lastly, the sample size collected is a small representation of Montana nurses, limited to western Montana. A better representation would have included nurses from across the entire state and not limited to two hospitals.

A further limitation to the study affecting participation was technology insufficiencies. In some of the rural facilities assessed, nurses did not have access to computers and therefore could not take the survey. Although, the majority of hospitals within the U.S. have some access to computers, many rural hospitals still largely depend on paper charting and have limited or no access to computers for personal use at work. Also, those who did have access to computers to participate were potentially burned out on taking surveys. Within the field of healthcare, employees are constantly being subject to local and national surveys, causing a potential survey burnout ultimately resulting in decreased response rates. Therefore, although a higher response rate would have been

beneficial, it may have proved difficult with the rural barriers present and the general lack of access to Montana nurses.

Finally, the last limitation of the survey involves the sensitive subject content of the survey. The topic of DB can be sensitive and intimidating for some participants. For those nurses who have experienced disruptive behavior, reflecting back on such incidences may have caused emotional trauma or fear of retaliation. These feelings alone may cause the nurse to decline participating in the survey. Also, some nurses may fear participating in the survey because it was sent out to their hospital email. They may have feared that their survey was seen or tracked by the hospital, which may result in their punishment for sharing hospital related events.

#### Research Question #1: Occurrence of Disruptive Behaviors in Rural Hospitals

The findings from this study suggest that the occurrences of disruptive behaviors in rural hospitals are similar to metropolitan nurses studied by Rosenstein and O'Daniel, 2008. According to the present results, 100% of respondents indicated that they had witnessed disruptive behavior from a physician, where as, 89.1% indicated that they had witnessed such behavior in a nurse. Interestingly, the occurrence rate of the two professions was different than Rosenstein and O'Daniel found. In this study, participants acknowledge that the percent of nurses engaged in disruptive behavior was much higher than that of physicians. In fact, 44.4% of respondents indicated that over 6-10% of nurses at their hospital displayed disruptive occurrence. In contrast, the majority of participants, 65.4%, stated that 2-5% of physicians exhibited DB. However, Rosenstein's and

O'Daniel's study demonstrated that a greater number of physicians show evidence of DB in comparison to nurses. Specifically, their results illustrated that 1-3% of physicians illustrated DB, as opposed to nursing DB with 0-1% of nurses displaying DB (Rosenstein & O'Daniel, 2008).

In this study, the incidence of DB occurred more frequently with nurses than with the physicians. In particular, 30.2% of participants indicated that nursing disruptive behavior occurs on a weekly basis and 18.9% on a daily basis. Participants answered that 18.9% of physician behavior occurs on a weekly basis and 0% occurs on a daily basis. Rosenstein found that physician DB occurred on a more regular basis than nurse DB; in fact, 22% of physicians displayed DB weekly in comparison to observed DB in 13% of nurses. Such results illustrate a possible difference between rural and metropolitan populations. In rural hospitals, this study may suggest that nurse DB occurs more frequently than physician DB. Rural settings have less physicians and specialist and have more nurses in comparison (Reschovsky & Staiti, 2005). Many rural areas have great difficulties attracting and maintaining physicians. In many cases, a rural community may only have a midlevel and or a physician that comes only once a month for patient visits (Reschovsky & Staiti, 2005). Therefore, nursing staff are expected to be nursing generalist and function under any circumstances (Winters & Lee, 2010). In a society where nurses maintain such responsibility and work under stressful circumstances, an environment of hostility may be produced (Randle, 2003). Thus, nurses in the rural setting may have an increased incidence of DB in comparison to its urban counterpart due to working in an environment with limited resources and challenging conditions. However, these results may also merely reflect that nurses see

more nurses on a daily basis in comparison to physicians, and therefore perceive an increased occurrence of DB in their colleagues.

In 2007, researchers found that 80% of health care workers surveyed, had personally experienced intimidation from a physician (Evans, 2007). In a nationwide study examining disruptive behavior, 96% of nurses indicated that they had experienced or witnessed a hostile work environment (Schmalenber & Kramer, 2009). Rosenstein & O'Daniel also found that 77% of healthcare respondents reported they had seen or been affected by DB (2008). However, physicians are not solely responsible for disruptive behavior; nurses have had a long history of interpersonal conflict in the profession. In a study analyzing the occurrence of nurse disruptive behavior, researchers found that over 50% of participants had experienced DB from other nurses (Randle, 2007). This study illustrates the frequent occurrence of such behavior in both physicians and nurses that has been demonstrated in the literature. For example, one participant stated:

I am very concerned with the horizontal violence that continues to occur on my unit between nurses and nurses and nurses and physicians. Even though education has been distributed about the importance of positive team-work and fighting negative work environment, nothing has changed.

Another participant stated:

I believe that physician disruptive behavior can cause more adverse events, however; I believe nurse disruptive behavior is much more prevalent in our hospital setting. I believe that this behavior can cause nurses to change jobs just because of staff dynamics and bullying.

These quotes illustrate both the occurrence and negative effects of disruptive behavior on staff interaction and environment. Nursing is considered a nurturing profession, however;

“it is paradoxical that within a discipline that has caring for others as its main focus, employee relationships are so poor” (Ferrell, 1997, p. 507).

This study also evaluated the setting in which disruptive behavior occurs the most. Nurses were asked if there was a particular setting or specialty in which disruptive behavior was present: 72.7% of nurses answered the ED, 38.6% indicated the ICU, and over 35% selected the medical and surgical units. The majority of participants, 78.6%, selected Cardiology as the specialty where DB is most often displayed.

The ED serves as a place full of unscheduled appointments, trauma, critical patients, lack of appropriate staff, and crowded waiting rooms (Rosenstein & Naylor, 2011). This environment has the appropriate features to breed disruptive behavior. In fact, in a recent study performed by Rosenstein and Naylor, 57% of participants observed disruptive behavior in the ED. Also, 54.7% of nurses witnessed disruptive behavior in ED nurses while participants observed 52.6% of physicians displaying DB (Rosenstein & Naylor, 2011). Some disruptive behavior specialists have speculated that DB is high in areas with increased stress, possible life and death consequences, and chaos, such as the ED or Cardiology department (Rosenstein & Naylor, 2011). This particular study coincides with Rosenstein & Naylor’s findings on the high occurrence of DB in the ED setting. One participant recollected several disturbing events in the ED:

1. An ER nurse telling a Native American pt to "F" off.
2. An anesthesiologist biting my head off for a simple question being asked.
3. An OB physician yelling loudly at a nurse at the nurse’s station. This was a common occurrence.
4. An ER physician and a Hospitalist having a loud argument in the middle of the ER.
5. A Cardiologist biting my head off when food was offered to his team. They spent most of the day here on their day off.

Also, another respondent stated, “We have a cardiologist that is constantly rude and disrespectful to nurses. Yet even though many nurses have made reports about his inappropriate behavior, nothing changes.” Lastly, a respondent reflected on an ED physician saying: “There is an ER physician who is absolutely rude to most everyone, patients, nurses, other clinicians.” The aforementioned responses illustrate specific examples of DB in the ED environment. Although the critical access hospital does not have an ICU, the three top areas where DB occurred the most frequently was in the ED, ICU, and Cardiology. Each of these areas has high patient acuity, critical interventions, and extreme environments, which increase stress levels and increase the possibility of DB occurring.

The occurrence of disruptive behavior is not new to the healthcare setting, however, the acknowledgment of such behavior has improved. Nevertheless, this study in addition to recent literature regarding DB imply that disruptive behavior continues and may be increasing in certain areas of healthcare.

Research Question #2:  
Disruptive Behavior and Adverse Events

Nurses in this study perceived a strong link between disruptive behavior and adverse events. Specifically, participants acknowledged that the occurrence of DB leads to increased adverse events, decreased patient safety, and increased medical errors. Responses to multiple open-ended questions demonstrated the significance of DB. When participants were asked about the potential of adverse events resulting from DB, more than 60% of nurses thought the potential existed. Below are recorded as reported

examples of participants' experiences with DB from open-ended questions within the survey:

1. I feel that disruptive behavior has many negative effects on both the staff and patient environment. If a nurse is scared to call a doctor, then a patient's life or well-being may be at high risk. Also, in our hospital nurse-nurse disruptive behavior happens often. Instead of outright verbal abuse, most of the abuse takes place through passive aggressive behavior, such as not helping the other nurse with tasks, or criticizing and monitoring everything a nurse is doing with her patients. Hopefully in the future a change can be made. Healthcare workers have to work closely to effectively care for patients. If this bond is broken both staff and patient relationships suffer.

2. There are some physicians that nurses' cringe when they have to call; no matter the reason for the call. This is detrimental to patient safety and makes it even more difficult to communicate effectively.

3. I believe that this is a very important issue that needs to be addressed in the healthcare setting. I see it too often, especially nurse-nurse. I believe patients suffer when nurses are abusive to each other, because the nurse may then be distracted, have a negative attitude, or be afraid to ask for help.

4. RN did not call MD because of past disruptive behavior incidences. MD was very rude and verbally abusive. Patient suffered because of my fear to call the MD.

5. When working on nights, there is one doctor I am terrified of calling. Every time I call him he either calls me an idiot and gets angry at me for calling at three in the morning. Even if his patient is not doing well, it takes courage for me to call the physician and usually he is so busy undermining me, that he refuses to give any orders for the patient.

6. On call physician did not want to come in to assess a patient with SOB, they said they would be in the morning. Patient had to be bagged and intubated because lack of response by the doctor.

7. There is one specific doctor who constantly has run ins with RNs and is constantly displaying disruptive behavior. Most RNs including myself wait the entire night shift until the next doctor is on to call for an order. This has caused a decrease in medical safety for the patients, because they do not get what they need until 12 hours later.

8. While performing a code, the physician yelled for me to initiate 4 L of fluid into the patient. The patient was already fluid overloaded, so I was concerned about this order. After initiating the first liter, the patient went into PEA, the physician then yelled out to give epinephrine. At this point, I spoke out and asked the physician if he was sure he wanted to give epinephrine in PEA. The physician looked at me and angrily yelled, 'you moron, you do what I tell you, you are just a nurse. I will do my job and you do yours, Dammit.' At this point, two other nurses stood behind my refusal to give epinephrine and instead continue CPR. The physician was so upset he left the code. The patient did not survive in the end, however, I felt I did the correct action. I will never have a civil relationship with this physician again. He continues to ignore me at work, and refuses to answer any of my questions.

9. I was afraid to ask a nurse to help to lift a patient in the ICU, because she was always bullying me and criticizing my practice. Therefore, I lifted this patient on my own causing a labral tear in my right hip. I am just recovering from surgery.

10. My patient was deteriorating in the ICU. I called the MD twice letting them know that the patient was having difficulty breathing, SOB, and decreasing BP. I asked the MD to come down and assess. He proceeded to let out a laugh and asked me if I had any idea how busy he was. He told me to be a nurse and put O2 on the patient (which I had already done) and give them a fluid bolus. I told the physician that I believed they needed more interventions, the physician told me to do my job and be a nurse and let them do theirs. The patient then decompensated, a code was called, patient was intubated, and died 4 days later of aspiration pneumonia.

11. Pt had a decline in status, notified physician, who focused more on being upset with being called. Pt continued to decompensate, requested physician at bedside, physician hung up on RN. Then called back screaming at nurse. Pt ended up in resp. failure-coded and was intubated. Physician in question came down for code and

was yelling at nurses stating compressions were not fast enough or deep enough. Then physician proceeded to berate staff for following ACLS incorrectly when ER physician was at bedside directing code. Physician was asked to step outside pt's room and eventually calmed down. Event was reported and physician has not been asked back to this facility.

12. While working in the ICU, I called a cardiologist to report a very elevated troponin as required by the hospital and the patient situation. The cardiologist yelled into the phone "You idiot I know the troponin is elevated, I will come in the morning. Don't call me again!" Two hours later the patient died of a fatal MI. I feel that this would have been prevented if the cardiologist would have given me an opportunity to speak. If he would have come in and performed a heart catheterization, when I called, the patient most likely would have lived. I was terrified to call the cardiologist back, when really my most important job was to advocate for the patient, no matter the consequence to me.

Such responses illustrate the negative effects of DB within the rural healthcare setting. Although, these results represent only the nurses' perspectives from specific hospitals in Montana, such results imply the significance of DB. According to the Institute of Medicine (IOM), "As many as 98,000 people die each year from medical errors that occur in hospitals" (Kohn, Corrigan, & Donaldson, 2000, p. 1). In the IOM's report, "To Err is Human," experts examine the amount of medical error that result in both adverse events and potential adverse events. The IOM acknowledges disruptive behavior as one of the causes of such events, and proposed solutions to addressing such behavior (Kohn, Corrigan, & Donaldson, 2000). This particular study reinforces the implications of disruptive behavior reported from the IOM. In another study conducted on Washington Labor and Delivery units, researcher found that 53% of participants witnessed adverse outcomes related to disruptive behavior (Veltman, 2007). Saxton, Hines, & Enriquez found that over 50% of respondents reported decreased patient safety

and increased error related to disruptive behavior (2009). Other research has also illustrated the detrimental effects of DB. These responses and perception of DB on patient safety similarly compare to the results Rosenstein and O'Daniel described. In their study, sixty-seven percent of participants directly correlated disruptive behavior with identified adverse events and medical errors (Rosenstein & O'Daniel, 2008). One respondent stated "disruptive behavior results in medication errors, slow response times, and treatment errors" (Rosenstein & O'Daniel, 2008, p.61). In this present study, over 60% of participants correlated DB with adverse outcomes and medical errors. Such results in comparison to Rosenstein and O'Daniel illustrate that DB affects the rural and urban populations similarly.

### Research Question #3: Psychological and Behavioral Effects of Disruptive Behavior

One of the main goals of this study was to assess the effect of disruptive behavior on psychological and behavioral variables such as stress, frustration, loss of concentration, and decreased teamwork. The results illustrated a negative perceived link between disruptive behavior and psychological and behavioral variables in the health care setting. Over 97% of respondents indicated that disruptive behavior caused them stress, frustration, and loss of concentration. Additionally, 100% of nurses specified that disruptive behavior produced reduced team collaboration, reduced communication, and impaired RN/MD relationships. Rosenstein and O'Daniel's research illustrated similar results. In their research, nurses answered that disruptive behavior affected stress (95%), frustration (95%), and loss of concentration (85%) (Rosenstein & O'Daniel, 2008).

Furthermore, over 91% of nurses indicated that disruptive behavior also effected team collaboration, communication, and impaired relationships (Rosenstein & O'Daniel, 2008). Both studies illustrate the severe effect disruptive behavior has on healthcare professionals. No matter the setting, DB can have negative consequences on staff environment and outcomes.

In 2007, Veltman conducted a study, which suggested that 39% of nursing respondents had reported changing or transferring out of their unit to avoid disruptive behavior. In addition, Rosenstein (2002) found that 30% of nurses had or knew of someone who had left their nursing position related to disruptive behavior. In this present study, one respondent reinforced this concept stating:

On our unit, we have had three nurses quite due to negative staff milieu. There are a couple of nurses who are rude, passive aggressive, demeaning, and manipulative. Their behavior is never addressed and nothing has changed even with reporting such behavior. Therefore, incredible nurses left because of ill feelings, increased stress, hurt feelings, and inability to function in such a negative environment.

In addition, an interesting finding was illustrated in one participant's response that suggests the rural effects of DB. This nurse stated,

Working in such a small setting, disruptive behavior does not occur to frequently, however; when it does occur, it is severe. When a physician or midlevel gets angry at me for forgetting to enter an order, or not report a lab value to them, it is very embarrassing. Usually it is in front of patients or other nurses. I always feel ashamed whether I was in there right or not.

Such statements reflect Rosenstein's (2002) findings that disruptive behavior can be linked to decreased nursing retention, reduced nursing satisfaction, and may lead to a negative work environment. Other participants also reflected on their experiences with

Disruptive Behavior below:

1. I am a new RN. Older more experienced RNs are demeaning and rude to me. There are many ways to perform one task correctly in nursing. If I do it different then they are used to, I am mocked and told that I am doing it all wrong.
2. Disruptive behavior in both doctors and nurses can cause frustration and increases the chance of medical errors to occur.
3. Being belittled in staffing in front of 12 other staff members of which we 2 have quit & one is going to [when referring to DB].
4. Seems as though behavior is something to gossip about, not something that is dealt with directly.
5. Nurses have changed shifts from day to night to avoid certain nurses and physicians. I personally changed because of a passive aggressive nurse on days and a disruptive, verbally abusive cardiologist.

Such statements are powerful indicators of the negative effects of disruptive behavior. These findings suggest that DB can potentially be responsible for decreased retention and satisfaction of nurses. Also, DB can cause damaging psychological effects such as depression, stress, anxiety, and frustration. Not only does disruptive have a damaging effect on patients, this effect extends to nurses' satisfaction.

#### Reporting Disruptive Behavior

This particular study evaluated the barriers to reporting disruptive behavior in addition to assessing organization disruptive behavior policies. Specifically, 50.9% of respondents implied that their facility had a code of conduct or policy for handling disruptive behavior. Of these respondents, 73.2% indicated that the current policy was not effective. Both of these questions had open-ended response sections in which employees could further expound upon their answers. One respondent stated, "I am not

aware of a reporting method, which alone proves, if one exists, it is not effective because lack of education or awareness.” In many open ended responses, the majority of nurses stated that if their facility did have a policy for reporting disruptive behavior it was ineffective or they were unaware of the policy. Another respondent reflected that her facility had a policy in place, however, she stated:

Nothing ever seems to change when problems arise regarding staff behavior. It is more of an emotional trauma to go through the process of addressing the behavior and having the potential of retaliation then just putting up with it, or avoiding it all together.

Interestingly, both hospitals surveyed had policies in place to address inappropriate behaviors. However, almost half of the nursing staff was unaware that a policy in place. This problem is also reflected in other research (Springer, 2008). Researchers suggest curbing this dilemma through suggesting that institutions make policies readily available and educate employees on the policy firsthand (JC, 2008; Springer, 2008).

However, if a facility does have a policy in place, employees may continue to choose not to report DB. Recent studies have demonstrated that victims in the healthcare profession are fearful of reporting DB due to fear of retaliation and “the stigma of being know as a whistle blowers” (Springer, 2008, p. 213). This particular study also validated such research through assessing barriers to reporting DB in the healthcare setting. Participants indicated that the “feeling that nothing ever changes” was the principal reason for not reporting disruptive behavior. Also, over 50% of respondents specified that both “fear of retaliation” and “lack of confidentiality” were barriers to reporting DB. One participant reinforced these barriers stating:

I have spoken with my supervisor about nurse to nurse disruptive behavior on our unit many times. Instead of something changing,

the supervisor broke confidentiality and spoke with the nurse who was committing rude and passive aggressive behavior and told her it was me who reported it. I was then taunted even more from the disruptive nurse for being a "tattle tail." This was very discouraging because I don't feel as though I have a safe place to report such behavior. I am currently seeking new employment after being here for 5 years because of such nurse disruptive behavior.

Another participant reflected on the challenges of reporting DB in the rural setting stating:

Working in such a small rural setting, it is very difficult to report disruptive behavior if it does happen. I would be afraid of severing relationships or having them try and get back at me. Even if a policy was in place, I am not so sure I would report it.

Such responses highlight the present barriers to reporting DB whether a policy is in place or not. These findings suggest that that when policy makers evaluate implementing a disruptive behavior policy or code of ethics, they must first evaluate how to overcome the aforementioned barriers to reporting DB.

#### Recommendations for Future Research

This study helped to validate the perceived destructive effects of disruptive behavior in the rural healthcare setting. Although multiple limitations were identified in this study, results were similar to Rosenstein's study in many ways, which utilized the same survey instrument. Overall, Rosenstein's study illustrated that 86% of respondents had witnessed disruptive behavior (Rosenstein & O'Daniel, 2008). Similarly, in both studies, over 75% of participants indicated that disruptive behavior had significant effects on patient outcomes, adverse events, and negative staff relationships (Rosenstein & O'Daniel, 2008).

This particular study demonstrates the destructive role disruptive behavior plays in the rural healthcare setting. The results of both this study and Rosenstein's research have established the occurrence and harmful effects of DB, however, the root cause of such behavior has only been speculated on in a few informal studies. Future research in this area may focus on specific triggers and causes for disruptive behavior. The John Hopkin's model used in this study as a frame work focuses on identifying triggers of disruptive behavior as the first step to approaching DB. If healthcare professionals can learn how to identify or reduce triggers the occurrence rate of DB may ultimately be decreased (Walrath, Dang, & Nyberg, 2011). Although triggers for disruptive behavior may be individual, understanding how the behavior develops would help individuals acknowledge what the behavior is and how to identify it.

Another implication for future research may include the field of Advanced Practice Registered Nurse (APRN). Future research could assess APRNs perception of the ramifications and occurrence of disruptive behavior in the healthcare setting. Especially in rural settings, APRNs hold many leadership positions, run privately owned primary care clinics, and work with interdisciplinary teams on a regular basis. If APRNs perceived a similar occurrence of DB as RN's, this may suggest that no matter the setting or position in healthcare, DB will occur. If APRNS did not perceive similar occurrence and ramifications of DB, then the setting and position of APRNs versus RNs may be assessed to see if the healthcare setting has an effect on the occurrence of DB.

An interesting study could be performed on the occurrence of DB in physicians versus APRNS, or just APRNs. In a study examining the occurrence of disruptive behavior between physicians, researchers found that 95.7% of respondents reported

regularly encountering physician disruptive behavior (Mustard, 2009). It would be interesting to see if there is a difference in occurrence between the two fields. The next question in this study could evaluate whether the difference in training causes DB. In many Medical Schools, students are subjected to DB from residents, other physicians, and fellow students (Colliver, Markwell, Verhulst, & Robbs, 2007). The intensity and hierarchy created in medical schools may create a mindset of superiority causing the occurrence of DB. Many APRN programs facilitate an environment of respect, learning, and teaching each other. A hierarchy is not created as residents and chief residents do not exist. The key question is whether disruptive behavior is a learned behavior from previous education/experience or if it is an intrinsic behavior.

#### Recommendations for Future Practice

This study exemplifies the occurrence and ramifications of DB in the rural healthcare setting. The results of this study may increase healthcare administrators, managers, and employees awareness of DB and the effects it has on patient outcomes and staff environment. Through establishing the harmful effects of DB, perhaps in the future, researchers could initiate an educational intervention. Implementing an educational program into an organization, which addresses how to identify, manage, and report disruptive behavior could enable researcher to evaluate the worth of such interventions. Educational classes could be coordinated and offered to help support appropriate ways of addressing and preventing DB. These classes could review developing communication skills, conflict management, and mutual respect as ways of preventing DB. According to Rosenstein and O'Daniel, "improving relationships among clinicians is the most

important factor in reducing the unwanted effect of disruptive behavior on clinical outcomes” (p. 63, 2008). The Joint Commission supports the implementation of educational classes and encourages facilities to create a code of conduct to address DB (JC, 2008). Disruptive behavior is a very sensitive subject and can be difficult to address. However, without practical education, it can decrease staff satisfaction, harm multi-disciplinary relationships, and result in adverse outcomes for patient.

In addition to education classes, if employers make an effort to institute and adopt the JC’s Leadership standard (LD.03.01.01) for establishing an effective policy and reporting system, the occurrence of DB may ultimately decrease. The organization must first draft a code of conduct that defines acceptable behavior within the institution. Once the code of conduct has been established, a policy regarding managing, reporting, and intervening must be developed. In many cases a committee is formed to create such policies and oversee the reporting process. An organizational process for safely reporting DB will reduce fear of retaliation for reporting such behavior. Once the behavior has been reported the organization needs to determine how and when to initiate disciplinary action (JC, 2008, 2011). In this particular study, over 94.3% of nurses do not report disruptive behavior because they feel that nothing will be changed or addressed. Also, over half of the participants felt that physicians or nurses who have been counseled on their behavior were unsuccessful. The organization needs to focus on creating a system for addressing behavior that will be successful and intolerant of DB, such as mediation, collaboration, and conflict resolution. A zero tolerance approach, in which administration, managers, and healthcare professionals do not tolerate DB, is advised by the JC (JC, 2008, 2011). This will help to facilitate and hold all team members

responsible for recognizing, reporting, and eliminating DB. Lastly, the organization must make an effort to educate all employees on the policies in place regarding DB. In this study, most organizations had policies in place; however, nurses were unaware of any policies regarding disruptive behavior or a code of conduct. If employees are unaware of established policies, they will be less likely to report or address DB. Establishing DB policies and educating employees will hopefully create proactive ways of acknowledging, addressing, and eliminating disruptive behavior in the healthcare setting. Therefore, a future study would be valuable to determine the effect of disruptive behavior education and policy implementation on the occurrence of DB.

Another future practice implication for APRNs is advanced education regarding disruptive behavior. APRNs are seen as leaders in the nursing field and serve as role models for nurses. As leaders, APRNs are in the position to educate other healthcare professionals about the harmful effects of disruptive behavior. If APRNs are well educated on DB and how to assess, address, and intervene, they may make an impact on other providers. APRNs are in the ideal role to educate others on the mal effects of DB. Also, through leadership and modeling how to prevent or address such behavior, APRNs may have a wide spread affect on the professionals around them.

Finally, a couple of additional practice implications include both the hiring and evaluation process of RNs. A future research study could be performed evaluating the hiring process of RNs at different facilities. An interesting question to address would be, “Are there screening tools or evaluation instruments used for assessing behavior?” Also, do employers believe that screening for DB is helpful or important in the hiring process? Examining ways to help prevent or identify DB such as assessing for it through the hiring

process may be helpful to prevent such behaviors. In addition, researchers may be interested in the process of RN evaluations after hire. If RNs have displayed DB in the healthcare setting, is it addressed during the evaluation or is it excused and not approached. In the future, can RN evaluations be helpful for addressing DB? In order to fully understand and address the complexity of disruptive behavior, both practice and research must be involved to adequately establish appropriate management guidelines for hospital practice.

### Summary

This particular study is consistent with previous studies performed in urban settings, which examined the occurrence and consequences of disruptive behavior in the healthcare setting. Both studies illustrate that the occurrence of disruptive behavior is high in both physicians and nurses in the hospital setting. However, in this particular study, rural nurses perceived a higher occurrence of disruptive behavior in nurses than physicians when compared to Rosenstein's results. In both studies, participants recognized that DB causes adverse events, decreased patient safety, and decrease staff relationships.

Although limitations to this study exist, there are important implications for future research and practice. Future research may help identify the triggers responsible for eliciting disruptive behavior in the healthcare setting. Also, if triggers are identified, health care providers can learn how to address, reduce, or avoid such triggers. In addition to identifying triggers, future research could examine the benefits of implementing education and policy programs for recognizing, addressing, and disciplining DB. If

organizations adopt the JC's Leadership standard, and implement effective policies for evaluating disruptive behavior, the incidence and effects of DB may decrease. Lastly, the APRN role can have an impact on disruptive behavior through modeling appropriate behaviors. Being in leadership positions, APRNs can educate others on the destructive effects of disruptive behavior and address procedures to address and eliminate the occurrence of such behaviors.

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APPENDICES

APPENDIX A

IRB APPROVAL

MONTANA STATE UNIVERSITY

Request for Designation of Research as Exempt from the Requirement of Institutional Review Board Review

(07/01/2011)

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THIS AREA IS FOR INSTITUTIONAL REVIEW BOARD USE ONLY. DO NOT WRITE IN THIS AREA.

Confirmation Date:

Application Number:

\*\*\*\*\*

\*\*\*\*\*

DATE: 11/4/12

I. INVESTIGATOR:

Name: Kara Addison

Department/Complete Address: Nursing Department:

710 Red Letter St.

Helena, MT 59601

Telephone: (406)-899-8488

E-Mail Address: kara.addison@msu.montana.edu

DATE TRAINING COMPLETED: 11/16/2010 [Required training: CITI

training; see website for link] Name of Faculty Sponsor: Susan Luparell, PhD, CNS, RN, Associate Professor of Nursing

II. TITLE OF RESEARCH PROJECT: An In-depth Analysis of Disruptive Behavior within the Rural Healthcare Setting.

III. BRIEF DESCRIPTION OF RESEARCH METHODS (also see section VII). If using a survey/questionnaire,

provide a copy with this application.

See Attached

IV. RISKS AND INCONVENIENCES TO SUBJECTS (also see section VII):

See Attached

V. SUBJECTS:

A. Expected numbers of subjects: 60-100

B. Will research involve minors (age <18 years)? No

(If 'Yes', please specify and justify.)

- C. Will research involve prisoners? No
- D. Will research involve any specific ethnic, racial, religious, etc. groups of people?  
(If 'Yes', please specify and justify.) No
- E. Will a consent form be used? (Please use accepted format from our website and provide a stand-alone copy. Do not include form here.) Yes, form attached.

VI. FOR RESEARCH INVOLVING SURVEYS OR QUESTIONNAIRES:

- A. Is information being collected about:
- |                                       |    |
|---------------------------------------|----|
| Sexual behavior?                      | No |
| Criminal behavior?                    | No |
| Alcohol or substance abuse?           | No |
| Matters affecting employment?         | No |
| Matters relating to civil litigation? | No |
- B. Will the information obtained be completely anonymous, with no identifying information linked to the responding subjects? Yes
- C. If identifying information will be linked to the responding subjects, how will the subjects be identified? (Please circle or bold your answers)  
-No identifying information will be used.
- D. Does this survey utilize a standardized and/or validated survey tool/questionnaire? Yes

VII. FOR RESEARCH BEING CONDUCTED IN A CLASSROOM SETTING:

- A. Will research involve blood draws? (If Yes, please follow protocol listed in the "Guidelines for Describing Risks: blood, etc.", section I-VI.)  
No

VIII. FOR RESEARCH INVOLVING PATIENT INFORMATION, MATERIALS, BLOOD OR TISSUE

SPECIMENS RECEIVED FROM OTHER INSTITUTIONS:

N/A

- A. Are these materials linked in any way to the patient (code, identifier, or other link to

IX. FOR RESEARCH INVOLVING MEDICAL AND/OR INSURANCE RECORDS  
N/A

- A. Does this research involve the use of:
- Medical, psychiatric and/or psychological records
  - Health insurance records
  - Any other records containing information regarding personal health and illness

If you answered "Yes" to any of the items in this section, you must complete the HIPAA Worksheet.

APPENDIX B

ROSENSTEIN PERMISSION LETTER

March 10, 2011

Dear Dr. Rosenstein,

I am a graduate student in the Family Nurse Practitioner program at Montana State University in Bozeman, Montana and have worked as an Intensive Care RN for two years at a small hospital in Helena, Montana. Over the years, communication and behavior within the clinical setting have been a keen interest of mine. I am very fascinated with disruptive behavior in the health care setting and its ramifications on patient care and staff milieu. While researching disruptive behavior, I have come across several of your recent studies. For my thesis, I plan to explore the effects of disruptive behavior in rural hospitals and am very interested in extending your study, "A survey of the impact of disruptive behaviors and communication defects on patient safety", to a specific target group: nurses working in small Montana hospitals. More specifically, I am curious to see if nurses within smaller hospital have similar perceptions of disruptive behavior as those in metro VHA hospitals.

I am writing to request permission to use your instrument for my study. As a part of my request, I would like free access and use of the data I collect for my thesis and any subsequent publications. In exchange for my request for free use and access, should you desire, I would agree to send my de-identified data and results to help further establish the psychometric properties of the instrument.

Thank you in advance for considering my request. I appreciate your time and look forward to your response.

Sincerely,

Kara Addison, RN, BA  
kara.addison@msu.montana.edu

March 12, 2011

Sounds great. Very interested in what you find. I continue to do a lot of work in this area moving beyond the data to what you can do about it in an effort to reduce causative factors, improve communication and collaboration, and reduce any ill effects on patients and staff. Please see my website at [www.physiciandisruptivebehavior.com](http://www.physiciandisruptivebehavior.com). Also attaching a few additional articles that just came out in the past several months. Happy to discuss with you at any time.

Alan H. Rosenstein MD. MBA  
[ahrosensteinmd@aol.com](mailto:ahrosensteinmd@aol.com)  
415 370 7754

March 17, 2011

Dr. Rosenstein,

Thank you so much for your valuable resources and information. Both your articles and website have already been very helpful. I am also very interested in efforts and strategies

mentioned in your articles to reduce causative factors and ill effects on patients.

For my thesis, may I have access and utilize your survey instrument used in "A survey of the impact of disruptive behaviors and communication defects on patient safety," and apply it to a specific target group: nurses working in small Montana hospitals? After I have implemented your survey and gather results, if granted access and permission, I would be very interested in discussing any differences between populations with you and making my results available to you as well. Also, if you agree to let me use your survey, how might I go about obtaining access and utilization for it?

Again, thank you so much for your time and consideration of my request.

Sincerely,

Kara Addison, RN, FNP

[kara.addison@msu.montana.edu](mailto:kara.addison@msu.montana.edu)  
406-899-8488

March 17, 2011

Sounds good. Survey attached

Alan H. Rosenstein MD. MBA

[ahrosensteinmd@aol.com](mailto:ahrosensteinmd@aol.com)

415 370 7754

APPENDIX C

SURVEY

## Nurse-Physician Relationship Survey: Impact of Disruptive Behavior on Patient Care

One potential consequence of disruptive behavior is its effect on collaboration and communication between physicians and nurses that may result in an adverse effect on patient care. The current survey is designed to assess the potential impact of disruptive behavior on adverse events, medical errors, patient safety, quality and other outcomes of care.

***(Survey Demographics: Please choose one in each category)***

***Clinical*** is defined as 50% or more of time spent with clinical duties

***Executive*** is defined as 50% or more of time spent with administrative duties

Title	Service	Demographics
<input type="checkbox"/> Physician (Clinical)	<input type="checkbox"/> Medical Service	<input type="checkbox"/> 19 Years or Younger
<input type="checkbox"/> Physician (Executive)	<input type="checkbox"/> Emergency Department	<input type="checkbox"/> 20-29 Years
<input type="checkbox"/> RN (Executive)	<input type="checkbox"/> Intensive Care	<input type="checkbox"/> 30-39 Years
<input type="checkbox"/> RN (Clinical)	<input type="checkbox"/> Surgical Services	<input type="checkbox"/> 40-49 Years
<input type="checkbox"/> Administration	<input type="checkbox"/> Other _____	<input type="checkbox"/> 50-59 Years
<input type="checkbox"/> Other _____		<input type="checkbox"/> 60 Years or Older
		<input type="checkbox"/> Male
		<input type="checkbox"/> Female

---

***“Disruptive behavior” is defined as any inappropriate behavior, confrontation or conflict ranging from verbal abuse to physical or sexual harassment. Please choose only one answer for each question unless otherwise stated. If you are completing the survey electronically, you can double click on any box and a prompt will appear. Under default value, click on “checked” and an X will appear in the box.***

- 1) On a scale of 1 – 10 with 10 being the most positive, how would you describe the overall atmosphere of nurse-physician relationships at your hospital?

1       2       3       4       5       6       7       8       9       10

Very negative > Barely Positive > Somewhat Positive > Mostly Positive > Very Positive

- 2) Have you ever witnessed disruptive behavior from a physician at your hospital?

Yes       No

3) Have you ever witnessed disruptive behavior from a nurse at your hospital?

- Yes       No

4). Are there any particular settings where disruptive behavior is most prevalent?  
(Check all that apply)

- ICU    OR    ED    OB    Med unit    Surg units    SNF  
 Other \_\_\_\_\_

5.) Are there any particular specialties where disruptive events occur most often? (Check all that apply)

- General Surgery    Cardiac Surgery    Cardiology  
 Orthopedics    Neurosurgery    Anesthesia  
 OB/Gyn    Other \_\_\_\_\_

5) What percentage of physicians would you say exhibit disruptive behavior at your hospital?

- None  
 1%  
 2-3%  
 4-5%  
 6-10%  
 More than 10%

6) What percentage of nurses would you say exhibit disruptive behavior at your hospital?

- None  
 1%  
 2-3%  
 4-5%  
 6-10%  
 More than 10%

7) How often does physician disruptive behavior occur at your hospital?

- Daily  
 Weekly  
 1-2 Times/Month  
 1-5 Times/Year  
 Never

8) How often does nurse disruptive behavior occur at your hospital?

- Daily
- Weekly
- 1-2 Times/Month
- 1-5 Times/Year
- Never

9) On a scale of 1 – 10 with 10 being the most serious, how serious of an issue is physician disruptive behavior at your hospital?

- 1     2     3     4     5     6     7     8     9     10

Not Serious > Minimally Serious > Somewhat Serious > Mostly Serious > Very Serious

10) How serious of an issue is nurse disruptive behavior in your hospital?

- 1     2     3     4     5     6     7     8     9     10

Not Serious > Minimally Serious > Somewhat Serious > Mostly Serious > Very Serious

11) From your perspective, do you think that disruptive behavior can potentially have a negative effect on patient outcomes?

- Yes     No

12) How often do you think disruptive behavior results in the following?

	Never	Rarely	Sometimes	Frequent	Constant
Stress	<input type="checkbox"/>				
Frustration	<input type="checkbox"/>				
Loss of concentration	<input type="checkbox"/>				
Reduced team collaboration	<input type="checkbox"/>				
Reduced information transfer	<input type="checkbox"/>				
Reduced communication	<input type="checkbox"/>				
Impaired RN-MD relations	<input type="checkbox"/>				

13) How often do you think there is a link between disruptive behavior and the following?

	Never	Rarely	Sometimes	Frequent
Constant				
Adverse Events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Errors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient safety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Quality of care	<input type="checkbox"/>				
Patient mortality	<input type="checkbox"/>				
Nurse satisfaction	<input type="checkbox"/>				
Physician satisfaction	<input type="checkbox"/>				
Patient satisfaction	<input type="checkbox"/>				

14) Are you aware of any potential adverse events that could have occurred from disruptive behavior?  Yes  No

15) If yes, how serious an impact do you think this could have had on patient outcomes?

- Not Serious  Somewhat Serious  Serious  Very Serious  
 Extremely Serious

16) Are you aware of any specific adverse events that did occur as a result of disruptive behavior?  Yes  No

b. If yes, please describe:

c. Could this have been prevented?  Yes  No

d. If yes, please describe:

19). Is there a code of conduct or policy for the handling of disruptive/ abusive behavior at your hospital?

- Yes  No

If yes, please explain:

19 a). Is the plan effective?

- Yes  No

Please explain:

20a). If you know of physicians who have been counseled about his or her behavior, on a scale of 1-10 with 10 being completely satisfied, rate the success of this process.

1     2     3     4     5     6     7     8     9     10

Not Satisfied > Minimally Satisfied > Somewhat Satisfied > Mostly Satisfied > Completely Satisfied

20b). If you know of nurses who have been counseled about his or her behavior, on a scale of 1-10 with 10 being completely satisfied, rate the success of this process.

1     2     3     4     5     6     7     8     9     10

Not Satisfied > Minimally Satisfied > Somewhat Satisfied > Mostly Satisfied > Completely Satisfied

21). Is there a non-punitive reporting environment for those who witness/experience disruptive behavior?

Yes     No

22). Are there any barriers or resistance to the **reporting** of disruptive behavior?

(Check all that apply):

- Fear of Retaliation
- Lack of Confidentiality
- The feeling that "Nothing ever changes"
- No feedback of results
- Other \_\_\_\_\_

Please explain:

Additional Comments (use additional space as necessary)

Your Title (optional) \_\_\_\_\_

APPENDIX D

NURSING DIRECTOR LETTER

Dear Nursing Director,

I am writing to ask your help with a local research study. My name is Kara Addison and I am a Family Nurse Practitioner student at Montana State University. I am conducting a research study for my master's thesis regarding disruptive behavior in the healthcare setting. I am collaborating with Alan Rosenstein, M.D. who established the JACO Sentinel Alert addressing disruptive behavior in 2008. Specifically, I am hoping to evaluate Montana nurses' perceptions of disruptive behavior and its impacts on interdisciplinary relationships, patient safety, and patient outcomes while working in small hospitals.

It would be greatly appreciated if your nursing staff could participate in this study. Listed below is information regarding my study and a letter inviting nurses to participate in the anonymous online survey. If you choose to participate, could you assist me or put me in contact with an individual at your facility who could forward all employed nurses a cover letter inviting them to participate in the survey, and the actual survey link (which I will provide). Please reply and let me know if you would be interested in participating in this study. Below is a survey link if you would like to view or participate in the survey:

<https://www.surveymonkey.com/s/VMFQ8DM>

If you have questions, please feel free to contact me at (406) 899-8488 or my thesis chair Susan Luparell at (406) 771-4459 or [luparell@montana.edu](mailto:luparell@montana.edu). Additional questions about human subject rights may be directed to Mark Quin, the director of the Institutional Review Board of Montana State University (406) 994-4707.

Thank you in advance for considering my survey request.

Sincerely,

Kara Addison  
Graduate Nursing Student  
[kara.addison@msu.montana.edu](mailto:kara.addison@msu.montana.edu)  
(406) 899-8488

APPENDIX E

SUBJECT CONSENT FORM

SUBJECT CONSENT FORM FOR PARTICIPATION IN HUMAN RESEARCH AT  
MONTANA STATE UNIVERSITY

Dear Nurse Colleague,

I am writing to ask your help with a local research study. You are being asked to participate in a research study regarding disruptive behavior in the health care setting. Your participation in this survey will help to further our understanding of disruptive behavior and its impacts on interdisciplinary relationships, patient safety, and patient outcomes while working in small hospitals. This study is being conducted as part of my thesis requirement in the graduate nursing curriculum at Montana State University. Your input in this study will further the understanding of nurse's perception of disruptive behavior in the health care setting.

I anticipate the total time to complete the questionnaire will be approximately 5-10 minutes. The anticipated risk of emotional integrity is the only noted risk as recalling emotionally challenging events related to disruptive behavior may disrupt your emotional integrity. There are no direct benefits to you. Participation is voluntary, and you can choose to not answer any question that you do not want to answer, and you can stop at anytime. You are free to decide not to participate in the study or to withdraw at any time without adversely affecting your relationship with the investigators or Montana State University College of Nursing. Your electronically completed questionnaire will serve as consent to participate. To maintain your confidentiality, no personal identifying information will be included on the questionnaires. Questionnaire data is returned anonymously and electronic responses cannot be tracked to the sender. Click on the link below to begin participation in the survey.

<https://www.surveymonkey.com/s/VMFQ8DM>

If, at any time, you have questions about the study, you may contact me at (406) 899-8488 or my thesis chair, Dr. Susan Luparell at (406) 771-4459 or luparell@montana.edu. Additional questions about the rights of human subjects can be answered by the Chairman of the Institutional Review Board at Montana State University, Mark Quinn, (406) 994-5721.

Thank you in advance for your time.  
Sincerely,

Kara Addison, RN, BA  
Graduate Nurse Student  
Phone: (406) 899-8488  
Email: [kara.addison@msu.montana.edu](mailto:kara.addison@msu.montana.edu)

APPENDIX F

COVER LETTER

Dear Nursing Colleague,

You have been invited to participate in a study regarding disruptive behavior in the health care setting. This study is being conducted as a part of the requirements for the Montana State University Nursing graduate program. Your participation in this survey will help to further our understanding of disruptive behavior and its impacts on interdisciplinary relationships, patient safety, and patient outcomes while working in small hospitals.

The survey is 22 questions and the anticipated time is approximately 5-10 minutes to complete. There are no anticipated risks or benefits with the exception of possible disruption of emotional integrity through recalling disruptive behavior. Your participation in this survey is entirely voluntary and your completion of the electronic survey will represent your consent. At any time, you may withdraw your survey without affecting your relationship with Montana State University or the Investigator.

To maintain confidentiality, no personal identifying information will be included on the questionnaire. Survey Monkey returns the survey data to the Investigator anonymously and electronic responses cannot be tracked to the sender.

If at any point should you have questions, please feel free to contact me at (406)899-8488 or my thesis chair Susan Luparell at (406)- 771-4459 or [luparell@montana.edu](mailto:luparell@montana.edu). Additional questions about human subject rights may be directed to Mark Quin, the director of the Institutional Review Board of Montana State University (406)994-9721.

Thank you in advance for considering my survey request. I am very grateful.

Sincerely,

Kara Addison  
Graduate Nursing Student  
[kara.addison@msu.montana.edu](mailto:kara.addison@msu.montana.edu)  
(406) 899-8488

APPENDIX G

REMINDER LETTER

Dear Nursing Colleague,

This is a reminder to please consider taking the survey regarding disruptive behavior if you have not already done so. A more detailed description of the study is attached. If you choose to participate, the following link will take you directly to the short survey regarding the impacts of disruptive behavior in the healthcare setting. Click on the link below to begin participation in the survey.

<https://www.surveymonkey.com/s/VMFQ8DM>

If you choose to complete the survey, your submission will imply consent and your data will be returned to me anonymously. Thank you in advance, I am most grateful for your assistance and time.

Sincerely,

Kara Addison

RN, BA, FNP student