J Nurs Care Qual
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Hospital RNs' Experiences With Disruptive Behavior

A Qualitative Study

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Disruptive behavior in healthcare has been identified as a threat to quality of care, nurse retention, and a culture of safety. A qualitative study elicited registered nurse experiences with disruptive clinician behavior in an acute care hospital. A conceptual framework was developed to provide a structure for organizing and describing this complex construct that includes 4 primary concepts: disruptive behaviors and its triggers, responses, and impacts. **Key words:** *disruptive behavior*, *focus group*, *nurse and physician disruptive behavior*, *qualitative study*, *workplace aggression*, *workplace incivility*, *workplace violence*

DISRUPTIVE CLINICIAN BEHAVIOR and its potential effect on organizational culture, nurse recruitment and retention, and the quality and safety of patient care are a growing concern in healthcare organizations that needs to be addressed.[1] Disruptive behavior is an overarching term applied to a wide range of "bad behaviors" that are reported in the healthcare literature. The American Medical Association[2] defines *disruptive behavior* as personal conduct, whether verbal or physical, that negatively affects or potentially may affect patient care including, but not limited to, conduct that interferes with one's ability to work with the other members of the healthcare team. While professionals and organizations have tried to self-regulate this behavior through zero-tolerance position statements and code-of-conduct policies, evidence from the literature confirms that disruptive behavior is still prevalent in healthcare.[3-9]

In July 2008, The Joint Commission published a Sentinel Event Alert in response to the growing recognition that disruptive behavior negatively impacts the quality and safety of patient care.[10] Regulatory standards now require organizations to have a code of conduct that specifically defines "acceptable and disruptive and inappropriate staff behaviors" and that "leaders create and implement a process for managing disruptive and inappropriate staff behaviors."[11(pp32–33)] These regulations are designed, in part, to establish a culture of safety and quality throughout an organization.

An essential first step to addressing disruptive clinician behavior is to gain an understanding of the frequency, types, and significance of disruptive behavior in healthcare organizations. The purpose of this study was to conduct focus groups with registered nurses (RNs) to gain an understanding of how RNs describe disruptive clinician behavior and its impact based on their observed and actual experiences on the front lines of patient care delivery. This article presents

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The study was funded by a State of Maryland Health Services Cost Review Commission Nurse Support Program I Grant. The authors thank Michael Heitt, PsyD, focus group facilitator, for his contributions to this study.

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Accepted for publication: October 24, 2009

the findings of the RN focus groups and the conceptual framework that guided this investigation.

CONCEPTUAL FRAMEWORK

Disruptive behavior is a complex construct. Recent literature reflects numerous disruptive behaviors, most of which have inconsistent or imprecise definitions. To fully understand this behavior, it is also necessary to examine the causes of disruptive behavior,[12-15] how individuals respond to these behaviors,[13,16] the effects of these behaviors on individuals[5,13,17-19] and organizations,[5,13,15,18,20,21] and the perceptions of harm to patients.[5,16,19,22] However, we found no conceptual framework in the healthcare literature that encompassed these interrelated concepts in a meaningful way. Adapting Pearson and colleagues' framework[17] on workplace incivility, we developed a conceptual model with 4 primary concepts to provide a structure for organizing and describing this complex construct: triggers, disruptive behaviors, responses, and impacts (Fig 1). A trigger to disruptive behavior is a trait or preceding event, condition, or cause that contributes to the occurrence of a disruptive behavior event. As previously defined, disruptive behavior is personal conduct, whether verbal or physical, that negatively affects or potentially may affect patient care and interfere with one's ability to work with the other members of the healthcare team.[2] A response is an individual's reaction or reply to the disruptive behavior. The impact is the direct or indirect effect the disruptive behavior has on a healthcare provider, patient, team, or organization.

METHODS

Design/sample

A qualitative study design elicited RNs' perspectives on disruptive clinician behavior in an acute care hospital. A purposive sample of 96 RNs was recruited from all practice settings (ambulatory, inpatient, and specialty/procedure areas) and all practice roles to participate in a focus group. Because participants had a similar context in terms of their roles, professional relationships, and practice settings, each focus group provided a safe environment to describe and share their personal experiences with disruptive behavior. The recruitment process included distribution of information about the study across the Department of Nursing via posters, internal Web sites, and individual letters to RNs ($N = 2467$). The focus group sessions were conducted during work hours in a private area.

Setting

The study was conducted in an acute care hospital within an academic medical center located in the Northeastern United States. The hospital has 925 staffed beds and 81 nursing

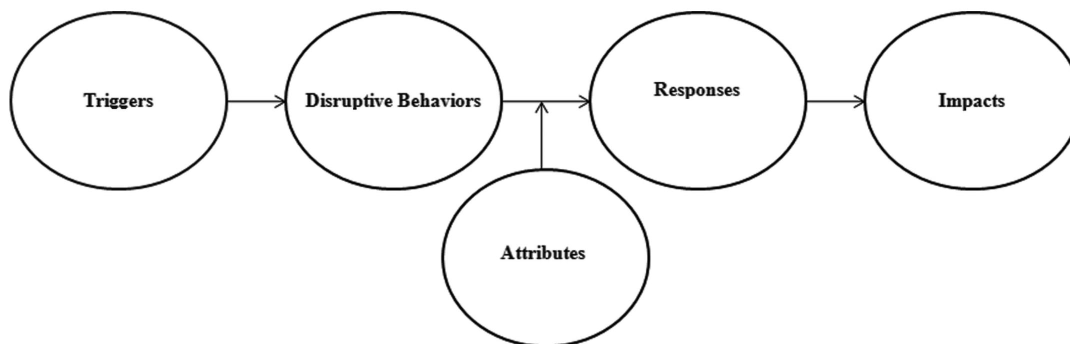

Figure 1. A conceptual framework for disruptive behavior. Reprinted with permission from The Johns Hopkins Hospital. Copyright 2008, Johns Hopkins Hospital.

units and provides tertiary care to local, regional, and international patients. This hospital is accredited by The Joint Commission and has Magnet recognition.

Data collection

After obtaining institutional review board approval and oral consent from participants, a clinical psychologist, external to the organization, facilitated 90-minute focus group sessions, using semistructured interview questions. Procedures for ensuring the confidentiality of sensitive information about disruptive behaviors included the use of pseudo names when describing individuals involved in disruptive behavior events. The sessions were audio-recorded and held between January and March 2008.

Interview questions, based on the conceptual framework, guided the focus group discussions. The 4 areas explored during these interviews were to (1) describe the types, characteristics, and diverse experiences that RNs had with disruptive clinician behavior; (2) identify the triggers that may precipitate disruptive behaviors; (3) learn how RNs respond to disruptive behavior; and (4) identify the impact of disruptive behavior on RNs, their patients, and their practice setting. The facilitator opened the sessions by asking participants to identify disruptive behaviors they had observed or experienced in their work setting. The participants were probed to further explain their comments in order to gain a deeper understanding of the RNs' experiences with disruptive behavior.

Data analysis

The audio-recorded sessions of the focus groups were transcribed verbatim and validated for accuracy against the original recordings. Nudist6,[23] a software program designed for narrative analysis, was used to manage the interview data and facilitate the coding process. Deductive and inductive processes were used to code the data.[24,25] These included the use of codes derived from the literature as well as new codes identified from the transcripts. Two members of the research team (D.N. and J.M.W.) independently assigned codes to text segments of the transcribed interviews. After achieving consensus on the codes through comparison and discussion, the full research team came together to review, identify patterns, and synthesize the initial codes into broader categories. Finally, these categories were further synthesized into major themes and organized according to the 4 primary concepts in the conceptual framework.

FINDINGS

Description of sample

Ninety-six RNs volunteered to participate in 1 of the 10 focus groups. Focus group size ranged from 7 to 14 RNs. Participants included nurse leaders, nurse managers, and shift coordinators ($n = 31$; 32.3%). Fifty-two percent ($n = 50$) of the participants were staff nurses from practice settings such as the operating room (OR), postanesthesia care unit, intensive care unit, emergency department, specialty procedure, and inpatient units. Nurses practicing in advanced roles, including nurse practitioners, clinical nurse specialists, and nurse educators, comprised 15.6% ($n = 15$) of the participants. Ninety-five percent ($n = 91$) of the participants were female, with an average age of 45 years and an average of 23 years of nursing experience. While the majority of participants were white (non-Hispanic) ($n = 68$; 70.8%), RNs of Asian ($n = 12$; 12.5%), Black or African American ($n = 9$; 9.0%), and Hispanic/Latino ($n = 3$; 3.1%) race/ethnicities also participated. Forty-three (44.7%) participants held a baccalaureate degree in nursing and 40 participants (41.7%) had a master's or doctoral degree. Nine participants (9.4%) had an associate degree in nursing. Four participants (4.2%) declined to answer the ethnicity or education questions.

Disruptive behaviors

Participants reported the occurrence of disruptive behaviors in all practice settings and between and among a wide variety of

Table 1. Disruptive behaviors: Themes, categories, and examples

Theme	Category	Examples
Incivility	Rude/disrespectful	Lacking courtesy, sarcastic, discourteous tone, not listening, ignoring, turning away, handing up phone during conversation
Psychological aggression	Engaging in gossip	Making derogatory comments behind one's back, spreading rumors, vindictive behavior, mean spirited comments, negatively labeling others
	Intimidation/threats	Instilling fear through body language; threatening harm to one's personal safety, property, or job security; being reported to one's manager; bullying
	Passive aggressive behavior	Negative attitudes expressed nonverbally, "copping an attitude," "setting you up" for failure or difficulty, avoiding or not communicating, avoiding work, work slow down, procrastination, deliberately not answering pages or other requests
	Refusal to do one's job	Refusing or intentionally not completing an assignment
	Verbal aggression	Yelling, raised voice, temper tantrums, angry outbursts, arguing, abusive tone of voice, using profanity
	Power play	Dominating or controlling others by position, withholding information at the expense of others
	Condescending language/dress down	Being publicly humiliated, put down, insulted, ridiculed, embarrassed, demeaned, berated, criticized in front of staff/patients
	Professional disregard	Being dismissed, not listened to, or deliberately ignored when advocating for a patient or expressing a professional opinion
Violence	Physical violence	Grabbing, shoving, pushing, hitting, slamming, fighting, throwing objects

healthcare personnel. A total of 168 different disruptive behaviors were identified and then synthesized into 21 categories. Within these categories, 3 themes or patterns of disruptive behavior emerged: incivility, psychological aggression, and violence. The 10 most frequently identified categories and examples of disruptive behavior within the themes of incivility, psychological aggression, and violence are presented in Table 1.

Workplace incivility was defined as low-intensity deviant behavior that violates workplace norms for mutual respect, may or may not be intended to harm the target, does not physically threaten the target, and may transcend organizational hierarchy.[26,27] The theme of incivility was captured in participants' comments about the rude and disrespectful behavior they experienced on a regular basis: "It's the overt or covert lack of common courtesy," "the sarcastic, curt, discourteous tone of voice," and "someone hanging up the phone in the middle of your conversation" or "ignoring you and walking away when you are trying to explain something."

Psychological aggression was defined as active or passive behaviors that intentionally inflict psychological injury to the target.[21,28] Three categories of disruptive behaviors in this theme were gossip, intimidation, and passive aggressive behavior. One participant reported that "gossiping is huge ... [it] can be quite maligning and very vindictive. People want to leave and run for the hills because of the intensity. You cannot undo the impact of gossiping on the unit."

Another form of psychological aggression described by the participants was the

presence of intimidating cliques on the nursing unit. Nurses, excluded from these cliques, reported that their nursing practice was "policed" by members of the clique. This intimidating behavior and its escalating effects are described in the following quote: "Cliques are always waiting for a particular nurse to make a mistake so they can crucify her ... then it moves into the gossip realm ... it just perpetuates and creates an unfavorable environment."

There was general consensus from the focus groups that passive aggressive behavior was exhibited through e-mails: "Passive aggressive people love e-mail ... the person who is uncomfortable with confrontation is definitely going to get into an e-mail war with you before they go face to face. It is very disruptive and results in mistrust."

Violence was the third theme of disruptive behaviors that emerged. *Violence* was defined as physical, active, and direct forms of aggressive behavior. One RN described an incident "on rounds one morning when the [attending physician] got so worked up and threw a pen that bounced off the cart and ... narrowly missed another physician's face.... [Since this attending] has such a long-standing history of this [type of behavior] rounds continued. It was like nothing had happened." Another example of physical violence included "a situation where two staff members got into a physical altercation on the unit ... about what their job responsibilities were ... resulting in shoving and pushing to the point that we had to call security."

Triggers to disruptive behavior

Participants were asked to identify triggers to the disruptive clinician behaviors they had observed or experienced in their practice setting. There were 137 different triggers coded. These triggers were synthesized into 19 categories and finally collapsed into 3 themes: intrapersonal, interpersonal, and organizational triggers.

Intrapersonal triggers were those traits or conditions occurring within the individual, such as personal characteristics, lack of competency, or fatigue that could lead to a disruptive behavior event. Nurses described "personalities that are controlling and aggressive", which inhibit effective communication by demanding that "it's this way," "I'm right," and "you follow what I say."

Focus group participants identified the actual or perceived lack of competency in a new RN as a trigger for disruptive behavior. An experienced nurse justifies "being harsh and critical" toward the new nurse because she is "concerned about patient safety ... if [she] hasn't worked with the new nurse in enough critical situations to trust her competency."

Fatigue was identified as another intrapersonal trigger. One RN describes how her fatigue can trigger disruptive behavior after working 3 or 4 12-hour shifts in a row: "[I] grab a snack here and there ... [I] do not eat well or rest [my] mind on a 12-hour shift ... how can [you] even think clearly to have a reasonable conversation with someone when you're hungry and really tired?"

Interpersonal triggers involve relationships between 2 persons. The use of status to control others and the lack of information to care for patients are 2 examples of interpersonal triggers. Both of these triggers are described by this nurse when she informed a physician about a laboratory result at 9:00 AM and again called the physician at 2:00 PM because no treatment had been initiated and no rationale provided. The physician's response to this call was "I'm the physician. I believe it's a contaminant and I'm not going to treat the patient." The nurse informed the physician that "the patient is unstable and the policy for an immunocompromised patient is to believe it is an infection and initiate treatment ... the physician got very upset that I was questioning her medical practice and role as a physician."

Organizational triggers referred to the systems, processes, culture, or a climate that inhibits interactions or work. The most frequently identified organizational trigger was pressure from high census, volume, and patient flow. One nurse captured the overall

Table 2. Triggers to disruptive behavior: Themes, categories, and examples

Theme	Category	Examples
Intrapersonal	Personal characteristics	Arrogance, passive aggressive, "chip on shoulder," "short fuse," "wired," aggressive, "type A personality," perfectionist
	Lack of competency	Actual or perceived lack of skills, knowledge, or ability; unwilling to admit not knowing, to ask for help; new to role, organization, or profession
	Fatigue	Twelve-hour shifts, number of hours worked, scheduling patterns, work-life imbalance
	Stress	Due to time pressures, fast-paced environment, rapid decision making, competing and/or unreasonable demands, lack of support, fear of making mistakes, unresolved conflict
	Personal issues impeding job performance	Physically or mentally unfit to perform job during work hours, family or financial issues, lack of support systems
Interpersonal	Use of actual or perceived status to control others	Status could include title, position, role, experience, expertise
	Lack of information to care for patient	Not communicating patient's plan of care, incomplete operating room postings, withholding information
Organizational	Pressure from high census, volume, patient flow	Lack of beds, financial pressures, complexity of patient care, boarding off service patients, backups in patient admissions, transfers, discharges
	Unit/organizational culture	Norms that foster not taking breaks, competitiveness, unrealistic expectations, acceptance of system inefficiencies, expected to be available at all times
	Chronic, unresolved systems issues	Lack of equipment, supplies, dietary items, schedules for testing procedures; medications not delivered; bed board status not maintained; lack of trust in support systems

sentiment of the focus groups as she described the increasing patient census as the clinical week unfolded. The interdependencies of ORs, postanesthesia care units, intensive care units, and inpatient units "can create tremendous stress . . . can we move our patients through the system? . . . everything backs up . . . everyone is stressed trying to figure out where these patients are going to go. As the week progresses, the disruptive behavior goes up. You have Monday behaviors that are OK, then boom, you have Wednesday behaviors and Friday behaviors." Table 2 presents the 10 most frequently identified categories and examples of triggers within the 3 themes.

Responses to disruptive behavior

Focus group participants also discussed their response, or lack of response, to disruptive behavior. Ninety-four responses were identified, which were coded, and 3 themes emerged. These included responses that were positive and negative, and instances when the respondents chose not to respond to the disruptive behavior.

Positive responses were those most likely to constructively address the disruptive

behavior. A total of 59 positive responses were coded and synthesized into 3 categories: address constructively, analyze the situation, and seek support. Nurses on one unit developed a constructive strategy to address "unacceptable behavior on rounds by creating a penalty flag that any member of the team could use to call a time out when the disruptive behavior was occurring ... thus empowering the staff to establish norms for acceptable behavior." Another nurse described how she steps back and analyzes the disruptive behavior event to "develop personal strategies for responding to such behaviors in the future." Nurses also reported seeking support from their peers, manager, security, or staff assistance programs, or by using the chain of command to address disruptive behavior.

Thirty-five negative responses were coded and synthesized into 4 categories: avoid, accept, accommodate, and react negatively to disruptive behavior. A nurse described how she avoids addressing the disruptive individual when she is "in an emotionally charged situation and I have not rehearsed in my mind the words that are going to come out ... [I] feel backed into a corner and take the path of least resistance." Nurses spoke about how they altered their own behavior to accommodate a disruptive individual with whom they have had prior negative interactions. "Prior [disruptive] behavior with an individual changes the level of collaboration that you feel you can have with the person and how you present patient issues" and "You approach the high risk personality differently because you know what will set them off."

While some nurses report that they avoided or accommodated the disruptive individuals, others accepted the negative behavior as "part of their job." This negative response was expressed in RNs' comments such as "you just have to deal with it," "manage it," "it's part of your role as a nurse," and "just move on."

Participants also discussed reasons why they do not confront the instigator of disruptive behavior. The 5 most frequently cited reasons included (1) lack of skills to confront, (2) not comfortable confronting, (3) fear of retaliation, (4) fear due to prior experiences with the disruptive person, and (5) unwillingness to deal with the negative attitude of the disruptive individual.

Instigators of disruptive behavior

Participants described disruptive behavior scenarios they had observed or experienced. From these scenarios, 225 disruptive behavior events were coded. Physicians were identified as instigators in 42% ($n = 95$) of these events; nurses in 29% ($n = 66$); support personnel such as patient care assistants, OR technicians, environment of care support associates in 27% ($n = 60$); and management in 2% of the time. These events occurred among many combinations of instigator/target dyads.

Impact of disruptive behavior

Participants were asked to describe the impact of disruptive behavior on themselves and others. Ninety descriptions were synthesized into 3 themes: impact on the RN, patient, and the nurse's practice setting. One nurse described the significant effects of incivility experienced with "everyday rudeness ... the impact of it is great ... it affects your morale, your investment, how long you are willing to work, whether you feel like coming to work."

Another nurse described the personal impact of psychological aggression, specifically verbal aggression, as she used the chain of command to address a "patient care issue that a [resident] will not listen or respond to ... as I move up the [physician] chain of command, I put myself in the firing line because that [attending] physician will go back to the resident ... [then] the resident walks right up to me in the middle of an open area ... explodes, wonders why I did what I did, questions me, and uses profanity. I feel threatened as a person. My face turns red, it takes my breath away and my heart speeds up."

Other nurses described further how disruptive behavior personally affected them, their practice setting, and the patient. "Threatening behavior does not feel good ... people internalize it, and it destroys an effective work

environment." Another nurse commented: "it absolutely leads to distraction and [jeopardizes] the quality and safety of patient care." Disruptive behavior can have a trickle-down effect on patients as one nurse stated: "patients are recipients of disruptive behavior as well. Somebody who is disruptive in the workplace is not going to turn it off when they go into the patient's room."

Finally, nurses described the impact of disruptive behavior on nurse retention. Each group of participants was asked if "they knew a nurse who had transferred to another unit or department due to disruptive behavior." Forty-six nurses (48%) responded yes. In addition, 33 (34%) stated that they knew nurses who had left the organization because of disruptive behavior.

DISCUSSION AND NURSING IMPLICATIONS

This study, guided by the conceptual framework, used the voices of RNs to gain insight into the types of disruptive behavior they had experienced or observed. Unlike most other published studies, RNs also described triggers to disruptive behavior, how they responded to this behavior, and the impact it had on themselves, their patients, and their practice settings.

The conceptual framework provided a structure for organizing the interrelated disruptive behavior concepts into meaningful categories and themes that facilitated a better understanding of the complex disruptive behavior construct. Insights from these RNs further informed the 4 primary concepts in the conceptual framework, triggers, disruptive behaviors, responses, and impacts, resulting in an expanded framework as illustrated in Figure 2.

Intrapersonal, interpersonal, and organizational themes were triggers for disruptive behavior. Of the top-10 trigger categories, the majority of the triggers leading to disruptive behavior were intrapersonal (see Table 2). These triggers require one to recognize how their internal state contributes to the occurrence of disruptive behavior because the corrective action often lies within the individual. An unexpected finding was the low frequency of interpersonal triggers considering that teamwork and communication are key processes in the delivery of patient care. Not surprising, all focus groups discussed production pressure from high census, volume, and patient flow, which became the most frequently identified organizational trigger. When investigating the root cause of a disruptive behavior event, each of these triggers and their potential contribution to the event should be assessed.

The disruptive behavior themes of incivility, psychological aggression, and violence represent a continuum of low- to high-intensity behaviors (see Table 1). Within these 3 themes, the majority of disruptive behaviors described by the focus group participants were categorized as psychological aggression; fewer behaviors were categorized as incivility or violence.

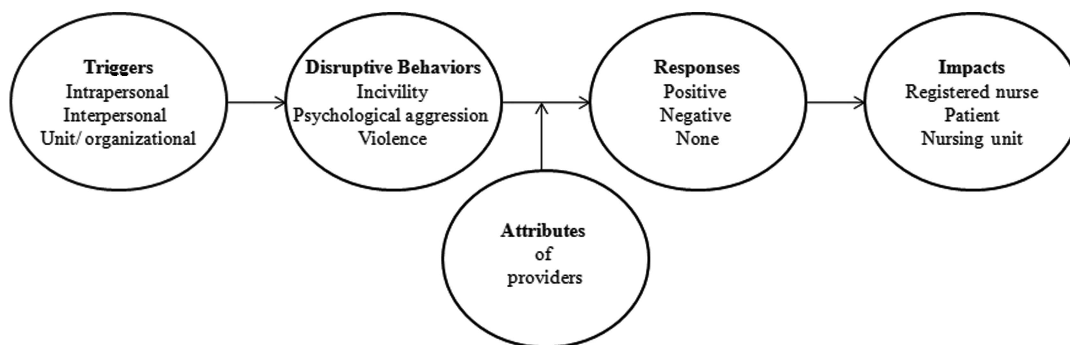

Figure 2. Expanded conceptual framework for disruptive behavior. Reprinted with permission from The Johns Hopkins Hospital. Copyright 2008, Johns Hopkins Hospital.

The "everyday incivilities" occurring in the workplace may be a reflection of the increases of incivility in society, which has now spilled over into the practice setting. Incivility may occur so frequently that staff does not recognize it as disruptive behavior nor "have time to address it"; incivility can become accepted as part of the organizational culture.

The intensity of psychological aggression may have been more readily recalled by the participants because of its personal and long-lasting impact. Many participants described scenarios that occurred several years ago yet remained fresh in their memory. For example, being a target of angry outbursts, public humiliation, or deliberately ignored when advocating for a patient took an "emotional and physical toll" on these RNs.

Fewer violent behaviors may have been reported because of organizational policies that clearly define violent behaviors and their consequences. To prevent violence, many organizations have implemented interventions such as risk assessment teams and anger management training. Although discussed as occurring in the past, sexual harassment was not identified as a current disruptive behavior because of these RNs' increased level of awareness through laws, training, and processes for reporting.

While psychological and violent behaviors are more readily recalled by participants, one cannot overlook that if workplace incivility is not recognized and addressed proactively, these behaviors can escalate or spiral into psychological aggression and/or violence.[21] This has implications for leadership and front-line nursing staff to recognize everyday incivilities as disruptive behavior, define acceptable standards of behavior, and hold staff and each other accountable for civil behavior.

The voices of these RN participants validated previously reported disruptive behaviors including rude and disrespectful behavior,[13,22] professional disregard when advocating for a patient,[1,4] engaging in gossip,[12,14] excessive micromanagement of one's work,[4] intimidation,[16,20] and verbal aggression.[12,14] A significant finding from this study was that technology, intended to enhance communication, at times escalated ineffective communication between team members. This included the indiscreet use of cell phones for texting or taking pictures that violated Health Insurance Portability and Accountability Act, and use of abusive e-mail messages to avoid face-to-face communication. As new information technology continues to proliferate, this finding has significant implications for patient and staff privacy. Inappropriate use of technology can have a detrimental impact on teamwork and communication.

This study adds further evidence that disruptive behavior has been observed or experienced throughout all levels of RNs and between and among major professional groups. Findings also validate that support personnel critical to nursing, such as patient care assistants, OR technicians, and those persons who support the environment of care, were also instigators or targets of disruptive behavior.[15,16,19] As the numbers and roles of individuals involved in disruptive behavior expand, the impact of behaviors on individuals and the organization also increases. As we found in our focus groups, disruptive behavior has an emotional toll on its targets as well as those who witness, hear about it, or instigate it and ultimately can erode values and deplete organizational resources.[26] Anyone observing the humiliation and degradation of others can be vicariously traumatized.[29] Nursing leadership investigating disruptive behavior events must also consider the impact it has on the staff that may have observed or heard about it through the "rumor mill."

Focus group participants identified a continuum of responses to disruptive behavior from actively addressing the disruptive person to choosing "not to speak up." This study supports previous research findings where the vast majority of individuals, when confronted with disruptive behavior including condescending, insulting, or rude behavior, verbal abuse, bullying, and threats, did not speak up and share their full concerns about the behavior with the instigator.[30] Since a

hallmark of nursing practice is advocating for self, patients, and others, nurses must master the core competency of effective communication. It is important to explore why nurses choose not to speak up in order to design effective interventions to develop competencies for constructively addressing disruptive behavior.

Disruptive behavior affects the RN, patient, and practice setting. The nurses described impacts such as being distracted from patient care, taking a physical or emotional toll on them personally, and creating conflicts for them between meeting patient care needs and meeting the operational needs of the hospital. They also expressed concerns that disruptive behavior can decrease the quality of care, create risks to patient safety, delay the delivery of care to patients, and disrupt working relationships among team members.

A key outcome of this study was identifying the impact of disruptive behavior on nurse retention. One third of focus group participants knew of individuals who had left this organization because of disruptive behavior, a finding consistent with previous research.[4,30–33] This finding has significant implications for nurse recruitment, retention, training, patient care delivery, and cost. With the looming nursing shortage, creating a healthy work environment to minimize disruptive behavior is a mandate for each member of the healthcare team.

For many focus group participants, these sessions served as a catharsis for pent-up emotions resulting not only from personally observing or experiencing disruptive behavior but also from the fact that when such behavior did occur, the instigators were not consistently and equitably addressed across professional disciplines. Many participants expressed gratitude to the focus group facilitator that these behaviors were now being openly discussed. Others voiced appreciation as they learned for the first time that they were not the only ones experiencing these behaviors. The participants expressed "hopefulness" that through their participation in the research a significant change in organizational culture would result. Increasing nurse leaders' and staff's awareness and creating an environment in which disruptive behavior is recognized, acknowledged, and openly discussed are important in establishing a culture of civility and patient safety.

LIMITATIONS

There are several limitations to this study. First, while the conceptual framework provided these researchers with a structure for studying disruptive behavior, it presents the variables of interest as having a linear relationship. This influenced the researchers' approach to the data collection and also may have influenced the analysis of the qualitative data. Nonetheless, our analysis of the focus group data helped us recognize that interdependencies and feedback loops do exist among the model concepts and establishing these relationships would add to the body of knowledge about this construct.

Second, while we know that a variety of healthcare team members contribute to the problem of disruptive behavior, participation in the focus groups was limited to RNs because of the funding agency's requirements. It is possible that our findings from this study could be further enhanced if a diverse group of healthcare professionals and support staff was included.

In addition, the nurses who participated in the focus groups were a convenience sample who responded to a request for volunteers and thus were not representative of the population of RNs employed in this organization. Notably, on average these participants were older, more experienced, more educated, and less diverse than the RN population employed in the hospital where this study was conducted. It is possible that these RNs volunteered because of their exposure to disruptive behavior and its impact over time; participating may have given them an opportunity to "to tell their story" about their experiences with disruptive behavior. Finally, findings from these focus groups represent RNs' experiences and observations in an academic medical center and may not be representative

of RNs' experiences in teaching or community hospital settings or in other major medical centers. In spite of these limitations, RNs' experiences as described here provide important insights into the disruptive behavior construct and provide direction for future investigations of disruptive behavior in acute care settings.

CONCLUSION AND NEXT STEPS

The findings from these focus groups underscore the complexities inherent in the construct of disruptive behavior. Our conceptual framework provides structure for future research.

On the basis of our findings, a survey instrument is being developed. It will be used to conduct a systematic organizational assessment to establish the prevalence of disruptive behavior in the organization and the triggers, responses, and impacts of this behavior on RNs. Findings from this organizational assessment will ultimately determine the nature and type of interventions that will be designed, implemented, and evaluated to effectively manage this phenomenon.

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