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Lateral Violence in the Emergency Department

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by

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Abstract

This study examined the types, frequency, and scopes of emergency room nurses' personal experience with disruptive behavior and its impact on staff, their patients, and the organization. Seventy registered nurses completed the Johns Hopkins Disruptive Clinician Behavior survey. Descriptive statics were used to analyze results. The most significant findings included: (a) Passive aggressive behavior was the most commonly reported form of disruptive behavior occurring on a daily basis, (b) RN's were identified as the most common instigators of disruptive behavior, (c) pressure from high census, volume, and patient flow was identified as the most common trigger of disruptive behavior occurring on a daily basis, (d) 62.3% of respondents generally agree they treat unprofessional behavior with confidence, but do not report it, (e) 88.5% of respondents stated they would report unprofessional behavior if it negatively impacted patients, and (f) 91.7% of respondents stated that unprofessional behavior decreases their job satisfaction, with 53.3% stating they have considered transferring to another unit, changing organizations, or resigning.

Keywords: lateral violence, horizontal violence, bullying, harassment, nurse-on-nurse violence, disruptive clinician behavior

Acknowledgments

I would like to thank my family and friends for their love and support. Without you, I would never have made it this far, and I wouldn't be the woman I am today. I love you all.

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CHAPTER I

Introduction

Lateral violence can be defined as an act of violence against ones' peers (Becher & Visovsky, 2012). Lateral violence can be expressed in overt or covert ways. Overtly, acts of lateral violence consist of name-calling, gossiping, excessive blaming of fellows, putting down of others, and unnecessary shouting at peers. Covertly, these may include unfair allocation of duties, roles and assignments, refusing to offer help when needed or asked for, ostracizing and exclusion of others, and ignoring (Corbin, Dumont, & Brunelle, 2011). Lateral violence occurs in many settings with the workplace being one of them. One of the workplaces that have recorded alarming rates of incidences of lateral violence is the healthcare institutions' emergency departments (ED) (Becher & Visovsky, 2012). This research study focuses on lateral violence in the Emergency Departments in the United States healthcare system.

Problem Statement

Lateral violence has been identified as a growing problem in nursing. Research indicates that in the mid-1990s, the percentage of cases of lateral violence reported that originated from emergency departments was 9%. Fifteen years later, the rate of occurrence of lateral violence had doubled and now stands at 18% (Corbin et al., 2011). Research further indicated that emergency departments are just second to medical-surgical units in terms of prevalence of lateral violence. Nurses in medical-surgical units reported a 23% chance of experiencing or witnessing lateral violence, followed by emergency departments at 18%, critical care units at 12%, and obstetric departments at 7% (Christie & Jones, 2014). Among nurses working in emergency departments, 48%

cited verbal abuse and being ignored as the main form of lateral violence (Becher & Visovsky, 2012). This occurred to newly promoted or admitted nurses. Among nursing students on nursing placements, 53% felt the most common form of lateral violence perpetrated against them was being put down every time they did something wrong and being unfairly criticized even when they were not at fault (NurseTogether, 2013).

More concerning is that, more than 52% of nurses that experience or witness lateral violence does not report or talk about it (NurseTogether, 2013). The inability or unwillingness to vent causes depression, cardiovascular complications, and a passive attitude that is detrimental to patients care. Some nurses believe that by ignoring a fellow nurse who needs their help to attend to a patient is revenge against that fellow nurse but, in reality, the nurse is rebelling against the patient and the oath they took. Ultimately, it is the patient that suffers the consequence of the lateral violence among the nurses.

Justification of the Research

The increase in lateral violence has resulted in an increase in mental health conditions, such as depression and schizophrenia, among clinical nurses (Anderson, 2011). When nurses are not happy, their motivation and job satisfaction decreases. Eventually, these lead to higher employee turnover rates, which increase the healthcare institution's expenses and shortage of staff (Pai & Lee, 2011). Most importantly, lateral violence among nurses has compromised the quality of healthcare service by reducing the levels of optimal patient care (Anderson, 2011). Lateral violence has specifically been identified as more prevalent among nurses working in emergency departments (Corbin et al., 2011). Many patients have experienced relapse in their conditions because one nurse refused to help another nurse claiming to be too busy when their help was needed or

sought. Most of the decisions and medications nurses in emergency departments make determine whether a patient lives or dies (Christie & Jones, 2014). It is, therefore, crucial that the incidences of lateral violence between nurses working in emergency departments are kept to a minimum.

Purpose

The purpose of this research study was to determine the risk factors of lateral violence on nurses working in emergency departments and how they affect the delivery of optimal patient care. In a bid to achieve this, the study seeks to achieve the following objectives:

1. To determine the type, frequency, and scope of clinicians' personal experience with disruptive behavior and its impact on staff, their patients, and the organization.
2. To compare the disruptive behavior experiences of RNs.
3. To draw conclusions and make useful recommendations to policy makers and hospital administrators on how to alleviate lateral violence and, in effect, promote delivery of optimal care.

Research Question

This research study aims to answer the following research question:

What are the types, frequency, and scopes of clinicians' personal experience with disruptive behavior and its impact on staff, their patients, and the organization?

Theoretical Framework

Conti-O'Hare's Theory of the Nurse as a Wounded Healer served as the theoretical framework for this study. This theory has been used in similar studies in the

past and is the most relevant nursing practice theory in this instance (Corbin et. al., 2011). This theory states that people choose the professions they chose because of the experiences they have had in the past. As such, most nurses chose to be nurses because they experienced pain in the past and wish to relieve fellow humans of their pain (Anderson, 2011). The hurting experience and consequent trauma motivates these nurses to provide better, optimal patient care to their patients. This, however, hugely depends on whether and to what extent the nurse has been able to transform the traumatic experience and pain experienced in the past into self- therapy (Christie & Jones, 2014).

Conti-O'Hare's theory suggested that nurses have, at some point in their lives, had traumatic experiences, which motivated them to pursue the nursing profession. These traumatic experiences are not forgotten, but carried on throughout one's life. So the nurses are inherently walking wounded individuals who are in denial of their woundedness (Christie & Jones, 2014). If these nurses are placed in stressful situations and do not have a suitable avenue to vent they perpetrate this hurt on others, thus lateral violence. The victims, who are also walking wounded individuals, in turn perpetrate it on others. The cycle of lateral violence is thus created and hard to break. This happens when the individuals have not effectively managed their pain and hurt (Anderson, 2011).

However, if the pain is identified, transformed, and transcended, the nurse finds healing. The nurse transforms from being a walking wounded individual to a wounded healer offering quality healthcare to patients because of better understanding of the patient's hurt and need for care (Christie & Jones, 2014). The nurse is then able to use this healing and emotions it evokes to deliver the most optimal and compassionate patient care to the patients. This theory is informative since it shows the origin of lateral

violence among nurses. It is also insightful since it shows the different effects lateral violence can have on individuals. Conti-O'Hare's assumption that human beings experience trauma at one point in their lives which then shape their decision making and outcomes in life is congruent with other nursing theories (Pai & Lee, 2011). The assumption that a person has the power to determine their reaction on whether to make therapeutic use of self or not is also central to this study as it determines how nurses react to lateral violence and how this is impacted on the quality of healthcare services offered. This theory, in essence, provides that the capability to deal with the traumatic experience and lateral violence determines the ability of a nurse to optimally care for patients. This theoretical framework is displayed in Figure 1.

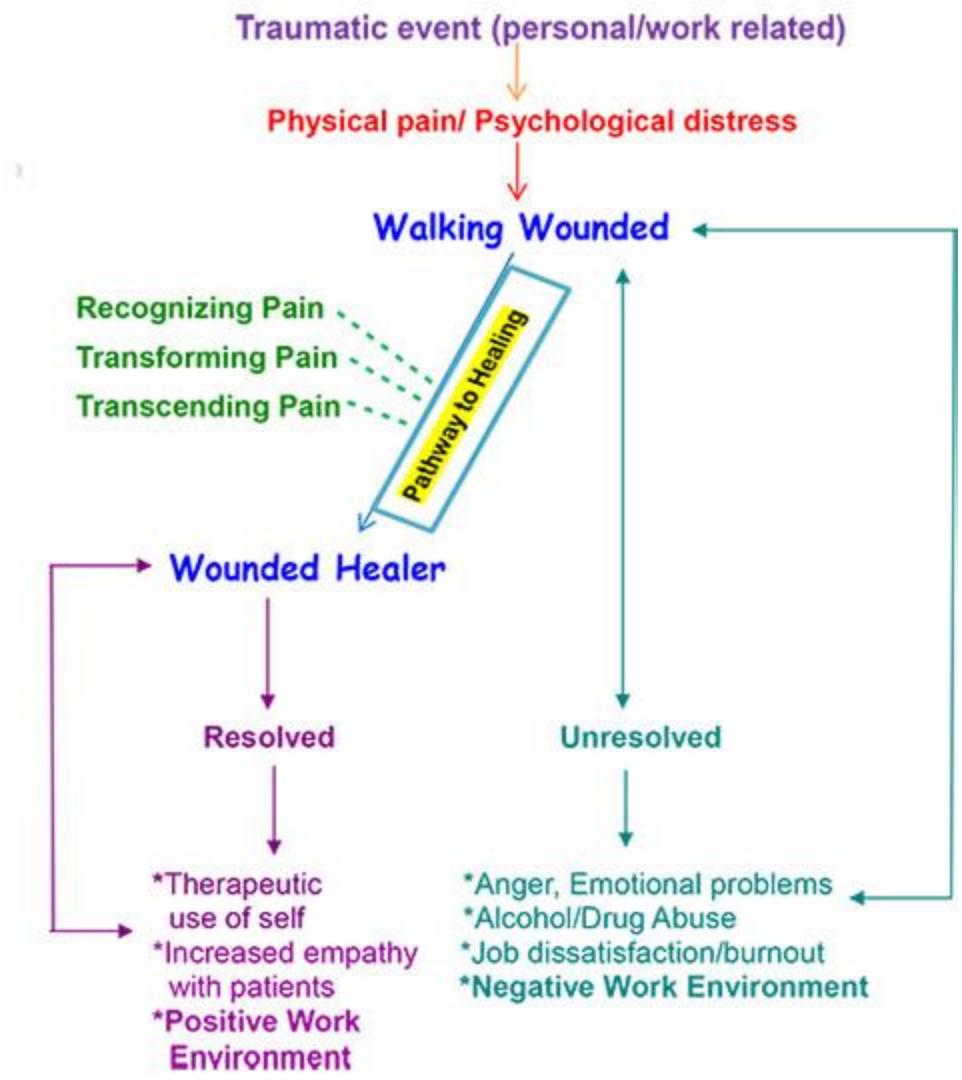

Figure 1. Diagram Depicting Conti-O'Hare's Theory of the Nurse as a Wounded Healer

Definition of Terms

- Walking wounded: These are nurses who experienced pain and traumatic experiences in the past but are yet to address this pain and hurt. They live in denial and when facing life stressors they vent on their peers and others consequently leading to negative results in their work (NurseTogether, 2013).
- Wounded healer: These are nurses who have experienced pain and traumatic experiences in the past but have already identified and resolved and risen above their traumatic experiences. These individuals are capable of using their past pains and traumatic experiences as motivation towards offering better healthcare services to their patients (NurseTogether, 2013).

Summary

Lateral violence among nurses working in emergency departments has been identified as a big problem in the U.S. Healthcare System (Christie & Jones, 2014). This has necessitated brainstorming possible reasons for this phenomenon and how it and its effects can be alleviated to ensure patients receive optimal patient care. Conti-O'Hare's Theory of the Nurse as a Wounded Healer helps identify the most critical assumptions upon which this study is based. The assumption is that all nurses are walking wounded individuals and have been motivated by their traumatic experiences to work in the nursing profession (Anderson, 2011). Nurses, who are able to transform their hurt and traumatic experience into therapeutic use of self, become better nurses.

CHAPTER II

Literature Review

A literature review was conducted by searching a variety of databases and search engines. These databases included Cumulative Index to Nursing and Allied Health Literature (CINAHL), ProQuest, Area Health Education Center (AHEC) digital library, Medline, and the search engine Google. Key terms for the search included lateral violence, bullying, horizontal violence, workplace violence, and disruptive behaviors.

Literature Related to Problem Statement

A review of the literature shows that lateral violence has been identified as a big threat to the major objective of nursing and healthcare provision in hospitals. Various aspects of lateral violence have been studied and have shown to have negative impacts on the nurse's mental health and quality of care provided to patients.

Lateral Violence

Roche, Diers, Duffield, and Catling-Paull (2010) used a cross-sectional collection of data by surveys and primary data collection for one week periods on 94 nursing wards in 21 hospitals in two states of Australia. Nurses were surveyed using The Nursing Care Delivery System and the Nursing Work Index-Revised. Staffing and skill mix was obtained from the ward roster and other data from the patient record. About one third of nurses participating perceived emotional abuse during the last five shifts worked. Reports of threats (14%) or actual violence (20%) were lower, but there was great variation among nursing units with some unit rates as high as 65%. Reported violence was associated with increased ward instability (lack of leadership; difficult MD and RN relationships). Violence was associated with unit operations: unanticipated changes in

patient mix, proportion of patients awaiting placement, the discrepancy between nursing resources required from acuity measurement and those supplied, more tasks delayed, and increases in medication errors. Higher skill mix (percentage of registered nurses) and percentage of nurses with a bachelor of science in nursing degrees were associated with fewer reported perceptions of violence at the ward level. Intent to leave the present position was associated with perceptions of emotional violence but not with threat or actual assault.

Magnavita and Heponiemi (2011) used a retrospective survey in three Italian university schools of nursing. At the end of a lecture, 346 of 349 students agreed to fill out a questionnaire that included domains on violence, mental health, job stress, and organizational justice. This group was compared with 275 nurses from a general hospital. The prevalence of subjects reporting at least one upsetting episode of physical or verbal violence during their lifetime activity in clinical settings was 43% in nurses and 34% in nursing students. Nurses reported more physical assaults, threats, and sexual harassment during the previous 12 months than students. Nurses were mostly assaulted or harassed by patients or their relatives and friends, whereas students often reported verbal and also physical violence on the part of colleagues, staff, and others, including teachers, doctors, and supervisors. Verbal violence was associated with high levels of psychological problems, as measured by the 12-item version of the General Health Questionnaire, in both students and nurses. Verbal violence was also associated with high job strain, low social support, and low organizational justice, but only among nursing students.

Kaplan, Mestel, and Feldman, (2010) used a cross-sectional collection of data surveys. Six hundred and seventeen respondents completed a Provider Conflict Questionnaire as well as a 10-item stress survey. Work was the main stressor according to 78.2% of respondents. The stress index was moderately high, ranging between 10 and 48. Females demonstrated a higher stress index. Disruptive behavior showed a significant positive correlation with increased stress. This study concluded that employees of institutions with less disruptive behavior exhibited lower stress levels. This finding is important in improving employee satisfaction and reducing medical errors. It is difficult to retain experienced nurses, and stress is a significant contributor to job dissatisfaction. Moreover, workplace conflict and its correlation to increased stress levels must be managed as a strategy to reduce medical errors and increase job satisfaction.

Barrett, Piatek, Korber, and Padula (2009) sampled registered nurses (RNs) from four diverse patient care areas, chosen on the basis of low scores on the National Database of Nursing Quality Indicators (NDNQI) RN-RN interaction subscale. A quasi-experimental pre-post intervention design without a control group was employed. The intervention focused on lateral violence and team building. A qualitative component focused on the impact of the intervention on overall group dynamics and processes. RN scores on the Group Cohesion Scale and the RN-RN interaction scores improved post-intervention. Group sessions focused on building trust, identifying and clarifying roles, engaging staff in decision making, role-modeling positive interactions, and holding each other accountable.

Berry, Gillespie, Gates and Schafer (2012) surveyed 197 RNs employed in practice for less than two years. These nurses completed the Healthcare Productivity

Survey, Negative Acts Questionnaire, and a demographic survey. The majority of RNs reported a workplace bullying (WPB) event within the previous month, with 57.9% the direct targets and another 14.7% witnesses of WPB behaviors. Using a weighted Negative Acts Questionnaire score, 21.3% of RNs were bullied daily over a six month period. When asked if bullied over the past six months, approximately 44.7% of RNs reported repeated, targeted WPB, with 55.3% reporting no WPB. WPB acts were primarily perpetrated by more experienced nursing colleagues. Further, work productivity regression modeling was significant and RN productivity was negatively impacted by workplace bullying.

Budin, Brewer, Chao, and Kovner (2013) used data from the fourth wave of a national panel survey of early career RNs that began in 2006. The final analytic sample included 1,407 RNs. Descriptive statistics were used to describe the sample, analysis of variance to compare means, and chi square to compare categorical variables. RNs reporting higher levels of verbal abuse from nurse colleagues were more likely to be unmarried, worked in a hospital setting, or worked in a non-magnet hospital. They also had lower job satisfaction, and less organizational commitment, autonomy, and intent to stay. Lastly, they perceived their work environments unfavorably.

Sellers, Millenback, Kovach, and Yingling (2009-2010) conducted a study using the MacGregor-Burns Transformational Leadership theory, which focuses on the interaction of leaders and those being led as collaborators working toward mutual benefit, as a theoretical framework. In the pilot, a convenience sample of registered nurses in New York State who are members of the New York Organization of Nurse Executives (NYONE) completed demographic information and part one of Briles' Sabotage Savvy

Questionnaire, a tool that measures occurrences of horizontal violence (HV) and nurses' knowledge of HV. Part one (40 questions) of the questionnaire determined if the study participant had ever been sabotaged or had knowledge of sabotage in the work setting. The questionnaire was completed via an e-mailed survey and through distribution to those attending the 2008 Annual Leadership Meeting of NYONE. Descriptive statistics including percentages mean, median, mode, and standard deviations, and other measures of dispersion were calculated. In addition, Chi Square analysis, where appropriate, was used to determine the presence of differences in frequencies among groups. The findings were consistent with the theoretical literature that suggests that HV is so ingrained in nursing's organizational culture that it is not recognized; until a phenomenon is recognized and named little can be done to alter it. Nurses pride themselves in being part of a caring profession. It is incongruous then, and most likely creates cognitive dissonance among practicing nurses, if behavior such as HV is endemic.

McKenna, Smith, Poole, and Coverdale (2003) conducted a study to explore the prevalence of horizontal violence among nurses in their first year of practice. An anonymous survey was mailed to nurses in New Zealand who had become licensed in the year prior to November 2000. Five hundred and fifty-one completed questionnaires were returned. Information was requested on the type and frequency of interpersonal conflict, a description of the most distressing event experienced, the consequences of the behavior, and training to manage such events. The Impact of Event Scale was used to measure the level of distress experienced. Many new graduates experienced horizontal violence across all clinical settings. Absenteeism from work, the high number of respondents who considered leaving nursing and scores on the Impact of Event Scale all indicated the

serious impact of interpersonal conflict. Nearly half of the events described were not reported, only 12% of those who described a distressing incident received formal debriefing, and the majority of respondents had no training to manage the behavior.

Randle (2003) conducted a three year longitudinal study of self-esteem in 39 nursing students. Bullying emerged as an important theme in the qualitative interviews. Of the students participating in the study, 90% reported that the process of becoming a nurse was distressing and psychologically damaging. Their experiences were often negative and had repercussions on how they felt about themselves as student nurses and as individuals. All the students who participated were able to provide examples of nurses who used their position and power to bully subordinates. Student nurses on the receiving end of bullying tactics felt powerless, reacted by working harder at fitting in, and maintained the status quo to make other nurses respond to them positively. Toward the end of their course when students were able to reflect, they had a greater awareness of the power that nurses exercised over them. Randle concluded that students begin to assimilate such tactics into their nursing practice as they identify with becoming a nurse during their education program

Curtis, Bowen, and Reid (2007) used a questionnaire to investigate 152 second and third year nursing student's experiences of horizontal violence (either directly experienced or witnessed). Analysis identified five major themes: humiliation and lack of respect, powerlessness and becoming invisible, hierarchical nature of horizontal violence, coping strategies, and future employment choices. More than half of the sample indicated that they had experienced or witnessed horizontal violence; importantly, most of these also indicated that it would impact on their future career and/or their

employment choices. Strategies are discussed that could be implemented to reduce the effect of horizontal violence, including giving a higher priority to debriefing within a supportive university environment, and teaching assertiveness and conflict resolution skills within the Bachelor of Nursing Degree.

Literature Related to Theoretical Framework

No studies were found that linked lateral violence and Conti-O'Hare's Theory of the Nurse as a Wounded Healer.

Strengths and Limitations of Literature

Strengths

The literature available on this topic is significantly diverse on the basis of the population covered and the different periods of study. For instance, the different studies involved take into consideration different aspects of humanity, which include the cultural, social, and economic differences of the study group (Vessey, Demarco, & DiFazio, 2011). The intercultural aspect of healthcare services is well considered through the comparative nursing practices from different geographical and cultural backgrounds. On the other hand, the number of sources from which the compilation of the literature was done is sufficient for ensuring validity of the findings and the eventual inferences driven from the studies (Sellers et al., 2009). The fact that the sources of data used in the compilation involved both primary and secondary data sources validates the findings of the research studies, and by extension, the validity of the literature, which makes it stronger and valid for use in determination of solutions to the existing problems (Roche et al., 2010).

Weaknesses

Despite the significant level of information provided by the literature, it is evident that the findings of the studies from which the information is obtained exhibits a significant level of assumptions, which may not hold true for the entire nursing profession globally (Sellers et al., 2009-2010). Similarly, the lack of comprehensive studies from other geographical regions of the world means the assumptions made on the basis of the western population may not give a perfect reflection of the other overlooked population.

Summary

This review is a basic analysis of the different forms of lateral violent behaviors witnessed within the healthcare settings. The findings from the review suggested that lateral violence is a common phenomenon as demonstrated through the different findings from the studies. The main objective of the nursing practice is the provision of quality healthcare services to the patients at the least inconveniences possible. However, the lateral forms of violence have great effects to the patient both directly and indirectly. The negligence prompted by the forms of violence, which include victimization and bullying of the nursing staff, are seen to be the most prominent forms of malpractice within the nursing practice. Therefore, patients are bound to suffer from these uncouth professionalisms, especially through reception of low quality, delayed, or missed medical attention from the healthcare providers.

The lack of proper mechanisms for conflict resolution and management of team spirit are among the challenges to be addressed in order to guarantee violent-free working environment. There is need for brainstorming among the different health stakeholders in

order to develop effective measures to curb violence related malpractices and enhance quality of service for the patients. This review similarly identified the different frameworks upon which the study assumptions are based, most notably, that the sample study used in acquisition of the findings is a representative of the nursing practice in entirety. There is an assumption that every nurse is affected by the traumatic and torturous workplace violence, which have impacted negatively on their passion for the job they do.

CHAPTER III

Methodology

The purpose of this study was to determine the types, frequency, and scopes of emergency room nurses' personal experience with disruptive behavior and its impact on staff, their patients, and the organization. The following chapter presents the design, setting, sample, methods, and ethical considerations to protect human subjects, instrument, data collection procedure, and data analysis procedure used in this project.

Research Design

A descriptive study was used to gather information regarding the experiences of emergency department nurses with lateral violence. The Johns Hopkins Disruptive Clinician Behavior survey was sent out for participants to complete.

Setting

Various emergency departments throughout the United States were the selected setting for this study. The emergency departments were not associated with any one type of facility, organization, or region within the United States.

Sample

Snowballing was used to recruit 70 licensed registered nurses. To be eligible for the study, participants must be licensed registered nurses who were currently working in an emergency department in the United States.

Protection of Human Subjects

Prior to conducting the surveys, the researcher obtained permission from the Internal Review Board (IRB) form the University. Informed consent (Appendix A) was obtained prior to participants voluntarily completing the questionnaire and demographic

forms. The informed consent form explained the purpose of the study, the rights of the participants in the research study, and provided detailed information concerning the potential risks and benefits of the study. Each individual participant was provided the opportunity to read and have explained the information on the consent form. A copy of the consent was included at the beginning of the survey stating that participants provided informed consent by completing and submitting the form to the researcher. The participants who participated in the research survey were informed that their participation was strictly voluntary and that their participation and answers would be kept confidential.

Instruments

Participants were asked to complete a demographic form developed by the researcher and the Johns Hopkins Disruptive Clinician Behavior Survey. The demographics form (Appendix B) was used to determine the age, gender, years in nursing, and the type of facility the participants currently work in.

The researcher distributed the 48-item Johns Hopkins Disruptive Clinician Behavior Survey (Appendix C). Prior to the data collection, permission to use the tool was obtained (Appendix D). The Johns Hopkins Disruptive Clinician Behavior Survey was designed to facilitate empirical research to reduce disruptive clinician behaviors. Studies have determined that the tool is reliable (Cronbach α = .79-.91), shows high content validity (Content Validity Index = .97), and has significantly high correlations with theoretically selected variables (Dang, Nyberg, Walrath, & Kim, 2014).

Data Collection

The survey was randomly distributed to nurses via the social media site Facebook via wall postings and personal email addresses. Those registered nurse colleagues were then asked to forward the electronic survey to other registered nurse colleagues they feel may be interested in participating in the study.

Data Analysis

Individual surveys were collected via the website SurveyMonkey and reviewed for completeness. The researcher entered data into a personal computer using the Statistical Package for Social Sciences (SPSS), Version 22. Data from the questionnaire were analyzed quantitatively using descriptive statistics.

CHAPTER IV

Results

The purpose of this study was to determine the types, frequency, and scopes of emergency room nurses' personal experience with disruptive behavior and its impact on staff, their patients, and the organization. The following chapter outlines the statistical analysis of the findings.

Demographics

Of the 70 participants, 88.6% (n=62) were female compared to 11.4% (n=8) male. Further, 91.4% (n=64) were White (non-Hispanic) while 4.29% (n=3 were of mixed racial background. Type of emergency department employment included 61.4% (n=43) in a Level I Trauma center, 15.7% (n=6) in a Level II Trauma center, 15.7% (n=5) in a Level III Trauma center, and 22.9% (n=16) work in a Community Hospital. Educational background of participants included 45.7% (n=32) with an associate's degree, 45.7% (n=32) with a bachelor's degree, 4.3% (n=3) with a master's degree, and 4.3% (n=3) reported other. The frequency distribution of the demographic variables of participants is presented in Table 1.

Table 1

Frequency Distribution of Demographic Variables of All Participants

Demographic Variable	*n*	%
Gender		
Female	62	88.6
Male	8	11.4
Ethnicity		
White (non-Hispanic)	64	91.4
Mixed racial background	3	4.29
Asian	1	1.43
Black or African American	1	1.43
Hispanic/Latina(o)	1	1.43
Type of Emergency Department		
Level I Trauma Center	43	61.4
Level II Trauma Center	6	15.7
Level III Trauma Center	5	15.7
Community Hospital	32	22.9
Education		
Associate	3	45.7
Bachelors	3	45.7
Masters	3	4.3
Other	3	4.3

The average age of the registered nurses was 37 (sd=11.17) years, with a minimum of age of 23 years and a maximum age of 66 years. Most of the nurses who responded to the questionnaire have been registered for an average of 10 years with the years ranging from a minimum of less than one year to a maximum of 40 years.

Data Analysis

Descriptive statistics were used to determine the types and frequency of emergency room nurses' personal experiences with disruptive behavior.

Types and Frequency of Disruptive Behavior

Participants reported various types and frequencies of disruptive behavior in the workplace including conflict, condescending language, intimidation/threats, passive aggressive behavior, physical violence, professional disregard and rudeness/disrespectfulness. Frequency distributions are displayed in Table 2.

Table 2

Frequency Distribution of Reported Disruptive Behaviors

Behavior	*n*	%
Conflict		
Never	2	2.94
Rarely	22	32.4
Monthly	20	29.41
Weekly	18	26.47
Daily	6	8.82
Condescending language		
Never	7	10.29
Rarely	22	32.35
Monthly	20	29.41
Weekly	14	20.59
Daily	5	7.35
Intimidation/Threats		
Never	20	29.41
Rarely	31	45.59
Monthly	6	8.82
Weekly	7	10.29
Daily	4	5.88
Passive aggressive behavior		
Never	3	4.41
Rarely	16	23.53
Monthly	12	17.65
Weekly	16	23.53
Daily	21	30.88
Physical violence		
Never	36	55.4
Rarely	25	38.46
Monthly	4	6.15
Weekly	0	0
Daily	0	0
Professional disregard		
Never	8	12.31
Rarely	25	38.5
Monthly	17	26.15
Weekly	7	10.77
Daily	8	12.31
Rudeness/Disrespectfulness		
Never	6	9.23
Rarely	18	27.69
Monthly	19	29.2
Weekly	11	16.92
Daily	11	16.92

Person Instigating Disruptive Behavior

Further, 87.7% (n=57) of all respondents claimed to have observed another coworker as a target of unprofessional behavior. With 47.7% (n=31) of all respondents attributing unprofessional behavior that had the most negative impact on them (over the past year) to attending/staff physicians (18.5%, n=12) and staff nurses/registered nurses (29.2%, n=19). Most respondents experience unprofessional behavior especially from registered nurses on a monthly basis (27.4%, n=18) with more than half the respondents claiming that this behavior has been going on for more than a year (54.8%, n=34).

Triggers of Unprofessional Behavior

Participants reported various triggers of unprofessional behavior in the workplace including chronic, unresolved system issues; lack of competency; staff diversity; lack of teamwork; personal characteristics; pressure from high census, volume, and patient flow; and environmental overload. Frequency distributions are displayed in Table 3.

Table 3

Frequency Distribution of Triggers of Unprofessional Behaviors

Behavior	*n*	%
Chronic, unresolved systems issues		
Never	1	1.64
Rarely	9	14.75
Monthly	15	24.59
Weekly	13	21.31
Daily	23	37.7
Lack of competency		
Never	3	3.28
Rarely	24	39.3
Monthly	17	27.87
Weekly	12	19.67
Daily	6	9.84
Staff diversity		
Never	12	19.67
Rarely	34	55.7
Monthly	7	11.48
Weekly	5	8.20
Daily	3	4.92
Lack of teamwork		
Never	3	4.92
Rarely	16	26.23
Monthly	13	21.31
Weekly	16	26.23
Daily	13	21.31
Personal characteristics		
Never	2	3.28
Rarely	11	18.03
Monthly	17	27.9
Weekly	16	26.23
Daily	15	24.59
Pressure from high census, volume, pt flow		
Never	1	1.64
Rarely	3	4.92
Monthly	8	13.11
Weekly	17	27.87
Daily	32	52.46
Environmental overload		
Never	1	1.64
Rarely	7	11.48
Monthly	9	14.75
Weekly	17	27.87
Daily	27	44.26

Response to Unprofessional Behavior

Subsequently, most respondents (62.3%, n=38) generally agree that they treat unprofessional behavior with confidence but unfortunately most respondents do not report this behavior through a hospital reporting system. Interestingly, most respondents (57.3%, n=35) do not accommodate the unprofessional person's behavior in order to "avoid rocking the boat". This however seems to suggest that most respondents have an alternative preferable channel/mode of reporting and/or settling issues related to unprofessional behavior. This has been further reiterated by the fact that 88.5% (n=54) of the respondents either generally or completely disagree with not speaking up when they observe behavior that could negatively affect patients or employees. Further, about 62.3% (n=68) of all respondents attempt to clarify the reason for their unprofessional behavior while 47.5% (n=29) seek to support their supervisor/manager in addressing the unprofessional person.

Unfortunately, disruptive behavior has led to a number of key negative impacts at the work place. About 50.8% (n=31) of the respondents end up doing other people's work in order to avoid dealing with their unprofessional behavior. However, 95.1% (n=58) of the respondents would not hesitate to report deteriorating patient conditions to the unprofessional provider despite 33.3% (n=20) of respondents not being comfortable in addressing the unprofessional behavior. This is encouraging, in a sense, given the fact as it indicates that at the end of the day, the patient's life is more important than any personal differences between the clinicians.

Reason for Not Addressing Unprofessional Behavior

A number of factors have been identified that lead to disruptive behavior going unaddressed. Most respondents (45%, n=49) generally claim that they do not address unprofessional behavior either because they lack time or due to fear of the unprofessional individual. However, the major reason for this is that 51.7% (n=31) of the respondents' feel that nothing ever gets resolved when they address the person engaged in unprofessional behavior.

Impact of Unprofessional Behavior

Also, 88.33% (n=53) of all respondents feel that unprofessional behavior decreases their morale while 91.66% (n=55) feel that unprofessional behavior decreases their job satisfaction, 81.67% (n=49) feel that unprofessional behavior takes an emotional toll on them. In addition, 68.34% (n=41) of all respondents felt that unprofessional behavior causes them ethical dilemmas, 36.66% (n=22) of respondents reported unprofessional behavior causing them to have physical symptoms, while 81.67% (n=49) report that unprofessional behavior hinders their working relationships with team members, 6.67% (n=4) of respondents report that they have considered transferring to another unit, department, or residency program within their organization due to unprofessional behavior. Another 40% (n=24) report that they have considered seeking a position or residency in another organization due to unprofessional behavior, 6.67% (n=4) state that they plan to resign from their organization due to unprofessional behavior. The frequency distribution of the impact of unprofessional behavior is in Table 4.

Table 4

Frequency Distribution of Impact of Unprofessional Behavior

Unprofessional Behavior	*n*	%
Decreases my morale	2	3.33
Completely Disagree	5	8.33
Generally Disagree	26	43.33
Generally Agree	27	45.00
Completely Agree		
Decreases my job satisfaction		
Completely Disagree	2	3.33
Generally Disagree	3	5.00
Generally Agree	26	43.33
Completely Agree	29	48.33
Takes an emotional toll on me		
Completely Disagree	2	3.33
Generally Disagree	9	15.00
Generally Agree	25	41.67
Completely Agree	24	40.00
Causes ethical dilemmas for me		
Completely Disagree	4	6.67
Generally Disagree	15	25.00
Generally Agree	25	41.67
Completely Agree	16	26.67
Causes me to have physical symptoms		
Completely Disagree	11	18.33
Generally Disagree	27	45.00
Generally Agree	14	23.33
Completely Agree	8	13.33
Hinders my working relationships with team members		
Completely Disagree	2	3.00
Generally Disagree	9	15.00
Generally Agree	36	60.00
Completely Agree	13	21.67
In the past year I have		
Considered transferring	4	6.67
Considered another organization	24	40.00
Planned to resign from my organization	4	6.67
Not Applicable	25	46.67

CHAPTER V

Discussion

Nursing is considered the most stressful career with several studies indicating high levels of stress and burnout among the professionals than any other members of any professional bodies (Vessey et al., 2011). From a nurse psyche, there can be enormous amounts of pressure originating from personal relationships, daily living stressors, and caring of families among other sources. Like any other people, nurses are in dire need of a quick outlet where they can vent their negative cognitions and emotions they encounter in their day-to-day working environment.

Unfortunately, their peers who form the vulnerable group end up becoming the outlet hence become victims of lateral violence situations. Those who are most targeted in the working environment include the new graduates who need to be mentored and new nurses in the working environment that are unfamiliar of the operations of the unit or the daily duties. Finally, the nurses who are on the night shift and perceived not to be working hard compared to those who are working on other shifts. In the end, these victims become the wound that perpetuates in the working environment thus propagates the lateral violence into a cycle of violence (Taylor & Rew, 2011)

Implication of Findings

This study analyzed the types, frequency, and scopes of clinicians' personal experiences with disruptive behavior and its impact on staff, their patients, and the organization. The findings highlight the complexities associated with disruptive behavior. It is quite evident that there are a range of different types of disruptive

behavior, all of which rarely occur except for passive aggressive behavior and rudeness/disrespectfulness, which occur on a daily and monthly basis respectively.

The most common triggers of disruptive behavior identified in clinicians included chronic unresolved systems issues, pressure from high census, volume, patient flow, environmental overload, and lack of teamwork. However, this has brought about varied responses from different clinicians with some opting to speak up while others opting to pick up the slack left behind by unprofessional individuals. All in all, disruptive/unprofessional behavior has led to demoralization of other team members and subsequent loss of job satisfaction, which increases staff turnover. Healthcare organizations need to carefully review disruptive clinician behavior and put in place measures to curb this before it spirals out of control posing an imminent threat to quality of care and patient safety.

Application to Theoretical/Conceptual Framework

Conti-O'Hare's Theory of the Nurse as a Wounded Healer served as the theoretical framework for this study. This theory stated that people choose the professions they chose because of the experiences they have had in the past. As such, most nurses chose to be nurses because they experienced pain in the past and wish to relieve fellow humans of their pain (Anderson, 2011). The hurting experience and consequent trauma motivates these nurses to provide better, optimal patient care to their patients. This, however, hugely depends on whether and to what extent the nurse has been able to transform the traumatic experience and pain experienced in the past into self-therapy (Christie & Jones, 2014).

The Theory of the Nurse as Wounded Healer delineated how nurses can be affected by witnessing or experiencing lateral violence. The survey measured the effect of lateral violence on nurses by evaluating the impact of unprofessional behavior. The study found that lateral violence affects nurse's morale, job satisfaction, and takes an emotional toll on them.

Limitations

There were several limitations to the study that may have had an influence on the results. Data was collected randomly via a social media website, so therefore there was no tracking of how many surveys one particular person completed. Second, even though the survey targeted nurses, since the survey was posted on a social media website, there was no way to track if individuals whom completed it were truly nurses. Third, there was no way to track whether the surveys were completed with other individuals, or if any discussion about questions occurred.

Implications for Nursing

Any kind of violence in the working environment directly leads to serious negative outcomes for nursing professionals and other healthcare professionals, organization and the patients. Research showed that unsettled conflict and disruptive behaviors that lead to conflict adversely affected the safety and the quality of care delivery. On the other hand, healthcare systems are struggling with a shortage of nursing that is continuously being experienced, and this is projected to increase as more nurses go into retirement. Lateral violence has an adverse impact on the nursing profession ability to retain both new and long-term colleagues.

Nursing professionals recognized the need for cultural change to help in eliminating the effects of lateral violence at personal, organizational, national, and international levels. Interdisciplinary collaboration, training that addresses disruptive behaviors, and communication and education opportunities suggested improvements in the nursing fraternity. In the strategies being proposed, nurses are trained on how to delay automatic thoughts and have a different response through strategies that empower towards addressing lateral violence.

Nursing organizations do recognize that any kind of lateral violence in a working environment is serious. It is, therefore, important for the nursing profession to spearhead the steps of addressing this problem in the working place so that the process of recruiting and retaining nurses can be improved. The efforts being made to bring improvement in the care of patients are linked to the environment of the working place for nurses. A culture of safety is not natured by disruptive behaviors seen among the healthcare providers. It is clear by the virtue of the evidence provided that the impact of the disruptive behaviors that lead to lateral violence are serious and cause a negative impact in the nurses environment of work.

The problem caused by lateral violence in the working environment is broad reaching. Its implications are clear to both the current and the future projection of the shortage of nurses in the working places, in addition to quality of the care and safety being delivered to the patients. Disruptive behaviors that lead to lateral violence in the working environment has an enormous impact on the nursing profession's ability to recruit new nurses and the ability of the entire healthcare system and other nursing employers to retain nurses (Ferns, Stacey, & Cork, 2006).

Recommendations

According to Ferns et al. (2006), the following strategies are recommended so that any disruptive behavior that leads to lateral violence can be eliminated:

- Nurses together with nurse leaders, supervisors, and managers must adopt a model of professional ethical behavior.
- Recognize in advance and address appropriately any behavior that is disruptive in the working place through enhancing conflict resolution and conflict management
- Healthcare workers should reflect on their behaviors and communicate with each other respectively
- The healthcare professional should participate in collaborative-interdisciplinary approaches to prevent any violence from emerging.
- Work hand in hand to ensure the mission, vision, and values of the working environment are reflecting the professional code of ethics.
- Providing necessary support to any individual who has been impacted directly or indirectly by the lateral violence
- Promoting education and counseling to the victims of lateral violence
- Dissemination of information to the healthcare professionals as well as students to address conflict and at the same time provide the needed information on how to change behaviors that lead to lateral violence in the working environment.
- Evaluating the efficacy of the strategies needed to eliminate any lateral violence behavior from the working place.

Conclusion

Lateral violence and any other bullying behaviors in the emergency department that harms not only the healthcare personnel, but also the patients who are beings served. Research has pointed out that communication breakdowns and lack of team working are the main causes of errors being witnessed in the emergency department (Ferns et al., 2006). In any case, health professionals are afraid of speaking up because they feel intimidated by other healthcare workers. Rude behaviors in working environment have a significant impact on the healthcare workers and their ability to perform any cognitive task. On an ethical point of view, tolerant of any lateral violence is wrong and violates the basic oath of health care professionalism to keeping the patients safe.

On many levels, the effect of lateral violence is costly to the patients, the nurses who are victimized, their co-workers, and the entire hospital and the health system. Errors may result from the destructions that lateral violence seem to cause to an emergency department that already is full of stress, and this may put patients in further risk. The health workers and other personnel working in the emergency department must be educated to recognize and correct violence laterally to offer protection to their patients and themselves.

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Appendix A

Informed Consent

Lesley Swafford, RN, BSN is conducting a research study on how often nurses' experience or witness lateral violence in the Emergency Department and that experience affects the nurse. Lateral violence is unkind, distasteful, discourteous behavior nurses portray towards one another. Examples of lateral violence include: backstabbing, gossiping, rolling of the eyes, constant criticism, isolation, unequal assignments, angry outbursts, threats, undermining and sarcasm. Anyone who experiences stress related to lateral violence, or the completion of this survey is encouraged to seek help with their Employee Assistance Program.

The study consists of an electronic question survey. This questionnaire and demographic form will take approximately 30 minutes or less for you complete. Individual results of the study will NOT be shared and all study data will be aggregated and remain confidential.

Participation in this study is completely voluntary. You have the right to decline to participate. You may decide to stop participating in this study at any time before or after beginning the questionnaire. By completing and submitting your questionnaire and demographic form, you are providing your informed consent and that will serve as evidence of your consent to participate in the study. If you decide to participate in this study, please complete the questionnaire and demographic form electronically within 2 weeks of receiving the documents. You may electronically submit them back to the researcher. Please do not include any personal information or identifying marks on the form.

If you have any questions about the study you can call the researcher, Lesley Swafford at 704-472-6965 or the thesis advisor, Dr. Tracy Arnold at 704-406-4359.

Thanks in advance for your participation.

Appendix B

Demographics

Instructions: This is a demographic data collection form that requests information about you. This information will be used for research purposes only. Please answer each question truthfully and to the best of your ability and knowledge. All information provided will remain confidential.

Thank you for your participation.

1. How many years have you been a Registered Nurse (RN)? _____

2. What type of Emergency Department do you practice in?
    a. Level I Trauma Center
    b. Level II Trauma Center
    c. Level III Trauma Center
    d. Community Hospital

3. What is your gender?
    a. Male
    b. Female

4. What is your age? _____

5. What is your highest educational background in nursing?
    a. Associate's Degree in Nursing
    b. Bachelor's Degree in Nursing
    c. Master's Degree in Nursing
    d. Doctorate Degree in Nursing
    e. Other (please specify)

Appendix C

Johns Hopkins Disruptive Clinician Behavior Survey

1. What is your gender?
    a. Male
    b. Female

2. What is your racial/ethnic group?
    a. Asian
    b. American Indian or Alaskan Native
    c. Black or African American
    d. Hispanic/Latina(o)
    e. Native Hawaiian or Other Pacific Islander
    f. White (non-Hispanic)
    g. Mixed Racial Background
    h. Other

3. How many years have you been a Registered Nurse? _____

4. What is your age? _____

5. What is your current practice setting?
    a. Level I Trauma Center
    b. Level II Trauma Center
    c. Level III Trauma Center
    d. Community Hospital

6. What is your highest educational background in nursing?
    a. Associate's Degree in Nursing
    b. Bachelor's Degree in Nursing
    c. Master's Degree in Nursing
    d. Doctorate Degree in Nursing
    e. Diploma in Nursing
    f. Other (please specify)

In the past year, consider unprofessional behavior you have personally experienced by health care team member(s) (i.e., nurses, managers, physicians, support staff, or ancillary staff.) Examples of the behaviors are in parenthesis. Check the frequency of occurrence.

7. Conflict (ex. Contentious interactions and/or unresolved disputes between and among team members).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly

    e. Daily

8. Condescending Language/Dress Down/Power Play (ex. Being publicly humiliated, put down, insulted, ridiculed, embarrassed, demeaned, berated; criticized in front of staff/patients; pulling rank; dominating or controlling by rank or position; withholding information at your expense).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

9. Intimidation/Threats/Harassment (ex. Instilling fear through body language; threatening harm to your personal safety, property or job security; being reported to your manager/supervisor; bullying; excessive monitoring of your work; having someone "ride you" at work; "do this or else"; hazing).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

10. Passive aggressive behavior (ex. Co-workers intentionally not taking patient report when requested; incomplete sign-outs; negative attitudes expressed non-verbally; "copping an attitude," "setting you up" for failure or difficulty; avoiding or not communicating; avoiding work; work slow down; procrastination; deliberately not answering page or other requests.
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

11. Professional disregard (ex. Being dismissed, not listened to, or deliberately ignored when advocating for a patient or expressing a professional opinion; intentional disregard for hospital policies, procedures, protocols; taking credit for other's work).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

12. Rude/Disrespectful (ex. Lack of courtesy; sarcasm; discourteous tone; yelling; raised voice; not listening, ignoring, turning away; hanging up phone during conversations; engaging in malicious gossip; exclusion by cliques).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

13. In addition to your personal experience, have you observed other coworkers who have been the target of unprofessional behavior?
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

14. Physical violence (ex. Grabbing; shoving; pushing; hitting; slamming; fighting; throwing objects).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

15. In the past year, the role of the person whose unprofessional behavior has had the most negative impact on me is a (an)
    a. Attending/Staff Physician
    b. Fellow Physician
    c. Resident Physician
    d. Intern
    e. Affiliate Provider (Physician Assistant, Nurse Practitioner, CRNA, Certified Nurse Midwife)
    f. Nurse Leader (Nurse Manager, Assistant Nurse Manager, Shift Coordinator)
    g. Advanced Practice Nurse (Case Manager, Nurse Educator, Clinical Nurse Specialist)
    h. Charge Nurse/Preceptor
    i. Staff Nurse (Registered Nurse, LPN)
    j. Patient Care Assistant (Clinical/Patient Care Technician, Certified Nursing Assistant, Certified Medical Assistant)
    k. Pharmacist
    l. Therapist (Respiratory, Physical, Occupational, Speech)
    m. Social Worker
    n. Dietician/Nutritionist

o. Administrative Assistant (Clerical Associate; Registrar; Patient Services Coordinator; Customer Services Staff)
p. Clinical Ancillary Department Staff (Pharmacy; Respiratory Therapy; Physical/Occupational/ Speech Therapy; Social Work; Laboratory; Radiology; Pathology; Information Technology)
q. Non-Clinical Ancillary Department Staff (Admitting; Medical Records; Human Resources; Volunteer Services; Patient Relations; Security; Chaplain Services)
r. General Services Staff (Linen; Environmental Services; Patient Transport; Materials Management; Facilities; Dietary)
s. Department Leader (Chairman; Administrator; Director; Assistant Director; Manager)
t. Hospital Leader (President; Chief Operating Officer; Vice President)
u. Other

Role of the Unprofessional Person

16. In the past year, approximately how often have you personally experienced unprofessional behavior by the person identified in Question 15?
    a. 1 time only
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

17. Approximately how long has this unprofessional behavior by the person identified in Question 15 been going on?
    a. Less than a month
    b. 1 to 3 months
    c. More than 3 months, but less than a year
    d. A year or more

Triggers of Unprofessional Behavior

The following items (examples in parentheses) identify potential trigger(s) of unprofessional behavior(s). In the past year, consider the presence of these trigger(s) and check how frequently they resulted in unprofessional behavior(s) in your work area.

18. Chronic, unresolved system issues (ex. Lack of equipment, supplies, dietary items; unavailable patient transport; lack of schedules for testing procedures; medications not delivered; bed status not maintained; lack of trust in support systems).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly

    e. Daily

19. Lack of competency (ex. Actual or perceived lack of skills, knowledge, or ability; unwilling to admit not knowing; unwilling to ask for help; new to role, organization, or profession).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

20. Staff diversity (ex. Lack of sensitivity to cultural norms, values, differences such as gender, sexual preferences, socioeconomic status, religion, race, ethnicity, and language; generational differences).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

21. Lack of teamwork (ex. Not helping others; not cooperating; not holding others accountable; inconsistent team membership due to rotation schedules; not seeking input from others).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

22. Personal characteristics or issues impeding job performance (ex. Arrogance; passive aggressive; “chip on shoulder”; “short fuse”; “wired”; aggressive; perfectionist; unfit to perform job responsibilities; venting frustrations on others; personal issues).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

23. Pressure from high census, volume, and patient flow (ex. Lack of beds; financial pressures; complexity of patient care; boarding off-service patients; backups in patient admissions, transfers, discharges).
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly

e. Daily

24. Environmental overload (ex. Due to noise; interruptions; confined workspace on unit; lack of quiet space on unit; chaotic work environment)
    a. Never
    b. Rarely
    c. Monthly
    d. Weekly
    e. Daily

Response to Unprofessional Behavior

The following focus on responses to unprofessional behavior(s). Check your level of agreement with each statement.

25. I address unprofessional behavior with confidence.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

26. I report unprofessional behavior through a hospital reporting system.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

27. I accommodate the unprofessional person's behavior to "avoid rocking the boat."
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

28. I do not speak up when I observe behavior that could negatively affect patients or employees.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

29. I attempt to clarify the reason for the unprofessional behavior.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

30. I seek support from my manager/supervisor to address the unprofessional person.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

31. I do other people's work to avoid dealing with their unprofessional behavior.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

32. I do not report deteriorating patient conditions to the unprofessional provider.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

Reason for Not Addressing Unprofessional Behavior

The following statements are reasons for not addressing unprofessional behavior. Check your level of agreement with each statement.

33. I am not comfortable addressing unprofessional behavior.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

34. I do not have time to address unprofessional behavior.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

35. I avoid addressing the unprofessional person due to fear.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

36. I do not address because unprofessional behavior is the accepted norm.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

37. I feel nothing ever gets resolved when I address the person engaged in unprofessional behavior.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

38. I find it difficult to address the unprofessional person due to their status in the organization.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

Impact of Unprofessional Behavior

The following statements focus on the impact of unprofessional behavior on you, your work area, and/or your patients. Check your level of agreement with each statement.

39. Unprofessional behavior decreases my morale.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

40. Unprofessional behavior decreases my job satisfaction.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

41. Unprofessional behavior takes an emotional toll on me.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

42. Unprofessional behavior causes ethical dilemmas for me.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

43. Unprofessional behavior causes me to have physical symptoms
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

44. Unprofessional behavior hinders my working relationships with team members.
    a. Completely Disagree
    b. Generally Disagree
    c. Generally Agree
    d. Completely Agree

45. In the past year: CHECK ONE
    a. I have considered transferring to another unit, department, or residency program within my organization due to unprofessional behavior.
    b. I have considered seeking a position or residency program in another organization due to unprofessional behavior.
    c. I plan to resign from my organization due to unprofessional behavior.
    d. Not Applicable

Patient Harm Due to Unprofessional Behavior

46. In the past year, unprofessional behavior event(s) resulted in a "near miss" for an error or adverse event to my patient(s).
    a. Yes
    b. No
    c. Not applicable

47. In the past year, unprofessional behavior event(s) resulted in harm to my patient(s).
    a. Yes
    b. No
    c. Not sure
    d. Not applicable

48. If YES to Question 47, which of the following responses best describes the level of harm that occurred: CHECK ONE
    a. Temporary harm to my patient (ex. Requiring treatment or intervention or prolonged hospitalization)
    b. Permanent harm to my patient (ex. Wrong procedure done, wrong site surgery)
    c. Harm requiring intervention necessary to sustain life (ex. Intubation, emergency surgery)
    d. Death
    e. Not Applicable (not involved in direct patient care)

Appendix D

Permission to Use the Johns Hopkins Disruptive Clinician Behavior Survey

Dear Lesley,

Thank you for your interest in using the *Johns Hopkins Disruptive Clinician Behavior Survey (JH-DCBS)*© . Johns Hopkins grants you permission, limited to the use of the JH-DCBS© for your MSN/MBA thesis. Permission is also granted to modify the following items so that you may make them context specific:

1. **Title or first page**
2. **Demographics**
3. **Question 14** [In the past year, the role of the person whose unprofessional behavior has had the most negative impact on me is a(an):]
4. **Final "Thank You" page**

We can either provide the *Survey* in paper form or can transfer it to you electronically via SurveyMonkey™ to a specific User ID that you provide. We will send it as soon as you let us know your preference.

A

s part of this agreement, we ask that you share your findings and provide us with a data file with your de-identified data so that we may continue to evaluate the validity of the survey. Please send Sharon Strobel, MS, RN, Study Coordinator, an estimate of when we may anticipate this information and provide the raw data in an Excel file format. The following reference may be used when reporting your results and findings:

Dang, D., Nyberg, D., Walrath, J.M., & Kim, M.T. (2014). Development and validation of the Johns Hopkins Disruptive Clinician Behavior Survey.

American Journal of Medical Quality, (in press).

We are very interested in your use of the JH-DCBS© and hope that you keep us apprised of your experiences, findings, presentations and publications related to its use. Please feel free to contact Sharon Strobel, MS, RN (Tel: 410-502-4612; email: sstrobe1@jhmi.edu) if you have any questions.

Sincerely,
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