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Intimidation and disruptive behaviors in the health care setting

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INTIMIDATION AND DISRUPTIVE BEHAVIORS IN THE HEALTH CARE SETTING

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by

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INTIMIDATION AND DISRUPTIVE BEHAVIOR

IN THE HEALTH CARE SETTING

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ABSTRACT

Intimidation and disruptive behavior can undermine patient care and cause staff dissatisfaction and turnover of professionals in the health care setting. These behaviors have been linked to patient safety issues, nurse satisfaction, nurse retention, as well as ineffective communication and collaboration (Fontaine & Gerardi, 2005; Institute for Safe Medication Practices (ISMP), 2004; Martin, 2008; Rosenstein & O'Daniel, 2005). The Joint Commission has made recommendations to reduce the incidence of disruptive behaviors. Hospitals are being asked to take responsibility, hold physicians accountable for their actions, and address workplace intimidation (ISMP, 2004; Rosenstein & O'Daniel, 2005; The Joint Commission, July 2008).

The purpose of this investigation was to examine the perception of intimidation and disruptive behaviors in the health care setting. Differences, if any, between perceptions and the frequency and effects of intimidation and disruptive behaviors was investigated. Data collected from identified variables can assist hospital administrators to understand the perceptions of intimidation and disruptive behaviors in their organizations and identify contributing factors that negatively affect those working in the health care setting.

This investigation utilized a convenience sample of nurses and administrators working in two hospital settings in a Midwest rural state. A pilot study with a sample size

of 7 and a larger convenience study with a sample size of 104 were used. This addressed the power analysis recommendation for at least 98 in the sample. This sample size will reduce the likelihood of a Type II error.

The first research questions investigated was, "What is the difference, if any, of perception of intimidation and disruptive behavior frequency among nurses with varying levels of work experience?" The second research question was, "What is the difference, if any, of perception of the effects of intimidation and disruptive behavior frequency among nurses with varying levels of work experience?"

It is hoped the results of the study will provide health care providers and administrators a better understanding of how intimidation and disruptive behaviors affect nurses, physicians, administrators, and hospitals. This will make it possible to find ways to improve collaboration and communication, patient outcomes, and relationships between health care providers in hopes that these improvements become integrated as expected professional health care practice.

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In Memoriam

Byron Joe Roblyer

January 18, 1941 *May 11, 2007*

DEDICATION

This research project is dedicated to my father, the late Byron Joe Roblyer. He left us too early, but he always encouraged me to follow my dreams and never quit. This dedication is shared with my mother, Velma Roblyer. She has amazing strength and has been extremely supportive through this incredible journey. To my children, Jessica and Bryan, who provided me with much needed distractions with all of the ball games and school activities, this is also for you.

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CHAPTER 1 – INTRODUCTION

Disruptive and intimidating behaviors can undermine patient care and cause staff dissatisfaction and turnover of professionals in health care settings. According to Rosenstein and O'Daniel (April, 2008) 77% of physicians and nurses admit to witnessing such behaviors. Intimidating and disruptive behaviors can foster medical errors, contribute to poor patient satisfaction, create adverse outcomes, increase the cost of care, and cause qualified clinicians, administrators and managers to seek new positions in more professional environments (Rosenstein & O'Daniel, April 2008).

In order to address intimidation and disruptive behaviors, the behaviors must first be defined. The Joint Commission defines intimidating and disruptive behaviors as "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" (The Joint Commission, August 2009). The American Medical Association (AMA) has a more elaborate definition. It defines disruptive behavior as "personal conduct, whether verbal or physical, that affects or potentially may affect patient care negatively" (Lazoritz, 2008). The AMA goes on to classify the behaviors into four types: intimidation and violence; inappropriate language or comments; sexual harassment; and inappropriate responses to patient needs or staff requests. Intimidation and violence include actions such as throwing objects, threatening violence, pushing or hitting others, finger pointing, and invading other's space. The most common display of intimidation is yelling. Inappropriate language or comments consist of racial slurs, profanity, and sarcasm, cynical or demeaning remarks. Sexual harassment includes jokes about sex and comments with sexual innuendo. Inappropriate responses to patient needs

for staff requests include late responses to pages, inflexible responses when asked for assistance, and writing inflammatory notes in the medical record. Disregarding policies and blaming others for adverse outcomes are also examples of inappropriate responses (Lazoritz, 2008; The Joint Commission, July, 2008).

There are some possible reasons for disruptive and intimidating behaviors in the health care setting. Physicians are expected to meet productivity demands, contain costs, and deal with possible litigation. They also have to deal with governmental oversight, managed care restrictions, and consumerism. These pressures cause physicians to feel demoralized which creates a victim mentality. Pressures can be made worse by the differences in authority, autonomy, empowerment, and roles on the health care team. Nurses are also affected by the pressures surrounding them in the health care setting. According to Lauve (2002) nurses have to deal with time demands, irregular schedules, shifting roles, and inadequate levels of compensation as compared to physicians. Changes in shifts and rotations also make it difficult for continuity of communication and trust among caregivers (Lauve, 2002; The Joint Commission, July, 2008). Contributing factors such as personalities, training, gender biases, historical behaviors, and environmental forces may not be easy to alter. However, other factors such as cultural tolerance, leadership support, policies, roles, and responsibilities can be changed (Lauve, 2002). Physician behavior was molded in school. Physicians were taught to think independently and take responsibility for their actions. This behavior creates autonomy and a domineering behavior pattern that does not promote team building and collaboration (Lauve, 2002). Historically, there has been tolerance and indifference to intimidating and disruptive behaviors. According to Rosenstein and O'Daniel (April 2008) hospitals were

reluctant to deal with disruptive physicians because physicians were not hospital employees. Physicians also generated revenue for hospitals so administrators did not want to upset physicians by telling them how to behave. Additionally, physicians were placed on pedestals because of their training and expertise. Organizations tolerated bad behavior as a way of doing business, claiming it was a minor problem with no ill effects to patients or health care providers (Rosenstein & O'Daniel, April 2008).

This investigation examined the perceptions of intimidation and disruptive behaviors in the health care setting as well as explored the relationships between years of work experience and intimidation in the health care setting.

Statement of the Problem

Intimidation and disruptive behaviors in the health care setting have been linked to patient safety issues, nurse satisfaction, nurse retention, as well as ineffective communication and collaboration (Fontaine & Gerardi, 2005; Institute for Safe Medication Practices (ISMP), 2004; Martin, 2008; Rosenstein & O'Daniel, 2005). These behaviors are the result of a longstanding hierarchical culture and have been accepted and tolerated for decades. As it becomes increasingly evident that patient safety, nurse satisfaction, and nurse retention are being affected, recommendations are now being made to reduce the incidence of the disruptive behaviors. Hospitals are being asked to take responsibility, hold physicians accountable for their actions, and address workplace intimidation (ISMP, 2004; Martin, 2008; Rosenstein & O'Daniel, 2005; The Joint Commission, July 2008). It is important to examine the scope and impact intimidation and disruptive behaviors have in the health care setting. The majority of disruptive incidents involve competent physicians who resort to poor behavior when they are under

stress. However, physicians are not the only ones who intimidate or exhibit disruptive behaviors. Nurses, patients, families, and supervisors also have been witnessed to display these behaviors. By addressing disruptive and intimidating behaviors in the health care setting, hospital administrators create a safe environment for patients, families, health care workers, physicians, and administrators. Organizations need to be committed to a culture of zero tolerance and take an active approach in addressing disruptive behaviors by increasing awareness of the harm that can result. Health care providers need to be educated on the effects of intimidating and disruptive behaviors, and policies need to be developed to establish expected standards of behavior because disruptive behaviors destroy the morale of workers, negatively affects service quality and drives away talented employees (Lauve, 2002; Rosenstein & O'Daniel, August 2008).

Addressing disruptive and intimidating behaviors inevitably increases communication and collaboration between nurses and physicians. This improvement allows for a multidisciplinary approach to patient care which could lead to improved patient outcomes.

Purpose of the Investigation

The purpose of this investigation was to examine the perception of intimidation and disruptive behaviors in the health care setting. Differences, if any, between nurses' perceptions of intimidation and disruptive behavior frequency and the years of work experience were investigated. Differences, if any, were also analyzed between nurses' perceptions of the effects of intimidation and disruptive behavior frequency and the years of work experience. Data collected from identified variables can assist hospital administrators to understand the perceptions of intimidation and disruptive behaviors in

their organizations and identify contributing factors that negatively affect those working in the health care setting. Increased understanding regarding the impact disruptive behaviors have in the health care setting will enable hospital administrators to address those behaviors that negatively impact health care workers and their patients.

Significance of the Investigation

Health care organizations are being asked to address intimidation and disruptive and behaviors by the Joint Commission. Determining care givers‟ perception of intimidation and disruptive behaviors in the health care setting, and identifying contributing factors that negatively affect those working in the health care setting provides a basis for developing policies and implementing procedures to address these behaviors.

Leaders must determine the prevalence of the problem in their organization. They can accomplish this by performing administrative rounds or by surveying their staff regarding the prevalence of the problem (Thrall, 2008). Once the magnitude of the problem is determine, project champions could be identified to represent executives, nurses, and physicians (Rosenstein & O‟Daniel, April 2008; Thrall, 2008). These project champions could work together to develop a behavioral policy or code of conduct that contains clear statements regarding the types of behaviors expected from all health care providers.

Intimidation and disruptive behaviors increase the likelihood of errors by nurses because nurses may hesitate to ask for clarification of an order or make suggestions about patient interventions in order to avoid disruptive physicians (Leape & Fromson, 2006). Additionally, exhibiting such behaviors distract physicians from their actual

responsibilities affecting their clinical judgment and performance. Finally, disruptive behaviors decrease patient confidence in their physicians and the organizations that allow these behaviors to exist. Disruptive and intimidating behaviors not only threaten patient safety but have a negative effect on staff morale, communication, and collaboration (Leape & Fromson, 2006). The information gathered in this investigation could provide insight regarding how patient outcomes are affected by intimidating and disruptive behaviors displayed by physicians and the impact the disruptive behavior has on nurses‟ decisions to interpret orders and interact with certain physicians.

This investigation could also assist future research to establish ways to improve physician-nurse collaboration and communication. Improving communication and collaboration could create a teamwork environment and a multidisciplinary approach to patient care. This could improve patient outcomes and lead to decreased length of stays for patients which could financially benefit health care organizations. Providing education regarding team building, collaboration, conflict management, time management, stress management, and phone etiquette for both nurses and physicians has been proven to be successful in improving lines of communication (Lauve, 2002; The Joint Commission, July 2008).

Theoretical Framework

King‟s Conœptual System and Theory of Goal Attainment is the theoretical framework chosen for this investigation. Imogene King‟s conceptual framework for nursing organizes around personal, interpersonal, and social systems (Frey, Sieloff, & Norris, 2002). Each of these three systems identifies human beings as a basic element of their system. The unit of analysis within the framework is human behavior in a variety of

social environments which would encompass all three of these systems (Alligood & Tomey, 2006). King further expands concepts from these three systems. Concepts related to the personal system are perception, self, growth and development, body image, learning, time, personal space, and coping. Further, concepts related to the interpersonal system are interaction, communication, transactions, role, and stress. Finally, concepts related to the social systems are organization, authority, power, status, and decision making. King (2007) provides insight into the interactions of human beings throughout these three systems (see Figure 1).

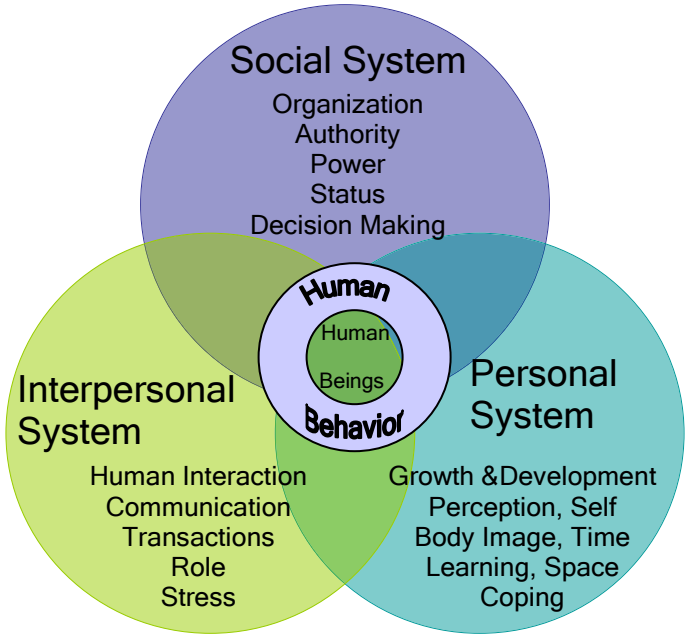

Figure 1. Schematic Model of Investigational Framework

Adapted from "King"s Conceptual System and Theory of Goal Attainment: Past, Present, and Future," by Frey et al. (2002). *Nursing Science Quarterly, 15,* p.108.

Frey et al. (2002) stated nursing administration had difficulty applying nursing frameworks and theories into their practice because most nursing theories focus on nursing issues, not administrative duties. King‟s work, however has demonstrated it can be utilized in the administrative setting. King‟s conceptual system major strength is its applicability with individuals, small groups, and organizations (King, 2007).

The schematic model illustrates how intimidating and disruptive behaviors influence and interact with all three systems. As human behaviors, intimidating and disruptive behaviors affect all three systems. In the social system, disruptive behaviors affect organizations; influence decision making; and involve power, status, and authority. The interpersonal system includes human interaction and communication which could be negatively influenced by disruptive behaviors in the social system. The personal system involves perception, learning, and coping. These perceptions affect how people learn and cope with disruptive behaviors. It is evident that all three systems interact and affect one another when evaluating human behavior.

There are four concepts in King‟s Theory of Goal Attainment: perception, communication, interaction, and transaction. These concepts form the transaction process (King, 2007). According to King, when transactions are made, goals are usually obtained. Nurses must be able to interpret behavior and intervene to assist individuals and groups experiencing crisis. King‟s theory also links critical thinking to the mental aspects of judgment which are important for perception, communication, and interactions with others.

Definitions of Variables

For the purpose of this investigation, the following terms were used:

1. Nurses

Theoretically, *nurses* are licensed practical nurses or registered nurses with varied levels of education ranging from diploma to master‟s prepared who interact with physicians in a hospital setting. These interactions occur in interpersonal systems and are linked by human behaviors to personal and social systems (King, 2007). Operationally, *nurses* are defined as nurses licensed in the state of Kansas and will be operationally defined by responses marked on the Institute for Safe Medication Practices (ISMP) Workplace Intimidation Survey.

2. Intimidating and disruptive behaviors

Theoretically, *intimidating and disruptive behaviors* are defined as "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" (The Joint Commission, August 2009). Perceptions of physician disruptive behavior, and the relationships between gender, age, and education and workplace intimidation will be operationally defined by responses marked on the Institute for Safe Medication Practices (ISMP) Workplace Intimidation Survey.

3. Years of experience

Theoretically, years of experience is the number of years a person has worked in the current position identified on the survey. Years of experience will be operationally defined by responses marked on the Institute for Safe Medication

Practices (ISMP) Workplace Intimidation Survey.

4. Gender

Theoretically, *gender* is either male or female. Gender will be operationally defined by responses marked on the Institute for Safe Medication Practices (ISMP) Workplace Intimidation Survey.

5. Education

Theoretically, *education* is the type of degree obtained based on the completion of degree requirements. These degrees could include high school, associate‟s degree, bachelor‟s degree, master‟s degree, doctorate degree, or medical school. The operational definition will be defined by responses marked on the Institute for Safe Medication Practices (ISMP) Workplace Intimidation Survey.

Research Questions

The first research question investigated was, “What is the difference, if any, of perception of intimidation and disruptive behavior frequency among nurses with varying levels of work experience?” The second research question was, “What is the difference, if any, of perception of the effects of intimidation and disruptive behavior frequency among nurses with varying levels of work experience?”

Assumptions

1. Nursing involves interactions between nurses and physicians.
2. Errors can negatively impact patient outcomes.
3. Nurses prefer to work in pleasant environments.
4. The responses on the questionnaire will be answered honestly and to the best of the respondents‟ abilities.

5. Responses will be reported anonymously.

Delimitations

1. Respondents will be from a small non-profit hospital in a Midwestern state.
2. The sample is a small convenience sample.
3. Since the study focuses on disruptive behavior, respondents who have never experienced or witnessed these behaviors will be excluded.
4. Data collection will include questions to determine respondents‟ experiences with disruptive behavior. Respondents may be asked to answer additional questions based on these experiences.

Limitations

1. Since responses will be voluntary there is potential for the results to be biased because those that are the most interested in this topic will be more inclined to participate in the survey.
2. Generalizing results from this study to populations that are demographically different will not be possible.
3. Although it is assumed that all responses will be honest and anonymous, the possibility remains that some responses may not be honest due to fear of retribution.
4. The survey is limited to nurse and physician interactions.
5. Findings cannot be generalized to larger hospitals or urban hospitals.

Summary

Investigations must occur to identify relationships between the perceptions of health care providers and the variables that affect these perceptions. Intimidation and

disruptive behaviors create hostile work environments and have been shown to affect both patients and health care providers. Additionally, health care administrators are now faced with new responsibilities since The Joint Commission added new leadership standards to address these behaviors. Health care administrators who ignore these behaviors expose themselves to litigation from both employees and patients. The information gained from this investigation will benefit hospital administrators as they strive to better understand how these relationships affect the perceptions of health care providers.

A statement of the problem, purpose and significance of the investigation, theoretical framework, definitions of variables, research questions, assumptions, delimitations, and limitations were included in this chapter. Chapter II will provide a literature review on this topic.

CHAPTER II – REVIEW OF LITERATURE

Chapter I focused on the need to examine the perception of disruptive and intimidating behaviors in the health care setting, as well as the importance to evaluate the relationships between age, gender, and education related to intimidation and disruptive behaviors. Chapter II introduces the historical developments leading to the behaviors of intimidation and disruptive behaviors. The research available in the nursing literature concerning variables related to intimidation and disruptive behaviors in the health care setting will be examined. These variables include communication and collaboration, physician-nurse relationships, and perceptions of intimidating and disruptive behaviors. The consequences of intimidating and disruptive behaviors will be included.

Historical Developments

Historically, nurses and physicians have encountered problems communicating and collaborating effectively. This is because the disciplines of medicine and nursing have different histories, political agendas, education levels, professional identities, values, and skills (Corser, 2000; Stein-Parbury & Liaschenko, 2007). Medicine and nursing share a common history of caring for the sick, however, nurses and physicians focus on different elements in that process. Medicine is deeply rooted in the Hippocratic tradition which teaches physicians to act for the patient‟s welfare; to do no harm; to keep in confidence what is learned; and to provide help for those in need (Storch & Kenny, 2007). This prompts physicians to focus on finding a scientific cure (Corser, 2000; Sirota, 2007). Contemporary nursing development began with Florence Nightingale. According to Storch and Kenny, Nightingale focused on the importance of listening to patients, upholding confidentiality, and putting patients‟ needs first. Nurses focus on caring and

are expected to be loyal to physicians, hospitals, and patients. These differences make effective communication and collaboration difficult between nurses and physicians. For example, physicians become impatient and rude on the phone when nurses call regarding a patient‟s condition and take forever to get to the point. This is because nurses are taught to describe conditions in detail, and physicians are taught to focus on specific issues.

Understanding the history which makes it difficult for nurses and physicians to communicate and collaborate effectively is helpful when studying intimidation and disruptive behaviors. However, it is still unclear why intimidation and disruptive behaviors are allowed to continue. Nurse and physician researchers have been studying intimidation and disruptive behaviors for years. Their studies strive to describe the perceptions, reasons, and consequences of these behaviors.

Helen C. Cox conducted a study on verbal abuse in nursing in 1987. She studied the incidence of verbal abuse and how it affected nurse turnover rates. She also sought to identify the major sources of verbal abuse. When discussing her findings on verbal abuse, Cox (1991) stated, “Verbal abuse is so prevalent in nursing that it is surprising any of us stay in nursing.” Cox performed another study in 1991 that examined oppressed group behavior to determine if managers and administrators were promoting submissiveness in the workplace. This study revealed that staff nurses and administration differed significantly when describing leadership styles. The study also showed that administration‟s support affected a nurse‟s decision to resign due to verbal abuse.

In 1999, The Institute of Medicine (IOM) report on medical errors titled *To Err is Human* gained attention from health care providers, health care organizations, patients,

and policymakers. This report revealed that 44,000 – 98,000 deaths occurred per year as the result of medical mistakes (Wachter, 2004). This was shocking because many people believed that as health care became more specialized and technology driven, quality and efficiency were improving as well. Obviously the report *To Err is Human* revealed much different results. This report, however, did make the dangers the patients face public and changed the focus of error prevention from punishment to system redesign (McCauley & Irwin, 2006). The IOM attacked the dysfunctional processes of the past and current health care system and called for a revolution in creating effective team performance and improved communication among health care professionals (McCauley & Irwin, 2006).

The *Silence Kills* study was conducted in 2005 by VitalSmarts and the American Association of Critical-Care Nurses. It revealed that more than three-fourths of caregivers regularly work with doctors or nurses who are condescending, insulting, or rude. This behavior is hurtful, but more importantly there is mounting evidence that these behaviors are also harmful. The study revealed that more than 20% of health professionals have seen actual harm come to patients as the result of such behaviors (Grenny, 2009).

Intimidation and disruptive behaviors have been studied for many years. Many of the suggestions for improving the situation are still applicable today. Why is it important to continue to study these same behaviors? These behaviors must be studied so they can be adequately understood and appropriately corrected. Studies continue to reveal an alarming increase in patient safety issues as the result of intimidation and disruptive behaviors. Research indicates patient safety issues can be improved by improving communication and collaboration and addressing intimidation and disruptive behaviors.

Communication and Collaboration

Communication with physicians is a significant component of nursing practice. Frequently, communication involves critical and emotional patient care situations. Successful collaboration helps physicians and nurses to communicate more effectively and allows them to find solutions to patient care issues. Review of literature reveals a significant relationship between collaboration and patient outcomes (Arford, 2005; Van Ess Coeling & Cukr, 2000; Narasimhan, Eisen, Mahoney, Acerra, & Rosen, 2006; Stein-Parbury & Liaschenko, 2007). Collaboration improves quality of patient care and decreases patient mortality while increasing job satisfaction and improving nursing morale by making nurses feel respected and valued (Kramer & Schmalenberg, 2003; Rosenstein & O'Daniel, 2005; Tschannen, 2004). By improving patient outcomes, patients'' length of stay also decrease which financially benefits health care organizations.

Physician and Nurse Relationships

There are differences in communication styles between nurses and physicians that can lead to a breakdown in collaboration and affect the way nurses and physicians relate to one another. These differences include gender, education, and status (Sirota, 2007). Gender traditionally gives males higher rank and status than females. Gender differences actually originate in childhood. Girls learn early on that acting too sure of themselves will make them seem bossy. They learn to influence groups by making suggestions rather than giving orders. Boys, on the other hand learn to strongly state their opinions to see if anyone will challenge them (Greenfield, 1999).

There are numerous past and present educational differences between physicians and nurses. Traditionally, medical training discouraged physicians from admitting fault

while nurses‟ training encouraged nurses to be subservient (Evans, 2007). However, as nursing education progressed from the hospital setting to the university setting, women found more intellectual stimulation and the powerful voice of feminism (Greenfield, 1999). As nurses began to improve their education, their desire to contribute more to patient care increased. Nurses learned to make recommendations in ways that physicians believed the ideas were their own.

Today, physicians and nurses continue to be educated differently. According to Rodgers (2007), nurses are taught to communicate descriptively and physicians are taught to be concise. When nurses talk to physicians on the phone, nurses describe everything in detail as physicians impatiently wait for them to get to the point. This often results in the physician being rude and blaming the nurse for not knowing what is going on. Negative emotions make communication even more difficult which leads to misunderstanding, errors, and conflict (Fontaine & Gerardi, 2005; Sheldon, Barrett, & Ellington, 2006). Physicians feel nursing is subordinate to medicine so they expect nurses to follow physician orders without question. However, nurses have legal, professional, and moral obligations to question and refuse to carry out unsafe orders (Arford, 2005; Evans, 2007). According to Evans, nurses discovered 86% of medication errors made by physicians before the medication reached the patient. The American Association of Critical Care Nurses notes, “A significant gap exists between what nurses are accountable for and their ability to participate in decisions that affect those accountabilities” (Evans, 2007).

Other issues that negatively affect physician-nurse communication and collaboration are the different ways hospitals treat nurses and physicians. Hospitals regard physicians as high-status customers with the premise the customer is always right

(Arford, 2005). This allows physicians to make demands with administrators. Nurses, on the other hand, are employees of the hospital and are expected to comply with administration‟s rules and regulations. Physicians are also accustomed to dictating what they want which contributes to poor communication (Dracup & Bryan-Brown, 2003). Sirota (2007) states poor communication will continue to exist as long as physicians view their roles as more superior and firmly in charge. Nurses are expected to defer to physicians when making decisions even though nurses are educated professionals who regularly offer advice regarding patient care. Deferring to physicians may initially prevent conflict, but it ultimately creates bad communication. Nurses see the broader health care picture, and they strive for consensus on how to best care for their patients. Physicians focus on justice, desire to rule out alternatives while looking at factual and measurable information, and are concerned about the scientific process to cure the disease (Cobanoglu & Algier, 2004). Nurses are concerned about the care aspect and the life experiences of the patient (Arford, 2005; Lindeke & Sieckert, 2005; Stein-Parbury & Liaschenko, 2007).

Perceptions of Intimidation and Disruptive Behaviors

Intimidation and disruptive behaviors have a negative impact on nurses and patients. Disruptive behavior contributes to workplace stress and burnout and is one of the most important influences on the quality of staff relationships (Rosenstein & O‟Daniel, 2005). According to Sirota (2007) more than a third of nurses were aware of other nurses who left the workplace because of physician behavior. Other nurses reported they have delayed care because they were too scared to call the physician (Rodgers, 2007). Physician intimidation makes it difficult for nurses to confront physicians on

important issues for fear of retaliation or lack of confidence that confrontation would help the situation (Evans, 2007). A nurse who is intimidated is reluctant to question orders which can lead to an adverse event that otherwise could have been avoided. The inability to have conversations regarding concerns about competence and ineffective behaviors indicates a lack of trust in health care settings (Fontaine & Gerardi, 2005). Organizations that protect physicians who demonstrate intimidation and disruptive behaviors contribute to unsafe care for patients and unhealthy work environment for nurses (Fontaine & Gerardi, 2005).

It is obvious that intimidation and disruptive behaviors should be addressed. However, it is not a simple process. This is because social influence is powerful. No matter how motivated people are to behave in certain ways, more often than not, people will give in to peer pressure. People will do almost anything to avoid rejection or gain acceptance (Grenny, 2009). Confronting bad and abusive behavior is difficult for most people because confrontation is difficult. As a result, many people choose to say nothing. Silence has become socially acceptable in the health care setting. According to Grenny, if health care organizations want to improve patient outcomes, administrators must change this culture of silence. Caregivers need to be given the knowledge and skills to speak up when inappropriate behavior emerges.

Critique of Research Studies

There are numerous journal articles written about communication and collaboration as well as relationships between nurses and physicians. Additionally many journal articles are available regarding intimidation and disruptive behaviors. However, research is somewhat limited in these areas. Fifteen research articles will be reviewed.

Seven studies examined communication and collaboration while also evaluating nurse-physician relationships, and eight studies investigated intimidation and disruptive behaviors. Early studies involving intimidation and disruptive behavior are reviewed to provide a historical background for this investigation. The earlier studies refer to intimidation and disruptive behaviors as verbal abuse.

Communication and Collaboration

Review of the literature revealed many studies involving communication and collaboration with seven of those studies being selected for this review. One study examined the effects communication had on patient outcomes and employee satisfaction, while two studies examined the nurses‟ and physicians perceptions of nurses and physicians of the effectiveness of communication and collaboration, and four studies examined variables affecting communication and collaboration and the impact they have on communication and collaboration.

The first study in this review examined The Joint Commission on Accreditation of Healthcare Organizations‟ suggestion that communication is a key component to avoid errors and other issues in health care. Maxfield, Grenny, McMillan, Patterson, and Switzler (2005) used a convenience sample (N = 1,700) to identify categories of conversations that are difficult, but essential for those in health care to master. The respondents included 1,143 nurses, 106 physicians, 266 clinical-care staff, and 175 administrators during 2004. The study showed that the conversations related strongly in the areas of medical errors, patient safety, quality of care, staff commitment, employee satisfaction, discretionary effort, and turnover. The concerns were then grouped into seven areas: broken rules, mistakes, lack of support, incompetence, poor teamwork,

disrespect, and micromanagement. Respondents were then asked to indicate the percentage of their coworkers with whom they had concerns. In regards to broken rules 84% of physicians and 62% of nurses and other clinical providers saw their coworkers take shortcuts that could be dangerous to patients. The median was 10%. When evaluating mistakes 92% of physicians and 65% of nurses and other clinical providers worked with people who have trouble following directions. Eighty-eight percent of physicians and 48% of nurses and other clinical providers saw their colleagues show poor clinical judgment. The median was 10%. In regards to lack of support 53% of nurses and other clinical providers reported their coworkers were reluctant to help, impatient, or refused to answer questions; 83% reported their coworkers complained when they had to help; 76% reported providing emotional support to other coworkers; and 64% said their coworkers picked up a share of the work when they needed help. In terms of incompetence 81% of physicians and 53% of nurses and other clinical providers had concerns about the competency of other nurses; 68% of physicians and 34% of nurses and other clinical providers had concerns about the competency of other physicians. In regards to poor teamwork 88% of nurses and other clinical providers had one or more teammate who gossiped or divided the team; 55% had a teammate who looked good at the expense of others. When evaluating disrespect, 77% of nurses and other clinical providers worked with someone who was condescending, insulting, or rude. Thirty-three percent worked with people who were verbally abusive. In terms of micromanagement 52% of nurses and other clinical providers worked with people who abused their authority by pulling rank, bullying, threatening, or forcing their point of view on them.

The study focused in detail on three of the seven categories of conversations:

incompetence, poor teamwork, and disrespect. According to Maxfield et al. (2005) significant correlations were discovered between people who are confident in their ability to have crucial conversations and positive outcomes for patients, the hospital, and themselves. When studying incompetence, there was a correlation between nurses and other clinical providers who are confident in their ability to confront people and better patient outcomes, $r = .336$, $p < .001$. Another correlation in regards to incompetence was found between nurses and other clinical providers who are confident in their ability to confront people and their intentions to stay in their unit and hospital, $r = .335$, $p < .001$. The most significant correlations were discovered when the researchers studied poor teamwork. A moderate correlation was found between nurses and other clinical providers who are confident in their ability to confront people and their morale, $r = .465$, $p < .001$. Researchers looked at disrespect or abuse and the correlations between nurses and other clinical providers who are confident in their ability to confront people and workplace satisfaction, $r = .271$, $p < .001$.The strength of the study was that it studied variables included in this current investigation. The limitation to this study was there was no mention of validity and reliability.

The next two studies of this literature review involve the perceptions of nurses and physicians in regards to communication. Both of these studies revealed that physicians perceived communication to be better than nurses did. Greenfield (1999) conducted a study regarding the differences between nurses‟ and physicians‟ attitudes and the effects they had on communication. The researcher developed the survey with his research associate and two nurses. The 15-question survey was given to the faculty of the researcher‟s department; a group of vascular surgeons from ten medical centers; and staff

nurses. There were 53 nurses and 63 surgeons who responded to the survey. No mention was made regarding validity and reliability studies. A selection of the questions is presented here. When responding to the question, “Patient care communication between nurses and physicians is open and effective”, physicians had a more positive reaction than nurses ($p = 0.027$). Nurses and physicians generally agreed ($p = 0.435$) to the question, “In the documentation of patient care, there is frequent duplication of effort between nurses and physicians”. The question, “Formal disciplinary action is more likely to be sought by physicians against nurses than against other physicians” resulted in nurses feeling significantly more strongly ($p = 0.002$). There was agreement that nurses should do more, but physicians felt more strongly ($p = 0.29$) about the question, “Nurses role in patient care should go beyond following the physicians‟ orders”. The question, “Communication between male nurses and male physicians is more collegial than between female nurses and female physicians” was supported more by nurses than physicians ($p = 0.047$). Nurses and physicians were extremely different in their views regarding the question, “The major responsibility of the nurse is to serve as the patient‟s advocate” ($p = 0.0001$). The question, “The education and training of nurses and physicians should be coordinated to allow more professional interaction” received mutual support, but was significantly stronger from nurses ($p = 0.029$). Physicians thought there was less improvement in quality ($p = 0.026$) than nurses in regards to the question, “The quality of nursing has improved significantly during the past 20 years”.

Strengths of this study include the responses to the questions were statistically analyzed; however mean and standard deviation were not mentioned. Limitations include lack of reliability and validity studies. The sample size was also small. This study was

relevant for this investigation because it studied nurse and physician perceptions of various issues in the health care setting.

While nurses and physicians agreed that education and training should be more coordinated in the previous study, the next study in this review revealed a significant difference in perceptions of the quality of communication and collaboration between surgeons and nurses. It was not surprising that the perceptions were less different between anesthesiologists and certified registered nurse anesthetists (CRNAs). Makary et al. (2006) surveyed operating personnel in 60 hospitals using the Safety Attitudes Questionnaire. The survey was refined from the Intensive Care Unit Management Questionnaire. It was developed and validated to measure teamwork in the surgical setting. A total of 2,135 surveys were returned from 2,769 handed out for an overall response rate of 77.1%. OR nurses had the highest response rate of 79%, and CRNAs had the lowest response rate of 67%. The respondents consisted of 222 surgeons, 1,058 operating room (OR) nurses, 564 surgical technicians, 170 anesthesiologists, and 121 CRNAs. Surgeons and anesthesiologists were predominately men with 8.6% of surgeons and 12.7% of anesthesiologists being women. ANOVA was used to test for differences in ratings of communication and collaboration among OR staff members. Surgeons, $F(4, 2058) = 41.73$, $p < 0.001$, differed significantly from OR nurses, $F(4, 2061) = 12.93$, $p < 0.001$. The differences were less significant between anesthesiologists, $F(4, 1990) = 53.15$, $p < 0.001$, and CRNAs $F(4, 1571) = 37.36$, $p < 0.001$. Physicians had the lowest ratings of communication and collaboration with 3.68 of 5.00, and OR nurses were given the highest ratings with 4.20 of 5.00. OR nurses rated collaboration with surgeons as 3.52 of 5.00 and surgeons rated collaboration with

nurses as 4.42 of 5.00.

Strengths of this study include validity and reliability tests were performed. Statistical analysis of the study was performed with statistically significant results. Additionally, the response rate was 71%. Limitations include that staff perceptions of communication can vary over time. Selection bias might have influenced results, but with a 71% response rate, it is unlikely. This study applied to this investigation because it studied the differences in perceptions of communication and collaboration between professions which affect intimidation and disruptive behaviors.

While it is interesting to examine the perceptions of communication and collaboration, it is important to examine what impacts communication and collaboration and ways it can be improved. Van Ess Coeling and Cukr (2000) studied communication styles that promote perceptions of collaboration, quality, and nurse satisfaction. The goal of the study was to identify whether usage or nonusage of three specific communication behaviors were associated with collaboration and improved quality of care and increased nurse satisfaction. The study used a non-randomized sample that included two groups. One group (n = 38) included graduate nursing students in the final seminar course in an advanced practice nursing program. The second group (n = 27) included nursing graduate students in the same course, but in another class. The study used a posttest design with nonequivalent groups utilizing a two-tailed t-test to identify significant differences in perceptions of collaboration. Participants participated in nurse-physician interactions at both ambulatory and inpatient sites at medical centers, teaching hospitals, and community hospitals. Interactions included both telephone calls and face-to-face communication. Participants were asked to indicate their perception of communication style used and

whether the outcome included collaboration, quality of care, and nurse satisfaction. Investigator-developed instruments were used. No reliability or validity studies were reported.

Findings indicated that if there was a significant difference in outcomes based on physicians usage or nonusage of communicator styles ($p = .000$). The same pattern was found when looking at nurses communicator styles, but the significance was at a lower level ($p = .001$). The major finding from this study was that usage of an attentive style and avoidance of a dominant style of communication made a significant difference in the nurses‟ perceptions of the three outcomes measured. When looking at whether there was a significant difference in how nurses perceived collaboration and whether an attentive communicator style was used or not used, findings indicated that nurse perceived physicians who used the attentive communicator style ($M = .68$, $SD = .47$), used more collaboration than physicians who did not use the attentive communicator style ($M = .36$, $SD = .48$), $t(63) = 6.13$, $p = .000$. Findings also indicated a significant difference in how nurses perceived collaboration and whether a dominant communicator style was used or not used, findings indicated that nurse perceived physicians who used the dominant communicator style ($M = .28$, $SD = .46$), used less collaboration than physicians who did not use the dominant communicator style ($M = .58$, $SD = .49$), $t(63) = -5.42$, $p = .000$.

A strength of this study is variables included in this study were included in this investigation. Strategies were also discussed to teach communication styles to healthcare providers to improve their communication skills. A limitation to this study is that other factors that influence collaboration such as gender, status, and power were not included in the study. Reliability and validity studies were also not performed on the tool that was

designed by the researchers of this study. This study applied to this investigation because perceptions of nurses, communication, and collaboration were variables in this investigation.

Tschannen (2004) also studied perceptions of collaboration, but instead of examining communication styles, this study examined the impact team orientation and organization commitment had on the perceptions of collaboration. Tschannen (2004) conducted a cross-sectional, non-experimental, retrospective study to identify the relationship among nurse and physician attitudes towards team, their commitment to their organization, and perceptions of collaboration. It was hypothesized that high levels of team orientation and organizational commitment would result in higher perceptions of nurse-physician collaboration on the work environment. The sample consisted of nurses and physicians on two surgical units in a Midwest hospital. Members on Unit A consisted of 34 nurses and 12 physicians. Unit B consisted of 37 nurses and 22 physicians. All staff members on each unit were surveyed. The survey tool used consisted of a combination of questions from a number of questionnaires: Organizational and Management in the Intensive Care Unit Questionnaire (Shortell et al., 1991), Wagner‟s Individualism-Collectivism Scale (1995), and the Organizational Commitment Questionnaire (Mowday, Porter, & Steers, 1982). Concept validity and reliability for each of the three scales were discussed. Reliability of the modified questionnaire was performed before data analysis for this study was begun. Teamwork scores were (M = 3.96, SD = 0.383) for nurses and (M = 4.06, SD = 0.264) for physicians. Commitment scores were (M = 4.07, SD = 0.45) for nurses and (M = 4.32, SD = 0.577) for physicians. The researcher created a new variable, titled overall fit, by adding the mean teamwork score with the mean

commitment score to evaluate how the degree to which teamwork and commitment levels combined affected collaboration scores. Overall fit scores were (M = 4.02, SD = 0.0295) for nurses and (M = 4.19, SD = 0.388) for physicians. Finally, collaboration scores were (M = 2.97, SD = 0.655) for nurses and (M = 3.16, SD = 0.328) for physicians. A positive relationship was found between overall fit and collaboration scores for nurses, r = .363, p = .03. A positive relationship was also found between overall fit and collaboration scores for physicians, r = .370, p = .028. As the overall fit variable increased, perceptions of collaboration increased.

A strength of this study was that validity and reliability were reported for all three of the tools used. Reliability was again measured prior to data analysis to ensure consistency among the measured items for the modified questionnaire. The response rate was also a strength. Unit A had a 71% response rate from nurses and a 56% response rate from physicians. Unit B had a 65% response rate from nurses and a 50% response rate from physicians. Limitations for this study include the inability to generalize the findings to a larger population. The study was also unable to identify the relationship between individual characteristics and perceptions of collaboration and actual behavioral attributes associated with collaboration. Also, since no instrument existed to measure what was studied, an instrument had to be created by combining three different tools. Finally, the researcher had to combine two variables to create a third variable in order to understand how teamwork and commitment affected collaboration. This study applied to this investigation because perceptions of nurses, communication, and collaboration were variables in this investigation.

In addition to examining the perceptions of communication and collaboration, the

next two studies examined different variables and the impact they had on communication and collaboration. Vazirani, Hays, Shapiro, and Cowan (2005) used an experimental design to assess the impact of a multidisciplinary intervention on communication and collaboration among physicians and nurses over a two-year period in a tertiary care hospital. Usual care was performed in the control group. A nurse practitioner, a hospitalist, and daily multidisciplinary rounds were added to the intervention group. One wing served as the intervention unit, the other served as the control unit. Attending physicians (n = 45) and house staff which included residents and interns (n = 111) were randomized to the intervention or control unit and remained in their designated group for the remainder of the study. The attending physicians were further randomized to provide educational equivalence for the house staff. Nurses (n = 123) did not change from one unit to the other during the course of the study. The nurses did not differ significantly in terms of years of experience or education so they were not randomized further for educational equivalence. Surveys were administered to the physicians and nurses to assess the degree of communication and collaboration on the two units. The physicians were surveyed immediately after the completion of their rotation. Nurses were surveyed biannually. Physicians rated communication and collaboration with nurses and nurses rated communication and collaboration with physicians. Scores were compared using 2-tailed t tests and paired t tests. Reliability was measured. Physicians on the intervention unit reported significantly higher collaboration with nurses than did physicians on the control unit with a score of 63.4 on the intervention unit versus 51.9 on the control unit ($p < .001$). Physicians did report greater collaboration with nurse practitioners than with nurses (score 71.8 vs. 63.4, $p < .001$). Nurses on the intervention unit did not differ

significantly in collaboration with physicians than did nurses on the control unit with a score of 44.9 on the intervention unit versus 46.6 on the control unit ($p < .47$). Nurses also reported greater collaboration with nurse practitioners than with physicians (score 50.3 vs. 44.9, $p < .06$). Communication with other physicians was greater on the intervention unit than on the control unit (score 80.0 vs.75.3, $p < .006$). Physicians also reported better general communication on the intervention unit than on the control unit (score 75.6 vs. 70.1, $p <.008$). The scores of the nurses on the intervention unit did not differ significantly from those of the control unit for communication with physicians (score 60.8 vs. 59.7, $p = .59$) and general communication among providers (score 63.2 vs. 61.3, $p < .39$). Nurses did report significantly better communication with nurse practitioners than with physicians (score 70.0 vs. 60.8, $p < .001$).

The strength of this study is that it is an experimental study. It showed that interventions can improve communication and collaboration between physicians and nurses. Additionally, it had 58% response rate from house staff, 69% response rate from physicians, and 91% for nurses. A limitation of the study was that there was some confusion about the role of the nurse practitioner in the study because the medical center had not employed a nurse practitioner prior to the study. To decrease the confusion, a checklist had to be created to define the role of the nurse practitioner. This study applied to this investigation because perceptions of physicians, nurses, communication, and collaboration were variables in this investigation. It was helpful to know that interventions do improve communication and collaboration as that may direct this investigation in future studies.

The final study in this review involving communication and collaboration

examined the impact training had on decreasing nurses‟ anxiety when calling physicians and improving the nurses‟ perceptions of their communication skills. This purpose of this study was to examine the implementation of a communication format titled SBAR. SBAR stands from Situation, Background, Assessment, and Recommendation. Rodgers (2007) conducted a quasi-experimental study consisting of a treatment group, but no control group, to pilot the implementation of the SBAR communication format. Nurse responses from a previous study by a different researcher indicated that disruptive behavior commonly occurred after placing telephone calls to physicians. A convenience sample of registered nurses was selected from three inpatient units. The tool consisted of 16 Likert-style items and two open-ended items. The nurses completed a pre- and post-training survey tool, and the tool was found to be reliable. A moderately strong inverse relationship was discovered between mean anxiety and mean skill scores ($p = 0.0000$). One-way ANOVA values showed significant differences between the mean anxiety scores from different nursing units ($p = 0.002$). The limitation to this study is only thirty-one surveys were returned with only nine of them including the pre- and post-training scores. In addition, one of the nursing units closed prior to post-training data collection. The strength of the study is it did indicate a strong inverse relationship between mean anxiety and mean skill scores which indicate further studies should be performed to test the effectiveness of the SBAR tool. Despite the fact that this study was unable to support the researcher‟s hypothesis, this study benefitted this investigation by indicating that education and intervention appear to affect communication between physicians and nurses.

Intimidation and Disruptive Behaviors

Review of the literature discovered several studies regarding intimidation and disruptive behaviors with early studies referring to these behaviors as verbal abuse. These studies examined the prevalence of intimidation and disruptive behaviors as well as the perceptions of the various effects of intimidation and disruptive behaviors. Cox (1987) conducted a random survey by mailing surveys to 1,000 nurses and 100 directors of nursing with response rates of 42.1% and 57.0% respectively. The survey tool was designed by the researcher to determine the incidence of verbal abuse in West Texas; assess the influence verbal abuse has on turnover rates; identify the major sources of verbal abuse; and identify the methods used by nurses to respond to verbal abuse. Content validity was determined by a panel of experts. Both nurses and directors of nursing perceived turnover rate was related to verbal abuse ($p = 0.0001$). Seventy-eight percent of staff nurses and 84% of directors of nursing listed physicians as the most common source of verbal abuse. However, the studied revealed turnover rate was not influenced by physicians, but immediate supervisors were. When evaluating the hypothesis "There is no statistically significant difference between directors of nursing and staff nurses in the frequency of verbal abuse the perceived effect of turnover and methods used to deal with verbal abuse", it was determined there were no statistically significant differences between directors of nursing and staff nurses in the frequency of verbal abuse ($p = 0.4213$) and the perceived effect of turnover. ($p = 0.2980$). However, there was a statistically significant difference between directors of nursing and staff nurses and methods used to deal with verbal abuse. ($p = 0.0341$). Predictors of success in dealing with verbal abuse were advanced education, desire to work, and job satisfaction

were statistically significant ($p = 0.0001$).

Strengths of the study include the fact that the study stated hypotheses and used *t* tests to determine differences. It was also a randomized study. Limitations include the lack of reliability studies. The study was significant as it provided a historical background for this investigation in regards to the perceptions of directors of nursing and staff nurses in the frequency of verbal abuse, perceived effects of turnover, and methods used to deal with verbal abuse.

Cox (1991) expanded the 1987 survey to identify how frequently verbal abuse occurred, its social sources, the nature of its impact on nurses, and ways to prevent its occurrences. The convenience survey consisted of 100 items and was published by *Nursing Management.* Readers of the magazine participated in the survey and consisted of nurse managers ($n = 459$) and staff nurses ($n = 709$). Correlation studies were performed on how nurses handle verbal abuse, the significant differences between nurse managers and staff nurses and the probability of resigning due to verbal abuse. No correlation was found between self-esteem and resigning due to verbal abuse ($r = -0.08$). Staff nurses and nurse managers differed significantly on submissiveness in the work setting, $X^2 (1, N = 1168) = 21.54$, $p < 0.001$. The style of nursing administration correlated positively, $r(1166) = 0.13$, $p < 0.001$, with the handling of verbal abuse. That is, the more participative the administration, the better nurses handled verbal abuse. How nurses perceived physicians value nursing correlated positively ($r = 0.14$) with how nurses handled verbal abuse. That is, the higher a nurse perceived physicians value to nursing, the more likely the nurse was to rate the handling of verbal abuse as good. Perceived levels of collaboration between nurse managers and staff nurses differed significantly,

X^2 (1, N = 1168) = 31.76, p < 0.001.

The strength of this study is that variables included in this study were included in this investigation. Limitations include that this is a non-random convenience sample. Also, no reliability or validity tests were performed. This study was significant as it provided further historical background for this investigation in regards to the differences and the correlations in perceptions of staff nurses and nurse managers.

Sofield and Salmond (2003) furthered the study of verbal abuse by using an adapted version of Cox‟s Verbal Abuse Survey to conduct a correlational descriptive study which described the experience of verbal abuse in a large multihospital system and determined the relationship of verbal abuse with intent to leave the organization. Randomized sampling was used. A thousand surveys were mailed with a 46% response rate (N = 461). Returned questionnaires were reviewed, and incomplete questionnaires were discarded (n = 4). The survey was shortened from 100 items to 40 questions. Validity was tested by five expert nurses reviewing appropriateness in measuring the concepts. Cronbach‟s alpha of 0.86 revealed good reliability. Ninety-one percent of respondents had experienced verbal abuse in the past month with the physician being the most frequent source of abuse followed by patients, families, peers, supervisors, and subordinates. Respondents agreed that 42% (n = 172) of the time, stressful events precipitated verbal abuse. More than 50% of the time (n = 238) respondents stated that verbal abuse was not related to stressful events. The Kruskal-Wallis test was used to examine verbal abuse, and it demonstrated no statistical differences between the three facilities. The majority (56%) of nurses felt unable to handle verbal abuse. When determining if verbal abuse contributed to the nursing shortage 67% (n = 273) said yes.

Pearson‟s correlation revealed weak but significant correlation between verbal abuse and looking for a new job, $r = .211$, $p < .001$. A weak but significant correlation was also found between verbal abuse and considering quitting in the next six months, $r = .250$, $p < .001$.

Strengths of this study include that validity and reliability tests were performed. This was also a randomized trial. No limitations were found. This study was significant for this investigation because it studied the perceptions of verbal abuse which was a variable studied in this investigation.

It is interesting to note only one study in this review examined contributing factors in regards to intimidation and disruptive behaviors. Anderson (2002) conducted this descriptive, randomized study that included 67 nurses. Closed and open-ended responses were obtained using the Workplace Violence Questionnaire and Demographics (WVQD) survey and the Child Abuse and Trauma (CAT) scale. The purpose of the study was to describe workplace violence events (WPVE) and contributing factors, especially a personal history of abuse. A purchased list of registered nurses was mailed out to 800 nurses with only 70 nurses responding. Three nurses returned incomplete questionnaires so they were dropped from the study. The majority of the participants were females (95.4%). The average nurse was 46 years old with over 20 years working in the profession. The majority of respondents reported a bachelor‟s of science degree (BSN) as the basic education level. Reliability studies were done of the WVQD revealing good internal consistency among items (alpha = .84). The CAT scale was found to have both internal consistency (Cronbach‟s alpha > .90) and good test-retest reliability for a 6-8 testing interval. The majority (71%) of nurses experienced emotional/verbal types of

WPVE. Nurses listed physicians as the most common perpetrators (41.3%) followed by other nurses (20.6%) and patients (20.6%). Respondents with a personal history of abuse reported more involvement in WPVE. Respondents with a personal history of abuse reported being "shouted or yelled at" more often than those without a personal history of abuse, X^2 (1, N = 67) = 5.406, p = .034. Nurses, with and without a personal history of abuse, reported similar types of emotional/verbal abuse (64.1% versus 50%). Over half (58.3%) of nurses with a personal history of abuse reported their "most bothersome" WPVE occurred in the first six years of employment as compared to 37.5% of nurses without a personal history of abuse.

Strengths of this study include that this is a randomized study. Reliability studies were also performed. Limitations include a low response rate with a large majority of respondents being female. This prevents generalization to other healthcare professionals. Additionally, this study may be biased because only those nurses most interested in abuse issues may have responded. This study is significant for this investigation as it evaluated the relationship between years of experience and the incidence of WPVE.

Review of the literature revealed an increase in the nation"s nursing shortage in 2002. This prompted researchers to discover more effective ways to recruit and retain nurses. Rosenstein (2002) and VHA West Coast conducted a convenience sample survey regarding nurse-physician relationships and the impact they have on nurse satisfaction and retention that included 720 nurses, 173 physicians, 26 administrators, and 281 who did not list their title. The survey instrument was created for the study after a literature searched failed to find an appropriate tool. The survey was emailed to each hospital asking them to distribute the survey to registered nurses, physicians, and administrators.

The survey consisted of 24 items with yes-no responses, open-ended questions, and Likert-type responses. The survey was tested internally by distributing it to twenty physician executives, various leadership councils, and a conference of nurses. Findings indicated the importance of disruptive behavior to nurse satisfaction and morale between nurses($M = 8.3$, $SD = 2.1$) and physicians ($M = 7.5$, $SD = 2.3$) was statistically significant ($p < 0.01$). The difference between physicians ($M = 7.5$, $SD = 2.3$) and executives ($M = 8.7$, $SD = 1.7$) was also statistically significant ($p < 0.05$). Tests of statistical significance were performed using a one-way analysis of variance (ANOVA). The ANOVA for the rating of the overall significance of nurse-physician relationships, $F(2, 900) = 4.452$, $p < 0.001$ indicated significant differences between nurses and physicians ($p < 0.01$) and significant differences between physicians and executives ($p < 0.05$). The ANOVA for physician awareness of the importance of nurse-physician relationships on nurse satisfaction, $F(2, 900) = 12.702$, $p < 0.0001$ indicated significant differences between nurses and physicians ($p < 0.01$) and significant differences between physicians and executives ($p < 0.05$). The ANOVA for the rating of physician value and respect for nurse input and collaboration, $F(2, 900) = 15.880$, $p < 0.0001$ indicated significant differences between nurses and physicians ($p < 0.01$) and significant differences between physicians and executives ($p < 0.05$). The ANOVA for the seriousness of disruptive physician behavior, $F(2, 900) = 6.440$, $p < 0.0001$ indicated significant differences between nurses and physicians ($p < 0.01$) and significant differences between physicians and executives ($p < 0.05$).

Strengths of this study include that statistically significant data were found in several areas regarding nurse-physician relationships, collaboration, and disruptive

physician behavior. In addition, causes of disruptive behaviors were identified in this study. Limitations include that this was a nonrandom convenience sample. It is possible that those who had witnessed intimidation and disruptive behaviors were more likely to respond than those who had not. Validity and reliability studies were also not performed. This study applied to this investigation because it studied concepts and variables in this investigation.

Rosenstein and O"Daniel (2005) conducted a study as a follow-up from the 2002 study. The purpose of the study was to examine nurses", physicians", and administrators" perceptions of disruptive behaviors for both nurses and physicians and the perceived impact the behaviors have on job satisfaction and nurse retention. A nonrandom convenience sample survey was conducted by VHA West Coast from April 2003 to January 2004 with a total of 1,509 respondents. Of those, 1,091 were nurses, 402 were physicians, and 16 were administrators. The independent variables were the perceptions of health care workers: nurses, physicians, and administrators. The dependent variables were negative patient outcomes: stress, frustration, loss of concentration, reduced team collaboration, reduced information transfer, reduced communication, and impaired nurse-physician relationships. The instrument was designed by the investigators with input from other VHA staff members and outside consultants. It included feedback from the first survey performed in 2002. The instrument was reviewed and tested internally by a subgroup of physicians and nurses from VHA hospitals to establish face validity. The survey was sent out by email to each hospital"s chief medical officer, chief nurse officer, and chief executive officer requesting them to distribute the survey to registered nurses, physicians, and administrators at their hospital. Of those that answered the question, 86%

of nurses (n = 675); 49% of physicians (n = 123); and 75% of administrators (n = 12) responded they had witnessed disruptive behaviors among physicians. When evaluating psychological or behavioral effects, 85% of physicians (n = 309); 91% of nurses (n = 957); and 94% of administrators (n = 15) felt disruptive behavior resulted in reduced team collaboration. The difference between physicians and nurses was statistically significant ($p < 0.01$). When evaluating psychological or behavioral effects, 85% of physicians (n = 208); 94% of nurses (n = 844); and 93% of administrators (n = 12) felt disruptive behavior resulted in reduced communication. The difference between physicians and nurses was statistically significant ($p < 0.01$). When evaluating the perceptions of the link between disruptive behavior and clinical outcomes, 60% of physicians (n = 222); 68% of nurses (n = 711); and 80% of administrators (n = 12) felt there was a link between disruptive behavior and adverse events. The difference between physicians and nurses was statistically significant ($p < 0.05$). When evaluating the perceptions of the link between disruptive behavior and clinical outcomes, 62% of physicians (n = 230); 73% of nurses (n = 767); and 80% of administrators (n = 12) felt there was a link between disruptive behavior and errors. The difference between physicians and nurses was statistically significant ($p < 0.01$). Significant differences between administrators and physicians and administrators and nurses were not able to be determined due to the small administrator sample size.

Strengths of this study include that surveys were received from a variety of hospital settings, and a large number of people responded. The use of charts and graphs made the results easier to understand. Another strength of the study is that definitions for adverse event and disruptive behavior were given. Limitations include that this was a

nonrandom convenience sample. It is possible that those who had witnessed intimidation and disruptive behaviors were more likely to respond than those who had not. A response rate was not able to be calculated because the study did not state the number of respondents who were sent the survey. Reliability studies were also not performed. This study applied to this investigation because it studied perceptions of nurses and physicians in the health care setting which were variables in this investigation. This study also had an instrument for measuring the perceptions of intimidation and disruptive behaviors.

While the first two studies by Rosenstein and O"Daniel focused on nurse satisfaction and retention, the third study examined the impact disruptive behaviors had on patient care. Rosenstein and O"Daniel (August 2008) and VHA West Coast conducted a third follow-up survey to assess the significance of disruptive behaviors and their effect on communication and collaboration and impact on patient care. The survey was a nonrandom convenience sample conducted from January 2004 through March 2007 with a total of 4,530 respondents. Of those, 2,846 were nurses, 944 were physicians, 40 were administrators, and 700 were other. Included in the other category were pharmacists, respiratory therapists, physical therapists, laboratory personnel, perioperative staff, and other healthcare workers. The response rate was 26% based on 388 member hospitals invited and 102 that chose to participate. The 22-question survey instrument was developed by the investigators since there was not a survey addressing the frequency, seriousness, or impact of disruptive behaviors. The survey was reviewed and tested internally by a subgroup of physicians and nurses from VHA hospitals. Surveys were field tested at Mayo Clinic Hospital and Barnes-Jewish-Christian Hospital and revisions were made accordingly. Surveys were forwarded to designated hospital contacts and

distributed accordingly. Respondents were self-selected, and completed surveys were sent to VHA West Coast for analysis.

A total of 77% of those responding to the survey reported they had witnessed disruptive behavior in physicians. Of this, 88% of nurses reported witnessing this behavior and 51% of physicians reported witnessing this behavior in their peers. The specialty most likely to exhibit these behaviors was general surgery at 28%. A total of 65% of those responding reported witnessing disruptive behaviors in nurses with 73% being nurses and 48% being physicians. When questioned about the perception of the impact disruptive behavior has on psychological and behavior reactions, 94% indicated disruptive behavior provokes stress and leads to frustration. Ninety-nine percent indicated that disruptive behaviors lead to impaired nurse-physician relationships. When asked about their perceptions to the link between disruptive behaviors and adverse events, 71% felt there was a link to medical errors and 27% felt there was a link to patient mortality. Eighteen percent reported that they were aware of a specific adverse event that occurred because of disruptive behavior that 75% felt could have been prevented.

Strengths of this study include the study had a large group of respondents. In addition, the survey instrument was reviewed and tested by prominent hospitals. Despite these strengths, there was no mention of reliability and validity studies, and the response rate was only 26%. Other limitations include the lack of statistical analysis. The study reported that data were analyzed using SPSS 15 for Windows, but the only results reported in the study were the percentages of the respondents answers. This study was significant for this investigation because it studied perceptions of disruptive behaviors by nurses and physicians in the health care setting which were the main variables in this

investigation.

The final study in this literature review examined intimidation in the workplace. Smetzer and Cohen (2005) reported on a survey conducted by the Institute for Safe Medication Practices (ISMP) regarding physician intimidation. The nonrandom convenience survey was performed in November 2003 by posting it on the ISMP website for approximately two months. The survey consisted of healthcare providers (N = 2,095). The healthcare providers were divided in three groups: nurses (n = 1,565), pharmacists (n = 354), and others (n = 176). The survey consisted of Likert-type questions and yes-no questions. Total results were differentiated by male/female, nurse, and physician. Validity and reliability studies were not performed, however, the survey was peer-reviewed for content and clarity. Respondents reported that during the past year, 88% encountered condescending language or voice intonation; 87% encountered impatience with questions; 79% encountered a reluctance or refusal to answer questions or phone calls. Almost half of the respondents (48%) reported being subjected to verbal abuse, 53% experienced threatening body language, while 4% experienced physical abuse. In addition, 69% of respondents reported being told to "Just give what I ordered". These occurrences did not appear to come from one or two difficult physicians. Thirty-eight percent of respondents reported that three to five individuals were involved, and 19% reported various occurrences with more than five individuals. Almost half (49%) reported their past experiences have altered the way they clarify orders or ask questions. Forty percent either assumed the order was correct or asked another professional to talk to the prescriber for them. Seventy-five percent have asked coworkers to interpret an order or validate its safety so they would not have to interact with the intimidating prescriber.

Almost half (49%) felt pressured to accept an order despite their concerns which lead to 7% of the respondents reporting they had been involved in a medication error during the past year where intimidation was involved. Female respondents (86%) outnumbered male respondents (14%), but only minor differences were reported in how they encountered intimidating behaviors. Nurses with less than two years of experience (n = 63) encountered intimidating behaviors less than experienced nurses. However, newer nurses had asked another professional to talk to an intimidating person more often than experienced nurses. Pharmacists (49%) reported more often than nurses (38%) that they asked another professional to talk to an intimidating prescriber about an order.

A strength of this survey includes the large number of respondents who participated in the survey. Limitations include the lack of validity and reliability studies. Another limitation includes that statistical analyses were not performed on the data obtained in this study. Only the percentage of respondents were reported. Further limitations include that less experience nurses may not have felt comfortable participating in the survey which may explain the low numbers of inexperienced nurses in the study. There also was no defined response rate so the survey findings might not be representative of health care providers in the United States. Finally, the survey asked respondents to reflect on the past year of their experiences, but there is no way to determine that respondents were able to limit their reflections to the past year. The study benefitted this investigation because the tool used in the study regarding workplace intimidation was used for this investigation.

Summary of Research

The literature review consisted of fifteen articles from 1987 to 2008.

Communication and collaboration as well as physician and nurse relationships were reviewed in seven articles, while intimidation and disruptive behaviors were reviewed in eight articles.

Literature review of communication and collaboration revealed increased communication and collaboration is related to improved patient outcomes. Several studies discovered that education improves communication and collaboration. Other studies showed nurse confidence, teamwork, and good relationships with physicians increase communication, collaboration, staff morale, and workplace satisfaction. The studies also revealed how physicians communicate affect nurses perceptions of collaboration and that physicians tend to believe collaboration exists more often than nurses. It was interesting to note that both staff nurses and physicians felt they collaborated better with ARNPs than with each other.

Studies involving nurse-physician relationships discovered differences in physicians and nurses perceptions in regards to the effects gender had on nurse-physician relationships. Differences also existed in what the nurse"s role was in regards to patient care. Physicians tended to believe communication was better between nurses and physicians than nurses. However, both nurses and physicians agreed that more education was needed to improve communication and collaboration. It was interesting to note that staff nurses and nurse administrators differed significantly in perceived levels of communication and collaboration.

Studies involving intimidation and disruptive behaviors revealed the majority of nurses have experienced intimidation and disruptive behaviors in the healthcare setting with most studies indicating physicians as the most common source. Other sources for

intimidation and disruptive behavior found were nurses, patients, families, and supervisors. These behaviors resulted in poor communication, decreased collaboration, turnover rate, nurse satisfaction, staff morale, frustration, and stress. Studies also showed that nurses, physicians, and administrators perceived these behaviors to lead to adverse events and errors. Predictors of being able to successfully handle intimidation and disruptive behaviors were advanced education, desire to work, and job satisfaction. Administrative support also appeared to be a factor in how well nurses were able to handle these behaviors.

Some differences were noted during the literature review. Those differences included whether level of experience affected whether nurses experienced intimidation and disruptive behaviors or not. Another difference was whether gender played a role in nurses‟ perceptions of their experiences involving intimidation and disruptive behaviors.

These studies showed that it is important to study intimidation and disruptive behaviors. By gaining a better understanding of how these behaviors affect nurses, physicians, patients, administrators, and hospitals, it will be possible to find ways to improve communication and collaboration, patient outcomes, and relationships between nurses, physicians, and administrators.

CHAPTER III – METHODOLOGY

A description of the methodology used for this investigation will be presented in this chapter. The research design, selection sample, protection of participants, data collection methods, instrument used, and statistical analysis plan will be discussed.

Research Design

The research design was non-experimental because there was no intervention performed. Comparative studies were performed. The data was collected once using a cross-sectional design. The perception of intimidation and disruptive behaviors in the healthcare setting was investigated as well as relationships between age, gender, and education and intimidation and disruptive behaviors. The intent of this investigation was to gain insight about intimidation and disruptive behaviors as well as the perceptions of nurses, physicians, and administrators regarding the effects intimidation. Comparative studies looked at whether there were differences in the perceptions of nurses, physicians, and administrators as they related to age, gender, and level of education. Polit and Beck (2008) classify this type of comparative, quantitative study as a Level IIb design since it was a single, non-randomized trial.

Selection of Sample

The pilot sample consisted of a small group of nursing directors working in a hospital setting in a Midwest rural state. The other sample consisted of a convenience sample of nurses and administrators working in hospital settings in a Midwest rural state. There was no age, race, gender, or education restriction of the participants. This investigation used a nonprobability, convenience sample since the selection process was non-random (Polit & Beck, 2008).

The sample size was determined by performing a power analysis. A power analysis can help to reduce the risk for Type II errors by estimating in advance the size of sample that is needed (Polit & Beck, 2008). A power analysis was determined by using power of .80, a level of significance for committing a Type I error as .05, and effect size as .40. This analysis indicated a sample size should be 98. According to Polit and Beck (2008) sample sizes less than 200 have a greater than 20% chance of having a Type II error.

Protection of Human Subjects

Approval for this investigation was obtained from Fort Hays State University Nursing Research Ethics Review Committee (NREC). It was determined that this investigation was exempt from full review from the Fort Hays State University Institutional Review Board (IRB) since the investigation involved adults and used a survey for its data collection. Approval was then obtained from the medical facilities involved.

There were no identified risks to the participants or the medical facility. The facilities were not identified nor were the participants. No identifying information was included on the demographic questionnaire or the actual survey for protection of privacy. Surveys and demographic questionnaires were stored in a locked cabinet that was accessible only by this researcher. Completion and return of survey indicated consent for participation in this investigation.

Data Collection Procedure

Nurses and nursing administrators were asked to complete the Institute for Safe Medication Practices (ISMP) survey on workplace intimidation (see Appendix A). The

participants were assured in writing that their responses were completely anonymous in order to elicit honest responses in a letter of participation (see Appendix B). Both the letter of participation and the surveys were placed in the hospital mailboxes of nursing directors and nurses. The completed forms were placed in the attached envelopes and placed in drop-boxes located in either staff break rooms or the Nursing Administration office. The investigator collected the envelopes on a daily basis. Data was collected until at least 98 surveys were returned.

Instrument

Demographic questions at the beginning of the ISMP survey were used to obtain information about the respondents. The questions contained basic demographic information on gender, age, education, years of experience in a healthcare setting, and current position title.

To determine the perceptions of intimidation and disruptive behaviors in the health care setting as well as the relationships between age, gender, and education, a survey instrument consisting of 22 questions was used. The 22-item survey titled ISMP Survey on Workplace Intimidation consisted of Likert-type questions and yes-no questions. Permission to use this tool was obtained by Allen J. Vaida, Pharm.D., FASHP, Executive Vice President of Institute for Safe Medication Practices. The survey instrument was developed in November 2003 by the Institute for Safe Medication Practices (ISMP) and published in the print editions of the ISMP *Medication Safety Alert!*® Acute Care Edition and the ISMP *Nurse Advise-ERR*™ and was posted on the ISMP Web site with a link from its home page (Smetzer & Cohen, 2005). Reliability and validity results were not mentioned. The survey was divided in four sections and was

designed for physicians/prescribers, pharmacists, nurses, supervisors, and others to respond. The first section was designed to measure the frequency of encounters and the type of potentially intimidating behaviors. The second section was designed to measure how many different individuals were witnessed committing these behaviors. The frequency and the potential effects of intimidation that respondents have encountered were measured in the third section of this survey. Finally, the fourth section of the survey was designed to measure the respondents‟ experiences regarding intimidation in the workplace. The first section contained eight potentially intimidating behaviors with a Likert scale using often, sometimes, rarely, or never. Often was defined as more than 10 times this year; sometimes was 3-10 times this year; rarely was 1-2 times this year; and never was no occurrences. Section two asked respondents how many different individuals committed the potentially intimidating behaviors if they responded sometimes or often in section one with the choices being 1-2, 3-5, more than 5, or NA. Section three contained seven potential effects of intimidation with the same Likert scale responses as section one. The fourth section contained six statements related to intimidation in the workplace using a dichotomous response, yes or no.

Data Analysis

Current position held, years of work experience, education level, gender, and age were all determined from the demographic information obtained from the demographic questionnaire. These descriptive statistics assisted in determining if the individual completing the survey was a nurse or administrator as well as the years of work experience. The demographic data was analyzed using the Statistical Package for Social Sciences (SPSS) software.

Inferential statistics are useful to draw inferences from smaller samples to larger ones (Salkind, 2004). Inferential statistics including parametric one-way ANOVA tests and nonparametric Kruskal-Wallis tests were used to analyze the data for each research question. Chronbach‟s alpha was also performed. An alpha level of .05 was significant for this investigation.

The first research question was answered by comparing the demographic information on the survey to the frequency of encountering intimidating behaviors. The frequency of encountering intimidation was answered by the sum of answers on the first table with often = 3, sometimes = 2, rarely = 1, never = 0. The second question was determined by comparing the demographic information on the survey to the frequency of experiencing potential effects of intimidation. The frequency of experiencing potential effects of intimidation was answered by the sum of answers on the first table with often = 3, sometimes = 2, rarely = 1, never = 0.

For the first research question, the independent variable (IV) was ordinal and the dependent variable (DV) was ordinal so Kruskal-Wallis tests were performed for both the pilot study and the large convenience study. For the second research question, the independent variable (IV) was ordinal and the dependent variable (DV) was ordinal so Kruskal-Wallis tests were performed for the pilot study and the large convenience study. One-way ANOVA tests were also performed for both research questions for the pilot and large convenience studies.

Summary

This chapter discussed the research design, selection of sample, protection of human subjects, data collection procedure, and instruments. The data analysis plan

including the level of variables and statistical methods for the research questions were also addressed.

CHAPTER IV – FINDINGS

This investigation examined the perception of intimidation and disruptive behaviors in the health care setting. Differences, if any, between nurses‟ perceptions of the effects of intimidation and disruptive behaviors and the years of work experience were analyzed. Differences, if any, were also analyzed between nurses‟ perceptions of the potential effects of intimidation and disruptive behavior compared to their years of work experience. A range of total years of work experience was obtained from the demographic information on the survey and compared to the nurses‟ perceptions of the frequency and the potential effects of intimidation and disruptive behaviors in the health care setting.

This chapter presents the findings of the data that were collected and analyzed from two hospitals in a Midwest state. The data were collected anonymously by the completion of the Institute for Safe Medication Practices (ISMP) survey on workplace intimidation. A small pilot study ($N = 7$) from one of the hospitals was collected to determine validity. A larger convenience study ($N = 104$) was then collected from both hospitals. Data were entered into the Statistical Packages for Social Sciences (SPSS) software for analysis. The level of significance for this investigation was set at 0.05.

Demographic Data

Ten surveys were given to a group of nursing directors for the pilot study. Of those that were returned ($N = 8$), one was not included in the investigation because it did not contain sufficient data for a total of 7 participants (see Table 1).

Table 1

Demographic Characteristics of Pilot Study (N = 7)

Variable	Characteristic	*n*	%
Position	Nurse	0	0.0
	Administrator	7	100.0
Years Experience	Less than 2	0	0.0
	2 – 5	1	14.3
	6 – 10	1	14.3
	Greater than 10	5	71.4
Education Level	Some college	0	0.0
	Associate"s degree	1	14.3
	Bachelor"s degree	4	57.1
	Master"s degree	2	28.6
Gender	Male	0	0.0
	Female	7	100.0
Age	20 – 30 years	0	0.0
	31 – 45 years	3	42.9
	46 – 65 years	4	57.1

For the larger convenience study a total of 247 surveys were sent out to nurses. Of those that were returned (*N* =106), two were immediately discarded as the participants were older than 65 years of age for a total of 104 participants (see Table 2).

Table 2

Demographic Characteristics of Convenience Study (N =104)

Variable	Characteristic	*n*	%
Position	Nurse	98	94.2
	Administrator	2	1.9
	No answer	4	3.8
Years Experience	Less than 2	7	6.7
	2 – 5	22	21.2
	6 – 10	13	12.5
	Greater than 10	60	57.7
	No answer	2	1.9
Education Level	Some college	3	2.9
	Associate‟s degree	48	46.2
	Bachelor‟s degree	47	45.2
	Master‟s degree	4	3.8
	No answer	2	1.9
Gender	Male	10	9.6
	Female	91	87.5
	No answer	3	2.9
Age	20 – 30 years	22	21.2
	31 – 45 years	39	37.5
	46 – 65 years	42	40.4
	No answer	1	1.0

The following demographic data were analyzed for both the pilot study and the convenience study: current position, years of work experience, education level, gender, and age. All of the participants ($N = 7$) in the pilot study were administrators with the majority of the participants ($n = 5$, 71.4%) having greater than ten years of work experience. The majority of the participants ($n = 4$, 57 %) had a bachelor"s degree with 28.6% of the participants ($n = 2$) having a master"s degree. All of the participants in the pilot study were female with the age of the participants being older than 30 years of age. The participants" ages ranged from 31 – 65 years with 3 (42.9%) of the participants" ages ranging from 31- 45 years and 4 (57.1%) of the participants" ages ranging from 46 – 65 years. See Table 1 for a summary of the analyzed data.

The convenience study consisted of a larger population ($N = 104$). The majority of the participants ($n = 98$, 94.2%) in the study were nurses with the remaining participants ($n = 2$, 1.9%) being administrators. A few of the participants ($n = 4$, 3.8%) did not indicate their current position. The majority of the participants ($n = 60$, 57.7%) had greater than ten years of work experience with a small number of participants ($n = 7$, 6.7%) having less than two years of work experience. A small portion of the participants ($n = 2$, 1.9%) chose not to answer the question regarding years of work experience. The majority of the participants either had an associate"s degree or a bachelor"s degree ($n = 48$, 46.2 %) and ($n = 47$, 45.2%) respectively. A few of the participants ($n = 2$, 1.9%) did not select a level of education. There were 91 (87.5%) female participants and 10 (9.6%) male participants in the sample study with 3 (2.9%) participants choosing no response. The participants" ages had a wide range. There were slightly more participants ($n = 42$, 40.4%) in the age range of 46 – 65 years. There were 39 (37.5%) participants in

the age range of 31 – 45 years and 22 (21.2%) participants in the age range of 20 – 30 years. One (1.0%) of the participants did not indicate an age range. See Table 2 for a summary of the analyzed data.

Findings of Research Questions

There were two research questions for this investigation. Both questions will be individually discussed in regards to the pilot study and the convenience study.

Research Question Number One

The first research question asked, "What is the difference, if any, of the perception of intimidation and disruptive behaviors frequency among nurses with varying levels of work experience?"

This question included the relationship between the total years of work experience and the nurses‟ perceptions of how frequently they have encountered intimidation and disruptive behaviors in their work place. To determine the total years of work experience, participants were asked to select from the following choices: less than 2 years; 2-5 years; 6-10 years; and more than 10 years. The perception of the frequency of the encounters of those intimidation and disruptive behaviors was determined by the sum of the numerical values assigned to participants‟ responses in a table that listed potentially intimidating behaviors. The nonparametric equivalent of the one-way ANOVA, the Kruskal-Wallis *H* test, was performed to analyze the data for both the pilot study and the convenience sample using the Statistical Package for Social Sciences (SPSS) software. One-way ANOVA was also performed to provide a comparison value. Cronbach‟s alpha was also performed.

For the pilot study, a Kruskal-Wallis test was conducted comparing the frequency of intimidation for nurses with varying levels of work experience. No significant difference was found ($H(2) = 2.88$, $p > .05$), indicating that the groups did not differ significantly from each other. Nurses with 2-5 years of work experience averaged 5.00, while nurses with 6-10 years of work experience averaged 7.00, and nurses with more than 10 years of work experience averaged 3.20. Years of work experience did not seem to influence the frequency of intimidation. A one-way ANOVA was computed for the pilot study comparing the frequency of intimidation to the various ranges of years of work experience. No significant difference was found ($F(2,4) = 1.645$, $p > .05$). The frequency of intimidation did not differ significantly by years of work experience.

For the larger convenience sample, a Kruskal-Wallis test was conducted comparing the frequency of intimidation for nurses with varying levels of work experience. No significant difference was found ($H(3) = 1.39$, $p > .05$), indicating that the groups did not differ significantly from each other. Nurses with less than 2 years of work experience averaged 59.79, and nurses with 2-5 years of work experience averaged 52.32, while nurses with 6-10 years of work experience averaged 44.75, and nurses with more than 10 years of work experience averaged 48.88. Years of work experience did not seem to influence the frequency of intimidation. A one-way ANOVA was computed for the convenience sample comparing the frequency of intimidation to the various ranges of years of work experience. No significant difference was found ($F(3,95) = 0.536$, $p > .05$). The frequency of intimidation did not differ significantly by years of work experience. Cronbach‟s alpha coefficient for the convenience sample was .755.

Research Question Number Two

The second research question asked, "What is the difference, if any, of the perception of the effects of intimidation and disruptive behaviors frequency among nurses with varying levels of work experience?"

This question included the relationship between the total years of work experience and the nurses" perceptions of how frequently they have encountered the effects of intimidation and disruptive behaviors in their work place. To determine the total years of work experience, participants were asked to select from the following choices: less than 2 years; 2-5 years; 6-10 years; and more than 10 years. The perception of how frequently nurses experienced the effects of intimidating and disruptive behaviors was determined by the sum of the numerical values assigned to participants" responses in a table that listed potential effects of intimidation. The nonparametric equivalent of the one-way ANOVA, the Kruskal-Wallis *H* test, was performed to analyze the data for both the pilot study and the convenience sample using the Statistical Package for Social Sciences (SPSS) software. One-way ANOVA was also performed to provide a comparison value. Cronbach"s alpha was also performed.

For the pilot study for the second research question, a Kruskal-Wallis test was conducted comparing the frequency of the effects of intimidation for nurses with varying levels of work experience. No significant difference was found ($H(2) = 3.40$, $p > .05$), indicating that the groups did not differ significantly from each other. See Table 3 for a summary of the analyzed data. Nurses with 2-5 years of work experience averaged 7.00, while nurses with 6-10 years of work experience averaged 1.50, and nurses with more than 10 years of work experience averaged 3.90. Years of work experience did not seem

Table 3

Frequency of Intimidation and Frequency of Effects of Intimidation by Years of Work Experience. Pilot Study (N = 7).

	Kruskal – Wallis		
Variables	*df*	*H*	*P*
Frequency of Intimidation	2	2.88	.237
Frequency of Effects of Intimidation	2	3.40	.183

*$p < .05$

to influence the frequency of intimidation. A one-way ANOVA was also computed for the pilot study comparing the frequency of the effects of intimidation to the four ranges of work experience. A significant difference was found among the years of work experience ($F(2,4) = 31.63$, $p < .05$). However, post hoc tests were not performed because at least one group had fewer than two cases.

According to Cronk (2006) numbers close to 0.00 represent poor internal consistency. The numbers close to 1.00 represent very good internal consistency. With small sample sizes, it is difficult to get an alpha coefficient of .70 or above. Cronbach‟s alpha is a reliability test that measures internal consistency (Cronk, 2006). The reliability alpha coefficient for the pilot study was .685.

To answer the second research question for the larger convenience study, a Kruskal-Wallis test was conducted comparing the effects of the frequency of intimidation for nurses with varying levels of work experience. No significant difference was found

($H(3) = 5.53$, $p > .05$), indicating that the groups did not differ significantly from each other. See Table 4 for a summary of the analyzed data. Nurses with less than 2 years of work experience averaged 57.67, and nurses with 2-5 years of work experience averaged 61.68, while nurses with 6-10 years of work experience averaged 49.75, and nurses with more than 10 years of work experience averaged 45.83. Years of work experience did not seem to influence the frequency of the effects of intimidation. A one-way ANOVA was computed for the convenience study comparing the frequency of the effects of intimidation to the various ranges of years of work experience. No significant difference was found ($F(3,96) = 2.154$, $p > .05$). The frequency of the effects of intimidation did not differ significantly by years of work experience. Cronbach‟s alpha coefficient for the convenience sample was .755.

Table 4

Frequency of Intimidation and Frequency of Effects of Intimidation by Years of Work Experience. Convenience Study (N= 104).

	Kruskal – Wallis		
Variables	*df*	*H*	*P*
Frequency of Intimidation	3	1.39	.707
Frequency of Effects of Intimidation	3	5.53	.137

*$p < .05$

Summary

This chapter has presented the data collected for this investigations research questions. The parametric and nonparametric inferential statistics used for the analysis of this data was also presented. The meaning of the data will be discussed in Chapter V.

CHAPTER V – SUMMARY AND CONCLUSIONS

A summary of the investigation, interpretation of the findings, and concluding remarks will be included in this chapter. Limitations of the investigation and recommendations for future research will also be discussed.

Summary of the Investigation

This investigation studied the perceptions of nurses in regards to intimidation in the health care setting. The relationship between total years of work experience and the frequency of how often nurses perceived they encountered potentially intimidating and disruptive behaviors as well as the frequency of how often nurses perceived they experienced potential effects of intimidation were studied. The investigational sites involved two hospitals in a Midwest state. The small pilot study had eight out of ten participants respond for a response rate of 80%. One survey did not contain sufficient data so it was not included for a total of seven participants in the pilot study. The larger convenience sample had 106 out of 247 participants respond for a response rate of 42.9%. Two surveys were not included in the survey because they were older than 65 years of age for a total of 104 participants in the convenience sample.

Interpretation of the Findings

Demographic characteristics and interpretation of findings are included. Findings are compared to current studies in the literature.

Demographic Characteristics

The demographics for the pilot study ($N = 7$) show the majority ($n = 5$, 71.4%) have greater than ten years of work experience with all ($n = 7$) of them being female. The majority ($n = 4$, 57.1%) had their bachelor"s degree with their ages ranging from 31-45

years (n =3, 42.9%) and 46 – 65 years (n =4, 57.1%). The demographics for the larger convenience sample (N = 104) show the majority (n = 60, 57.7%) have greater than ten years of work experience with most (n =91, 87.5%) of them being female. The age ranges were evenly divided with 40.4% (n =42) being 46 -65 years of age; 37.5% (n =39) being 31 – 45 years of age; and 21.2% (n = 22) being 20 – 30 years of age. These findings are consistent with other studies in the literature.

First Research Question

The first research question was, "What is the difference, if any, of the perception of intimidation and disruptive behaviors frequency among nurses with varying levels of work experience?" The current investigation reveals there is no significant ($H(2) = 2.88$, $p > .05$) and ($F(2,4) = 1.645$, $p > .05$) difference among the nurses with varying levels of work experience in the pilot study. The current investigation also reveals no significant ($H(3) = 1.39$, $p > .05$) and ($F(3,95) = 0.536$, $p > .05$) difference among nurses with various levels of work experience in the convenience sample. The frequency of intimidation did not differ significantly by years of work experience.

These findings are consistent with the earlier study performed by the Institute for Safe Medication Practices (ISMP) as reported by Smetzer and Cohen (2005). One explanation for this may be that less experienced nurses may be sheltered by more experienced nurses. The experienced nurses may interact with disruptive physicians so less experienced nurses can avoid the intimidating experience. These findings are different from the study performed by Anderson (2002). This study showed that over half of the nurses surveyed experienced intimidation within their first six years of employment. Current review of the literature reveals a lack of research containing

statistically analyzed data. Many of the studies contain qualitative research, but very few contain quantitative data. This provides guidance for future research.

Second Research Question

The second research question was, "What is the difference, if any, of the perception of the effects of intimidation and disruptive behaviors frequency among nurses with varying levels of work experience?" Although a significant ($F(2,4) = 31.63$, $p < .05$) difference was noted in the pilot study using one-way ANOVA, a significant ($H(2) = 3.40$, $p > .05$) difference was not found using the Kruskal-Wallis test. For the larger convenience sample there were no significant ($F(3,96) = 2.154$, $p > .05$) or ($H(3) = 5.53$, $p > .05$) differences found using either the parametric or nonparametric tests. Years of work experience does not seem to influence the perception of the frequency of the effects of intimidation.

There are several studies that investigate the effects of intimidation (Cox, 1987; Rosenstein, 2002; Rosenstein & O'Daniel, 2005; Rosenstein & O'Daniel, 2008; Smetzter & Cohen, 2005; Solfield & Salmond, 2003; However, the review of literature reveals no studies that investigate the perception of the frequency of the effects intimidation as compared to work experience.

Limitations

A limitation to this investigation involved the actual survey itself. The survey lacked the ability to assign a numerical value to participants" answers so further statistical analysis could be performed. After receiving approval from the Institute for Safe Medication Practices (ISMP) to modify their survey, numerical values were added to the responses from the table so the sum of the results could be used for parametric and

nonparametric statistical procedures. Another limitation included the number of surveys returned. The intent was to continue to collect surveys until at least 200 surveys were returned. Because only 106 surveys were returned, there is a 20% greater chance of having a Type II error (Polit & Beck, 2008). Since responses were voluntary, there is a potential for the results to be biased because of the possibility that only those most interested in this topic chose to participate in the survey. Additionally, it will not be possible to generalize these findings to populations that are demographically different. Findings also cannot be generalized to larger or urban hospitals. Other limitations include the possibility that some responses may not be honest due to fear of retribution. This possibility was diminished as much as possible by making the surveys anonymous and providing a neutral location for the nurses to return the surveys.

Recommendations

Findings from this investigation indicated that the years of work experience do not affect the perception of intimidation. However, there may be other variables that do affect the way nurses perceive intimidation. These variables could include age, gender and years of education. This investigation looked at intimidation by physicians. Open-ended comments on the surveys indicated that nurses perceive intimidating behaviors from their peers as well as physicians. Based on these observations, the following recommendations for nursing research, practice, theory development, and education are discussed.

Nursing Research

The following recommendations are made based on this investigation:

1. Investigate whether age, gender, or years of education influence nurses‟

perceptions of intimidation.

2. Expand the investigation to include generational differences and how they influence perceptions of others.
3. Evaluate how physicians and hospital administrators perceive intimidation in the health care setting.
4. Explore the perception of nurse to nurse intimidation in the health care setting.
5. Investigate the effects of intimidation and disruptive behaviors in the health care setting.

Nursing Practice

This investigation evaluated nurses‟ perceptions of intimidation and how they influenced the way nurses practiced. Despite the fact that the investigation revealed the number of years of work experience did not affect nurses‟ perceptions of intimidation, nurses still admitted to altering the way they practiced based on intimidation. They assumed medications were correct and safe rather than interact with certain care providers. They also asked colleagues for advice and researched information themselves in order to avoid interacting with potentially intimidating providers.

This investigation revealed the importance of continuing to study intimidation and disruptive behaviors to gain a better understanding of how these behaviors impact nursing practice. Intimidation and disruptive behaviors in the health care setting affect communication and collaboration between nurses and physicians. Good communication and collaboration create a teamwork environment and a multidisciplinary approach to patient care which could lead to improved patient outcomes.

Nursing Theory

Imogene King‟s Conceptual System and Theory of Goal Attainment was the theoretical framework chosen for this investigation. King‟s theory focuses on personal, interpersonal, and social systems (Frey et al., 2002) with each of these three systems indentifying human beings and human behavior as a basic elements in their systems. Intimidation and disruptive behaviors influence and interact with all three of these systems. King (2007) provides insight into the interactions of human beings and human behavior throughout all three of these systems. As human behaviors, intimidation and disruptive behaviors affect organizations and influence decision making in the social system. In the interpersonal system, intimidation and disruptive behaviors influence human interaction and communication. Finally, intimidation and disruptive behaviors influence the personal system when it comes to learning and coping. This theory was very applicable to this investigation. Future researchers should consider using King‟s theory for guidance in their research.

Nursing Education

Hospital administrators and nurse leaders need to provide education to nurses to improve and strengthen their communication skills. These skills need to include conflict resolution, assertive communication, and customer service. This will give nurses skills and confidence to speak up when they are confronted with inappropriate behaviors. The review of literature in this investigation demonstrated that education does improve communication (Rodgers, 2007; Vazirani et al., 2005).

All members of the health care team need to be educated on appropriate professional behavior as defined by each organization‟s code of conduct. The education

needs to focus on individual and professional respect. Additionally, formal education revolving around team building, collaboration, stress management, conflict management, and time management needs to be provided. Finally, education regarding proper phone etiquette would also improve communication among the health care team. Improving communication and collaboration will improve staff, patient, and physician satisfaction and improve patient outcomes.

Nurses would benefit from being mentored by their nurse leaders. Effective nurse leaders should understand the relationships necessary to produce positive outcomes and realize the importance of good communication skills while recognizing that nurses are partners who must establish collaborative and meaningful relationships in order to be productive (Malloch & Porter-O‟Grady, 2009). Effective nurse leaders can lead by example and demonstrate effective ways of handling intimidation and disruptive behaviors.

Finally, hospital administrators and nurse leaders should increase their understanding regarding generational differences. The coexistence of three generations in nursing is leading to conflict (Swearingen & Liberman, 2004) that is resulting in intimidation and disruptive behaviors among nurses. These generational differences impact personal and professional interactions, motivations, and values. According to Swearingen and Liberman (2004) the differences in generations are affecting performance and job satisfaction.

Summary

Addressing intimidation and disruptive behaviors in the health care setting will create a safe environment for patients, families, nurses, and physicians. Nurses‟ morale

will also increase as they realize they are valued and supported by their leaders. This will potentially increase employee and patient satisfaction, decrease nurse turnover, and improve communication and collaboration. This improvement will create an atmosphere of teamwork and allow a multidisciplinary approach to patient care which will improve patient outcomes.

Nurses and physicians see and view things differently. They were trained differently and their focus for their patients is different. However, nurses and physicians can significantly learn from each other by embracing what each profession has to offer. If physician-nurse collaboration becomes the norm, the dynamics of the nursing profession will change. Nurses will see themselves as change agents with significant ideas to offer instead of feeling subservient. Health care organizations will benefit as physicians and nurse work together to determine the best approach for patient care. Patient safety and positive outcomes will be the priority, and intimidation and disruptive behaviors will no longer dominate the health care setting.

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Appendix A

ISMP Survey on Workplace Intimidation

Institute for Safe Medication Practices (ISMP)
Survey on Workplace Intimidation

For the purpose of the survey, intimidation is defined by ISMP as: Any overt or covert interaction between healthcare professionals that results in either an intended or unintended reluctance to speak up about concerns, question patient care, or share an opinion on a subject.

(1) Please select the category that best describes you. Administrator category includes director, manager, or executive position.

Current position: Physician Nurse Administrator

Total years of experience: Less than 2 2-5 6-10 More than 10

Level of education: High School Some college
Associate's degree Bachelor 's degree
Master's degree Doctorate degree
Medical school

Gender: Male Female

(2) In the table below, please mark how frequently in the past year you've encountered potentially intimidating behaviors.

Key: Often = more than 10 times this year; Sometimes = 3-10 times this year; Rarely = 1-2 times this year; Never = no occurrences

Potentially Intimidating Behaviors	**Often**	**Sometimes**	**Rarely**	**Never**
a. Reluctance or refusal to answer your questions, return calls or pages				
b. Condescending language or tone of voice				
c. Impatience with questions				
d. Strong verbal abuse				
e. Negative or threatening body language				
f. Reporting you to your manager (actual or threat)				
g. "Just give what I/the attending ordered."				
h. Physical abuse				
i. Other (describe)				

(3) If you answered "Sometimes" or "Often" to any item in question #2, how many different individuals committed to potentially intimidating behaviors? Please select NA if the question does not apply. 1-2 3-5 More than 5 NA

(4) In the table below, please mark how frequently in the past year you've experienced the following potential effects of intimidation.

Key: Often = more than 10 times this year; Sometimes = 3-10 times this year; Rarely = 1-2 times this year; Never = no occurrences				
Potential Effects of Intimidation	**Often**	**Sometimes**	**Rarely**	**Never**
a. Despite concern (even if vague), I've assumed that a medication order is correct and safe rather than interact with a particular practitioner.				
b. Despite concern (even if vague), I've assumed that a medication order was correct and safe because of the stellar reputation of the prescriber.				
c. I've asked colleagues to help me interpret an order or validate its safety so that I do not have to interact with a particular provider.				
d. I've refrained from contacting a prescriber and attempted to clarify the safety of an order by researching the topic myself.				
e. I've asked another professional to talk to the prescriber (or other professional) about the safety of an order if it involves a particular intimidating person.				
f. I've asked/suggested/allowed a physician to give a medication himself despite concerns (even if vague) about its safety.				
g. Other (describe)				

(5) In the table below, please respond "Yes" or "No" to the following statements related to intimidation in the workplace.

Statements	**Yes**	**No**
a. Despite concern (even if vague), I've assumed that a medication order is correct and safe rather than interact with a particular practitioner.		
b. Despite concern (even if vague), I've assumed that a medication order was correct and safe because of the stellar reputation of the prescriber.		
c. I've asked colleagues to help me interpret an order or validate its safety so that I do not have to interact with a particular provider.		
d. I've refrained from contacting a prescriber and attempted to clarify the safety of an order by researching the topic myself.		
e. I've asked another professional to talk to the prescriber (or other professional) about the safety of an order if it involves a particular intimidating person.		
f. I've asked/suggested/allowed a physician to give a medication himself despite concerns (even if vague) about its safety.		
g. Other (describe)		

Appendix B

Letter of Participation

Dear participant,

I am conducting an investigation to examine the perceptions of nurses, physicians, and hospital administrators in regards to disruptive behaviors in the healthcare setting. Would you please assist me in this investigation by completing the attached survey? Your opinions and experiences are very important to me and are needed to give an accurate picture of intimidation and disruptive behaviors in the healthcare setting.

The survey is completely anonymous, so you are not asked to put your name on it or identify yourself in any way. Because the survey is anonymous, I hope you will feel comfortable giving your honest opinions. If you prefer not to answer any particular question, feel free to leave it blank. However, please answer as many questions as possible. If you have any comments or concerns about any of the questions, feel free to contact me by e-mail (janelle_wade@hotmail.com) or by phone (work: 620-232-0343, cell: 620-875-9099).

Please take 10 -15 minutes to complete the survey. Please return the survey in the attached envelope and place in the drop-box located in Beth Foster‟s office in Nursing Administration.

Your participation in the investigation is completely voluntary. By returning the survey, you will be granting permission to participate in the study. Thank you in advance for your assistance.

Sincerely,

Janelle Wade, MSN-c, BSN, RN
FHSU Graduate Student

Appendix C

Permission to Use ISMP Survey

Janelle,

Sorry for the delay but I have been traveling. Just let me know what you mean by 'using'. If you want to perform a study you can use it and just cite ISMP's copyright with the survey and our permission to use. If you are talking about some other use (e.g., adapting, online use) let me know. I assume you mean the former.

Good luck with your project.

Allen

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ISMP is a Federally Certified Patient Safety Organization (PSO). Contact us for more information on how we can assist you with your medication safety aims.

***Visit our consumer website and sign up for customized medication safety alerts**:*
http://www.consumermedsafety.org

From: admin@ismp.org [mailto:admin@ismp.org]
Sent: Monday, February 23, 2009 8:55 PM
To: Michelle Bell
Subject: Workplace intimidiation survey

Website Contact Form Submission

Referring web page: http://www.ismp.org/newsletters/acutecare/articles/20040325.asp

Department/Name Selection: professional development

Form information is shown below

Name: Janelle Wade

Email: janelle_wade@hotmail.com

Phone: 620-235-7505

Comment: I am a graduate student working on my masters in nursing and am very interested in workplace intimidation. I was wondering if it would be possible to use your workplace intimidation survey tool for my study? If would appreciate any consideration of my request. Pleas let me know if I should be contacting someone else for permission. Thank you. Janelle Wade Pittsburg, KS work email: janelle_wade@via-christi.org

Appendix D

Permission to Modify ISMP Survey

Hi Janelle,

We do not have any objections to the minor changes that you proposed.

Rachel

From: Rebecca Lamis
Sent: Monday, May 03, 2010 12:39 PM
To: Rachel Cohen
Subject: Copyright question

Hi Rachel,

This individual said that she already received permission to use our survey on Workplace Intimidation (please see initial email), but would like to now make a few modifications. I don't see any problems with this, but wasn't sure who to send to to get okay. Is this something you can follow-up on? Or, if not, do you know who I should ask? Thanks! -Becky

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From: Janelle Wade [mailto:janelle_wade@hotmail.com]
Sent: Monday, May 03, 2010 12:30 PM
To: Rebecca Lamis
Subject: RE: ISMP Response: Survey on Workplace Intimidation - 2003

I am working on my thesis regarding intimidation and disruptive behavior in the healthcare setting. In order to do some statistical analysis on some of the responses to the survey, I would like to make a couple modifications to the survey.

Those modifications include:

1. Renaming the columns from left to right to say never, rarely, sometimes, or often.
2. Assigning numerical value to each column: never = 1, rarely = 2, sometimes = 3, often = 4. Then I plan to sum each table for statistical analysis.

Do you have any objections to these minor changes?

Thank you.
Janelle Wade, MSN-c, RN
FHSU Nursing Administration Graduate Student
620-875-9099