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The Relationship between Disruptive Physician Behavior, Nurse Job Satisfaction, and Nurse Intent to Leave.

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This is to certify that the doctoral dissertation by

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Walden University
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Abstract

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MA, Lemoyne College, 2012

BS, SUNY Institute of Technology, 2005

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

Disruptive physician behaviors (DPBs) are a serious problem in healthcare and have been implicated in nurse turnover and patient safety issues. The purpose of this research was to determine the impact of DPBs on nurses' intent to leave. The research questions were used to examine the relationship between DPB, nurse job satisfaction, and nurse intent to leave their job, unit, organization, or the profession. Affective events theory was used to explain how stressful events in the workplace impacted turnover intentions. A nonexperimental, correlational, quantitative design was used. Data was collected through convenience sampling of members of the American Association of Critical Care Nurses, Association of periOperative Registered Nurses, and Academy of Medical Surgical Nurses who completed the modified Dang's John's Hopkins Disruptive Clinician Survey. Multiple logistic regression was used to analyze the data. Condescending language, dress down, and powerplay were associated with intent to leave the job or unit. Conflict, intimidation, threats, and harassment were associated with intent to leave the organization. Passive aggressive behavior was associated with intent to leave the profession. Physical violence was associated with intent to leave the job, unit, organization, and the profession. No predictor variables were independently associated with decreased job satisfaction. The findings of this research indicated a need to address DPBs. Addressing DPBs may prevent nurse turnover, improve patient outcomes, and improve the financial position of hospitals, preventing the closing of service lines. Availability of a variety of services may improve the health of the entire U.S. population.

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Dedication

I dedicate this dissertation in memory of my late mother and father, Shirley Evelyn LaBeef-Losito and Vito William Losito who loved so unconditionally. You taught me how to be strong and resilient. Through watching you, I learned the importance of perseverance and never giving up on your dreams. I love you and miss you so much. Until we meet again in Heaven.

To my amazing family-my husband Terry Brown and beautiful daughters Nicole and Lindsey who had to put up with me when things got tough and overwhelming. Thank you so much. Obtaining my PhD would not have been a reality without your support and sacrifices.

To my late sister and one of my staunchest supporters, Cheryl Ann Tarasenko, you left us too soon at the young age of 54. I miss our long phone calls and I miss you and think of you every day. I love you so much. Until we meet again in Heaven.

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Chapter 1: Introduction to the Study

Personnel from all healthcare disciplines deserve to be treated as valuable members of the healthcare team and the establishment of mutually respectful relationships is essential. Disruptive physician behavior (DPB) and concerns associated with it have been in the literature for the last 30 years (Sanchez, 2014). This behavior has been defined in the literature in different ways by various professional organizations with no one consistent definition (Saxton et al., 2009). It has been described as physical or verbal, passive and insidious, or aggressive, overt, and uncivil (John & Heitt, 2018). DPB has been characterized as uncivil or bullying and the difference between them was with intent to harm being characteristic of incivility and not bullying (Felblinger, 2009). DPB included yelling, threatening physical harm, degrading and condescending treatment, intentionally ignoring nurses, and sexual harassment (Kimes et al., 2015).

DPB has been a persistent problem in the healthcare environment for many years (Sanchez, 2014) and has had far-reaching effects for patients, nurses, allied health professionals, and administrators. It has been implicated in poor working environments, nurse stress, nurse dissatisfaction, and nurse turnover (Alharbi et al., 2020; Irvine & Evans, 1995; Rosenstein, 2002). DPB has had a negative impact on patient safety as it has been shown to be a barrier to effective interdisciplinary communication and collaboration that is essential to the provision of safe, quality patient care (Dang et al., 2016; John & Heitt, 2018; Keller et al., 2020; Kimes et al., 2015; Rosenstein, 2011b; Thind, 2018; Villafranca et al., 2018; Villafranca et al., 2017). Nurses and pharmacists have exhibited avoidance behaviors to avoid being subjected to DPB including not

calling to report critical clinical information about their patients and not calling to clarify medication orders (Cohen & Smetzer, 2005; Mirzaei et al., 2020). In addition, the United States nursing shortage is expected to grow exponentially possibly contributing to poor quality care as the nurse-to-patient ratio rises (American Association of Colleges of Nursing, 2022; Snavely, 2016).

Villafranca et al. (2017) identified disruptive behavior as a concern in the operating room. They reviewed and summarized the existing literature (1978-2017) on DPB in the perioperative setting and identified that much of the data comes from research outside the perioperative setting and that the research had significant limitations in methodology (Villafranca et al., 2017). These methodological limitations were related to sampling frames, statistical methods, and survey tools. Keller et al. (2020) conducted a systematic review of research published between 2002 and January 2020 on incivility in healthcare. The researchers used the Medical Education Research Study Quality Instrument (MERSQI) to assess the quality of studies reviewed and found that overall, the quality of the studies was low; however, the more recent research reviewed had higher MERSQI scores. These higher scores indicated an increase in quality of the studies. Identified methodological limitations included the reliance solely on participant perceptions, the same disruptive behavior event having been reported by multiple professionals, low response rates of questionnaires, and a lack of complex statistical analyses of the study data (Keller et al., 2020). Review of disciplinary records indicated a ubiquity of 6%-18% (Villafranca et al., 2017). Surgeons were found to be the most frequent instigators of DPB.

Mirzaei et al. (2020) conducted a descriptive qualitative study to examine Iranian nurses' experiences with disruptive behavior in the operating room. A total of 17 operating room nurses were chosen to participate. The first category extracted was working in a poisonous atmosphere. The nurses experienced offensive and uncivil behaviors including being humiliated, insulted, and blamed in front of other team members. Nurses' knowledge and skills were ignored. The experience of these behaviors resulted in discouragement, work-related fatigue, sadness, depression, anger, and lack of motivation. The second category extracted was role subtraction. Nurses described neglecting the patient and focused more on the needs of the surgeon to avoid disruptive behaviors on the part of the surgeon. The nurses experienced anxiety and stress which resulted in decreased physical and mental performance. One nurse explained that they became confused and made more mistakes while the surgeon was shouting or was visibly angry. The nurses experienced indifference and reduced commitment to aspects of their work to protect themselves from disruptive behaviors. One nurse described treating her fellow colleagues aggressively or badly after exposure to the same behavior by a surgeon. The third category was escape to a safe margin where nurses became silent and reticent after experiencing disruptive surgeon behavior. Nurses stopped contributing suggestions or giving opinions due to fear of interacting with surgeons. Nurses described withdrawing from or avoiding disruptive individuals and situations to protect themselves from the effects of this behavior and to protect their dignity. The nurses went as far as refusing to assist in the surgeries of certain disruptive physicians. The fourth category was adaptation to stay calm. Nurses partook in activities to increase their capabilities and skills by

reading or watching surgical videos with the goal of lessening the impact of disruptive behaviors. In addition, nurses sought support from nursing leadership and coworkers. The nurses identified the difficulty of the surgeries and the surgeons' characteristics as the reason for the behavior and that the nurses' performance was not the relevant factor. The fifth and last category extracted was indirect communication. In this category, nurses recognized their value in preventing life-threatening mistakes and their ability to improve outcomes of the surgeries, stopped cooperating, and supporting the surgeons. This was their way of objecting to the disruptive behavior of the surgeon and protecting themselves. Finally, the nurses punished the surgeons in retaliation for their disruptive behavior. One nurse stated that she purposefully did not give the surgeon a good laparoscopic lens during laparoscopic surgery.

Villafranca et al. (2018) cited a study conducted by Quine (2001) finding that 44% of nurses reported having been bullied in the previous year and 50% had witnessed bullying. The perpetrators in Quine's study were nurses that had bullied other nurses indicating that the disruptive behavior was not unique to physicians. Rosenstein and Naylor (2012) conducted a study of disruptive behavior in the emergency department and found that of 370 participants, 57% witnessed disruptive behavior by physicians versus 52% by nurses.

Walrath et al. (2013) conducted research on disruptive behavior among clinicians and found that it was most frequently observed in physicians, and clinical affiliates reported it as having had the most negative impact. Disruptive behavior on the part of physicians was being researched because of its potential to have a greater negative impact

on the healthcare team and because of the inherent power of their position in healthcare organizations (John & Heitt, 2018; Rosenstein, 2017).

More recent research has also focused on nurses' perceptions of disruptive behavior. Armmer and Ball (2015) admitted that horizontal violence was prevalent in healthcare organizations but the extent to which it has occurred is not known due to underreporting. They also recognized that the United States faces a severe nursing shortage with multiple contributing factors, but the central premise of their research was that horizontal violence played a part in the nursing shortage. The researchers conducted research to determine if a correlation existed between horizontal violence (nurse to nurse) and intent to leave. In addition, the researchers sought to describe registered nurse perceptions of horizontal violence. Armmer and Ball found a positive correlation between horizontal violence and intent to leave. The older more experienced nurses were more likely to have the perception that they were victims of horizontal violence. Nurses higher in age and years of employment were less likely to leave while younger nurses who perceived themselves as victims of horizontal violence were more willing to leave their job. Research on horizontal violence is ongoing in the United States due to the desire to understand the full extent of this phenomenon and the impact it has on nurses and their intent to leave (Armmer & Ball, 2015).

DPB in the nurses' work environment and its impact on nurses' job satisfaction and intent to leave has been researched. Bontrager et al. (2016) found that job satisfaction was a positive, independent predictor of intent to stay. Therefore, it is essential to understand what positively and negatively impacts nurses' job satisfaction. The effect of

nurses' job satisfaction, work conditions, and nurse burnout on nurse turnover has been cited frequently in the literature (Alharbi et al., 2020; Hair et al., 2014; Liu et al., 2016; Trepanier et al., 2013). Alharbi et al. (2020) found nurse participation in hospital affairs, nurse manager ability and leadership support to be positively associated with job satisfaction. Their research was contradictory with positive collegial nurse-physician relationships and job satisfaction having had an inverse relationship. However, bivariate correlations found a positive relationship between collegial nurse-physician relationships and job satisfaction. The authors thought this finding represented a suppression effect (Alharbi et al, 2020). Rodwell et al. (2014) studied the impact of abusive supervision on job satisfaction. They found that the abusive supervision which focused on nurses' tasks was significantly related to nurses' job dissatisfaction and increased intention to quit. Dang et al. (2016) conducted a study on disruptive clinician behavior and found an inverse relationship between nurses' job satisfaction and disruptive clinician behavior, specifically, psychological aggression where the aggressor passively or actively acted in a way that caused psychological distress to the target.

Although disruptive behavior has not been unique to physicians, disruptive behavior on the part of physicians has had the potential to have a much greater impact on healthcare due the relative power that physicians inherently hold (John & Heitt, 2018; Rosenstein, 2017). This power is a result of the hierarchical nature of healthcare which has placed physicians toward the top and disrespectful behavior on their part may lead to the experience of fear, anger, shame, confusion, uncertainty, isolation, self-doubt, and depression in the target of this behavior (Grissinger, 2017; Porath & Pearson, 2012). This

behavior has undermined critical conversations and collaboration between physicians and other healthcare disciplines that needs to occur for safe patient care. Research into the contributing factors of poor work environments, nurse stress, dissatisfaction, and turnover are essential to maintain an adequate nursing workforce capable of providing safe, high-quality patient care. Therefore, I conducted this research to determine if a relationship exists between DPB and nurses' intent to leave their job, organization, or the profession. If a relationship exists, healthcare leadership can develop strategies to proactively address it to mitigate its effect on nurses. This, in turn, may improve the work environment for nurses and increase retention. Increased retention may improve patient safety, patient outcomes, and satisfaction.

In Chapter 1, the background of the study is reviewed, and the extant literature related to DPB and nurses' intent to leave summarized. The gap in knowledge and need for the study is discussed. The problem statement and purpose of the study are highlighted. The research questions and null and alternate hypotheses are provided. I also present a brief description of the theoretical framework for the study which includes a rationale for its use and how it relates to the study questions. Next, the nature of the study including a rationale for the chosen design, description of the key variables, and a summary of the chosen methodology is provided. The independent variables (IVs), dependent variable (DVs), and key terms are identified and defined. The assumptions of this study are provided followed by the scope, delimitations, and limitations of the study. I then describe the significance of the study including potential contributions to the

knowledge of the impact of DPB in the literature along with the potential implications for positive social change. Finally, a summary of the main points of Chapter 1 is provided.

Background

Registered nurses make up the largest sector of healthcare personnel in the United States with 89% of the 5.2 million nurses currently employed making them invaluable in the quest to provide safe, high-quality patient care (American Association of Colleges of Nursing, 2023). America is the world's leader in healthcare and to maintain that standing, it needs a perpetual supply of nursing professionals, and that supply is threatened by an imminent nursing shortage (Snavely, 2016). The nursing workforce will shrink due to attrition from retirement and a shortage of nursing school faculty limiting enrollment in nursing programs. In addition, there is an inherently high attrition rate in the nursing profession with 30 to 70% of all new nurses leaving their job or the profession (Kim & Shin, 2020). These facts make it essential to determine the contributing factors to nurses' intent to leave their job, organization, or the profession. Stress was identified as a factor in nurse attrition establishing the importance of determining the impact of DPB on nurses' emotions, emotional health, and intent to leave (Snavely, 2016). The importance of key stakeholders, including policymakers and professional nursing organizations, to identify causes and shape legislation to address the shortage was stressed.

The Joint Commission (JC; 2008) recognized the detrimental effects of disruptive behavior and developed a new leadership standard for hospital accreditations addressing disruptive behavior and introduced the standard in a sentinel event alert. The new leadership standard requires hospitals to have an established code of conduct defining

acceptable, disruptive, and inappropriate behaviors. Hospital leaders are required to create and implement processes for managing disruptive and inappropriate behaviors. This action on the part of the JC, a major healthcare accrediting organization, established disruptive behavior as a real and serious issue affecting healthcare organizations and their ability to provide high-quality care resulting in positive patient outcomes. This validated DPB as a valid and critical issue to research.

The American Association of Critical Care Nurses (AACN, 2016) established the Standards for a Healthy Work Environment in 2005 responding to a plethora of research evidence linking medical errors, stress among health care workers, poor quality of care, poor patient outcomes, and personnel turnover to unhealthy work environments (Dang et al., 2016; Einarsen & Nielson, 2015; Giorgi et al., 2016; John & Heit, 2018; Li et al., 2018; Rapp, 2016; Saur & McCoy, 2016). This evidence of problems in the workplace environment and their negative impact on nurses and patient outcomes as well as recognition of this problem by a major professional nursing organization prompting the creation of healthy work environment standards underscored the need to identify and correct any factors that may contribute to a poor nurse work environment and establish and implement interventions to address them. I sought to determine nurses' reaction to DPB and the emotional toll it took on them and how it impacted their decision regarding communication with physicians and care of patients.

Many studies have implicated the nursing work environment as a contributing factor to nurses leaving their position, the organization or profession (Alharbi et al., 2020; Elmblad et al., 2014; MacKusick & Minick, 2010; Warner et al., 2016). Determining the

impact of DPB on nurses' work environment and nurses' reactions to it is essential. If a positive correlation between DPB and poor nurse work environment were to be found, my research may establish DPB as a contributor to nurse attrition and prompt healthcare administrators to address the issue improving the environment and positively impacting nurse retention.

Alharbi et al. (2020) examined the relationship between nurses' work environments and the outcome variables of emotional exhaustion, job satisfaction, and intent to leave in a sample of 497 nurses in Saudi Arabia. The components of the work environment studied, the IVs of participation in hospital affairs, nurse manager ability, leadership and support of nurses, collegial nurse-physician relationships, and patient dependency. They found participation in hospital affairs, nurse manager ability, and leadership support for nurses to be positively correlated with job satisfaction, however, they found more positive nurse-physician relationships to be correlated to decreased job satisfaction. Alharbi et al. suggested a suppression effect to account for this unexpected finding. The only IV that was found to be associated with intent to leave was nurse participation in hospital affairs.

Yurumezoglu and Kocaman (2016) conducted a study to determine nurses' intent to leave the organization and intent to leave the profession in a large sample of nurses in Turkey. They found that dissatisfaction and emotional exhaustion were the most important predictors of nurses' intent to leave the organization and intent to leave the profession. Nurse-physician collegial relationships were found to be correlated with lower nurse intent to leave but there were no results specific to nurse-physician

collegiality and nurse satisfaction. The researchers did not study the prevalence or types of disruptive physician behaviors. Additional research by Han et al. (2015) examined the impact of work-related factors like autonomy, work schedule, supervisory and peer support on nurses' job satisfaction; however, disruptive behavior on the part of physicians or nurses was not included in the IVs. This research provided support for the study of DPB and its impact on nurse satisfaction and intent to leave as an important topic of research.

Flinkman et al. (2010) conducted an integrative review of the research on nurses' intention to leave the profession. A synthesis of the findings of 31 studies was conducted and provided comprehensive information about the reasons why nurses' leave which is important to be included as background information for my research. The findings supported job dissatisfaction as a cause of nurse attrition and the importance of determining the impact of DPB on nurse job satisfaction. Dang et al. (2016) conducted a study to determine the impact of disruptive behavior on nurses' job satisfaction. The researchers found that as psychological aggression increased, job satisfaction decreased.

MacKusick and Minick (2010) conducted a qualitative study to determine factors that influenced registered nurses' decision to leave clinical practice. The participants of this research were new registered nurses that had already left the profession. They all identified unfriendly work environments including sexual harassment, hostile behavior from physicians and lack of support from nursing mentors and leadership as contributing factors to fatigue, exhaustion, and stress which resulted in leaving the profession.

MacKusick and Minnick identified DPB as an issue negatively impacting the new nurse work environment.

Walrath et al. (2013) found an association between disruptive behavior and nurses' intent to leave their current hospital. Their findings also supported a relationship between disruptive behavior and nursing faculty and physicians' intent to leave their job. Similarly, Sauer and McCoy (2018) found bullying to be prevalent and correlated with nurses' intent to change their unit and intent to leave their current employer. Finally, Armmer and Ball (2015) found horizontal violence and nurses' intent to leave to be correlated. My research sought to determine intent to leave their job and organization with the added outcome variable of intent to leave the profession. In addition, my research sought to determine more specifically, the impact physicians' disruptive behaviors had on nurse job satisfaction and intent to leave.

Disruptive behavior and its impact on healthcare personnel has been researched extensively; however, research specific to disruptive behavior on the part of physicians and how it affects nurses' job satisfaction and intent to leave the job, organization or profession has not been extensively studied. My research attempted to quantify DPB and its impact on nurses' job satisfaction and intent to leave their job, organization, and profession.

Problem Statement

DPB has been implicated in increased stress in the work environment, personnel turnover, and negative effects on patient safety; however, there is a paucity of research to support these claims (Goettler et al., 2011). This behavior has resulted in poor morale of

healthcare team members, an inability to focus or concentrate on tasks, poor collaboration and communication between the physicians and healthcare team members, and lack of the transfer of important clinical information (Sanchez, 2014). The negative effects of DPB have led to the provision of substandard care (Sanchez, 2014). The impact of DPB has far reaching effects and efforts to eliminate it should be a matter of national urgency for healthcare leaders.

After a review of the literature, I identified a gap regarding DPB and whether it was a factor in nurses' decision to leave clinical practice. According to Flinkman et al. (2010), there is a lack of quality research to identify if a relationship exists between DPB and nurses' intent to leave their job, the organization or profession. MacKusick and Minick (2010) admitted that their research provided only broad conceptualizations for why nurses leave the profession and suggested additional research is necessary to study the concepts in more detail to gain a deeper understanding of why nurses leave. Kimes et al. (2015) suggested that future research should be conducted to expand on DPB and its impact on the healthcare environment. Specifically, they suggested quantitative or mixed methods research.

DPB is a complex issue for healthcare leaders to address and has been a serious problem in healthcare for many years. Physicians are a valuable resource to healthcare organizations because they are high revenue producers (Goettler et al., 2011). This leads to hesitancy on the part of leaders to address this issue. However, nurses are also valuable as they play a pivotal role in the provision of safe, high-quality patient care.

Due to varying economic and other forces, the nursing shortage is expected to worsen over the coming years (American Association of Colleges of Nursing, 2022; Snavely, 2016). According to the American Association of Colleges of Nursing (2022), there will be 203,200 RN openings each year through 2031. At the same time, nurses are leaving the profession in large numbers. These facts prompted the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) to develop guidelines to deal with DPB and mitigate its impact on nurses' intent to leave the profession (Martin, 2008). Due to the looming nursing shortage, determination of contributing factors to nursing attrition is essential. According to MacKusick and Minick (2010), nursing is a stressful profession and 30 to 50% of all new registered nurses (RNs) either changed positions or have left nursing altogether within 3 years of graduation. This turnover, along with the aging nursing workforce, has contributed to a severe nursing shortage (Snavely, 2016). This impending nursing shortage underscores the need to improve the work environment of nurses by working to eliminate DPB and attempting to retain those nurses currently working in the profession.

Purpose

Although there is an abundance of research on nurse turnover, understanding of the causal mechanisms of nurse turnover is limited (Gilmartin, 2013). Research has identified factors associated with low nurse job satisfaction that resulted in nurse turnover including a lack of nurse autonomy over their work, long hours, a lack of support from peers and managers but disruptive behavior was not included as an IV (Han et al., 2015). Research has been conducted on the phenomenon of DPB and its impact on job

satisfaction and intent to leave but this research is not current. Additionally, much of the existing research had methodological limitations related to sampling frames, statistical methods, and survey tools (Villafranca et al., 2017). Research using sound methodological procedures to examine the phenomenon of DPB is needed to fill this gap in the literature. The purpose of my research was to explore whether disruptive behavior on the part of physicians was related to nurses' satisfaction and intent to leave their job, organization, or the profession.

Research Questions and Hypotheses

Multiple logistic regression was used to determine if there is a relationship between DPB and nurses' intent to leave their job, organization or the profession and nurse satisfaction. I used the following research questions in my study:

RQ1: What is the relationship between DPB and nurses' intent to leave the job or organization adjusting for age, gender, setting, and Magnet status?

$H_0$1: No statistically significant relationship exists between DPB and nurses' intent to leave the job or organization.

$H_1$1: A statistically significant relationship exists between DPB and nurses' intent to leave the job or organization.

RQ2: What is the relationship between DPB and nurses' intent to leave the nursing profession adjusting for age, gender, setting and Magnet status?

$H_0$2: No statistically significant relationship exists between DPB and nurses' intent to leave the nursing profession.

$H_1$2: A statistically significant relationship exists between DPB and nurses' intent to leave the nursing profession.

RQ3: What is the relationship between DPB and nurses' job satisfaction adjusting for age, gender, setting, and Magnet status?

$H_0$3: No statistically significant relationship exists between DPB and nurses' job satisfaction.

$H_1$3: A statistically significant relationship exists between DPB and nurses' job satisfaction.

Theoretical Framework

The theoretical framework for this research was affective events theory (AET). AET is a theory that can be used to explain employees' emotional experiences or mood and their reaction to stressful events in the workplace (Redmond, 2007). According to this theory, job behavior and performance can be explained by cognitions, behavior, and attitudes. Specifically, AET can help explain nurses' reactions to the experience of DPB, their resultant behavior and decisions they have made after the incident. These emotional experiences can contribute to job satisfaction if positive emotions are felt or job dissatisfaction if negative emotions are felt and in turn, can influence organizational commitment and nurses' intent to leave (Kabat-Farr et al., 2018.) Nurses experienced positive emotions or felt good about their job when provided with recognition, opportunity for growth and advancement, interesting jobs, and responsibility (Herzberg et al., 1959, as cited in Fisher, 2002) and when they experienced collegial nurse-physician relationships.

AET was used for my research because it aligns well with the research topic being studied and the research questions. I attempted to explain how the experience of disruptive behavior on the part of registered nurses impacted their decision to leave their job, organization, or profession. AET has been used in healthcare research and attempts to explain how events in the workplace impacted employee decisions. Therefore, AET was an ideal theory to help explain the decisions nurses made after experiencing disruptive behavior events on the part of physicians including yelling, showing disrespect, sexual harassment among other events. In addition, studies using AET require the exploration of the experiences of the participants which would best be captured in quantitative research by surveys which was the method of data collection for my research. One related theory in the literature was Lee and Mitchell's (1994) unfolding turnover model. In this model, nurses' decision to leave would be viewed as a series of psychological processes. The major components of this theory include shocks, scripts, image violations, job satisfaction, and job search. In this theory, the nurse would experience a shocking event which would lead to them scripting how to leave their job. The nurse then experiences an image violation as they come to realize that their values or career plans do not fit or are not supported by the organization resulting in decreased job satisfaction. Finally, the nurse decides to search for other jobs. This theory was not seriously investigated or considered for this research because AET had already been investigated and was considered perfectly aligned with my research topic.

Nature of Study

The research method chosen for my study was quantitative methodology. The goal of my research was to attempt to quantify the prevalence of DPB as experienced by the study participants. In addition, I sought to determine if DPBs (independent variables [IVs]) was a factor in nurses' intent to leave the job, organization or nursing profession and nurse satisfaction (dependent variables [DVs]). A correlational design was used to examine the relationship between the IVs and DVs (Wall-Emerson, 2015). The study population was a sample of registered nurses from various professional nursing associations in the United States. An online survey tool, SurveyMonkey, was used to collect data with an online survey. National nursing associations such as the American Association of Critical Care Nurses (AACN), Association of periOperative Nurses (AORN), and the Academy of Medical Surgical Nurses (AMSN) were used to disseminate the survey tool to members via email, postcard invitation and their websites.

Definitions

The following terms are essential to this study:

Bullying: Bullying was defined as "hostile remarks, verbal attacks, threats, taunts, intimidation, and withholding support" (American Nurses' Association, 2015, p. 2)

Disruptive physician behavior (DPB): A "personal conduct, verbal or physical that has the potential to negatively affect patient care or the ability to work with other members of the healthcare team" (American Medical Association, 2008, p. 1).

*Incivilit*y: "Rude, disruptive behavior that can result in distress and can progress to bullying and other threatening situations" (Schoville & Aebersold, 2020, p. 16).

Nurses' intent to leave the job or unit: The nurses' consideration for leaving their job or unit and seeking employment with the current organization due to experiencing DPB.

Nurses' intent to leave the organization: The nurses' consideration for leaving their organization and seeking employment in a different healthcare organization due to experiencing DPB.

Nurses' intent to leave the profession: The nurses' consideration for leaving the profession due to experiencing DPB.

Nurses' job satisfaction: A nurse being happy and content in their current position and organization without intent to leave.

Rude and disrespectful behaviors: A lack of courtesy, sarcasm, discourteous tone, yelling, raised voice, not listening, ignoring, turning away, hanging the phone during conversations, engaging in malicious gossip, or exclusion by cliques.

There are seven types of disruptive behavior termed unprofessional behaviors in the JH-DCBS. The examples of these behaviors and their definitions below were taken directly from the JH-DCBS (Dang, 2012) and were provided below:

Condescending language, dress down or power play: Public humiliation, being put down, insulted, ridiculed, embarrassed, demeaned, berated, criticized in front of staff and patients, pulling rank, dominating, or controlling by range or position, and withholding information at the target's expense.

Conflict: Contentious interactions and/or unresolved disputes between and among team members.

Intimidation, threats, and harassment: Actions that instill fear through body language, threatening harm to the target's personal safety, property, or job security, being reported to the manager/supervisor, bullying, excessive monitoring of work, having someone ride you at work, do this or else, or hazing.

*Passive aggressive behavior*s: Coworkers 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 slowdown, procrastination, or deliberately not answering pages or other requests.

Physical violence: Actions such as grabbing, shoving, pushing, hitting, slamming, fighting, or throwing objects.

Professional disregard: 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, or taking credit for other's work.

Assumptions

An assumption highlighted by the creator of the John's Hopkins Disruptive Clinician Survey (JH-DCBS) was that the words "disruptive clinician" in the survey have a negative connotation that could influence how the study participants answer the survey items and, therefore, changed the title to "Survey of Unprofessional Behaviors: Triggers, Responses, and Impacts" (Walrath et al., 2013). This revised title was not chosen for my research because the survey was scaled down to use only those subscales that would provide data relevant to the research questions hence the "triggers" subscale was not

used. The second assumption was that the participants would complete the survey with honesty, integrity, and without bias. Third, I assumed that DPB was correlated with nurses' intent to leave their job, the organization, or the nursing profession. Fourth, I assumed that study participants have experienced DPB and that they would want to complete the survey so that their voices could be heard in relation to their experiences with DPB. The final assumption of this study was healthcare administrators would use the findings of this research and recognize the seriousness of this issue. They would develop and implement strategies to address DPB and mitigate its effects on the healthcare environment, nurses, allied health professionals and most importantly, the quality of patient care and patient outcomes. It was important to be aware of and consider these assumptions. This was especially important with the final assumption that this issue would be addressed instead of accepted as status quo for it would be pointless to conduct my research if it were not assumed that the findings would be used to address the issue and its impact.

Scope and Delimitations

My research was limited to those RNs working in a hospital setting with membership in the AACN, AORN, or the AMSN and therefore was a small sample of the nursing workforce in the United States. The AACN has approximately 143,000 members but the members have opted out of receiving surveys via email (M. Altman, personal communication, May 2022). Therefore, it was suggested to solicit participation on the AACN Ambassador's Facebook page which would be approximately 1,000 RNs. I then found that the AACN Ambassador's Facebook page could only be used by the AACN

Ambassadors. The AACN members were solicited by postcard via the U.S. Postal Service. There were many nursing specialties that were excluded from this research such as obstetrics and gynecology, oncology, psychiatric, and nephrology including hemodialysis. With this study, I attempted to determine if there was a relationship between DPB and nurses' intent to leave their job, their organization, or the nursing profession.

According to the U.S Bureau of Labor Statistics (2019), only 1,698,700 of the approximately 4.7 million RNs (National Council of State Boards of Nursing [NCSBN], 2018) in the United States are working in the hospital setting. Therefore, the findings of my research were not generalizable to the whole RN population due to its small sample size. Another factor that affected the generalizability of my study's findings was the fact that the study was limited to critical care, medical surgical, and operating room nurses.

Limitations

My study had several limitations. First, as previously mentioned, limiting study participants to critical care, medical surgical, and operating room nursing reduced the generalizability of the study's findings to the overall nursing population. In this case, external validity was limited. Including medical surgical nurses in my research was an attempt to increase generalizability of the study findings. Second, as pointed out by Walrath et al. (2013), selection bias and a lack of representativeness of the study results were risks for this my due to the potential that study participants had been victims of DPB and to a lack of data on those nurses that chose not to complete the survey. In addition, the possibility of a low survey response rate, as is common in survey research

(Cox, 2016), could negatively impact generalizability and representativeness of the study findings. Therefore, the survey was sent to thousands of nurses to achieve the calculated sample size and mitigate the effect of a low response rate. Third, self-report surveys are susceptible to bias (Cox, 2016). Participants may intentionally or unintentionally misreport information when completing the survey. Unintentional misreporting may be due to participants not having the ability to clarify survey items which may result in misinterpretation of the survey items (Cox, 2016). The participants could have had trouble with recalling the event as my study was looking back retrospectively to past experiences with disruptive behavior. This could negatively impact the accuracy of the collected data. Finally, according to Walrath et al., the title of the survey has a negative connotation which could impact how the participants respond to survey items. Researcher bias could have been an issue with my study because I had experienced physical violence and bullying early in my nursing career. The online survey method reduced the chances of researcher bias as I would not have the opportunity to converse with participants and influence how they would answer the survey questions.

Significance

Disruptive behaviors in hospital clinical settings are a pervasive issue thought to negatively impact patient safety and nurse retention (Dang et al., 2015; Layne et al., 2019). According to Rosenstein and O'Daniel (2005) and Maxfield et al., (2005), there are few measures or tools to determine the causes and impact of disruptive behavior making it difficult to research and contribute to the gap in knowledge. Despite the pervasiveness and perceived impact of this behavioral issue, healthcare organizations do

not assess the prevalence, severity, or causes of disruptive behaviors. My research provided new knowledge in the literature on disruptive behavior and its impact on nurses' job satisfaction and intent to leave. Determining if DPB was a contributing factor to nursing job dissatisfaction and intent to leave may be one of the first steps toward changing the culture in healthcare organizations from one of resistance to addressing this disruptive behavior to a culture committed to addressing it. If DPB was found to negatively impact job satisfaction and nurse retention, then my research would underscore the importance of healthy work environments where mutually respectful and collegial nurse-physician relationships exist. In this type of environment, interdisciplinary collaboration would improve communication. This could possibly result in improved patient outcomes, improved nurse job satisfaction, and nurse retention. The new knowledge could be used to develop policies, preventative strategies, and interventions to address this behavior and reduce its prevalence. My research could contribute to positive social change by improving the ability of our healthcare system to provide safe, high-quality care through improved interdisciplinary relationships, nurse retention, and reduction in errors.

Summary

Nursing is a stressful profession and stress has been implicated in nurses' intent to leave (Snavely, 2016). The nursing shortage is expected to grow exponentially (American Association of Colleges of Nursing, 2022; Snavely, 2016); therefore, it was important to determine factors that contribute to stress in the nurses' work environment to retain nurses. One factor that has been implicated in nurse stress and intent to leave is DPB

(Irvine & Evans, 1995; Rosenstein, 2002). DPB and its impact on nurses' intent to leave their job, organization or the profession has not been extensively studied and current literature on this topic lacks in quality (Flinkman et al., 2010; Goettler et al., 2011; Keller et al., 2020; Kimes et al., 2015; MacKusick & Minnick, 2010; Villafranca et al., 2017). Hayes et al., (2006) conducted a review of the literature on nurse turnover which included 32 studies and found only five that included intent to leave the profession. I conducted this research to determine the impact of DPBs, the IVs, on the DVs of nurses' intent to leave their job, organization, or the profession. The research methodology for my research was a nonexperimental, correlational, quantitative design which explored whether a relationship exists between DPB and nurses' intent to leave their job, the organization, or the profession.

In Chapter 2, a review of the current literature relevant to DPB and its impact on nurses' intent to leave their job, organization, or the profession is provided. The identified gap in the literature for my research is explained. The theoretical framework used for this research is described in detail along with examples of its use in healthcare research. Finally, a summary of the major themes in the literature, the identified gap in the literature, as well as what is currently known and not known about this topic is provided.

Chapter 2: Literature Review

DPB has been rampant in healthcare for many years (Sanchez, 2014). This uncivil and inappropriate behavior has been implicated in poor work environments, nurse stress, nurse dissatisfaction and nurse turnover (Irvine & Evans, 1995; Johnson & Benham-Hutchins, 2020; Rosenstein, 2002; Villafranca et al., 2018). DPB constitutes a major threat to the provision of high-quality care and patient safety through its negative impact on communication and collaboration among nurses and physicians (Johnson & Benham-Hutchins, 2020; Rosenstein, 2009; Sanchez, 2014; Villafranca et al., 2018). Johnson and Benham-Hutchins (2020) conducted a systematic review of 14 research studies on bullying behavior among nurses conducted between 2012 and 2017. The findings of their review showed that bullying behavior among nurses increased nursing practice errors potentially harming patients. A review of the literature between the period of 1994 through 2008 found that nurse-physician disruptive behavior has a significant negative impact on patient safety and nurse retention (Saxton et al., 2009). Dang et al. (2016) recognized disruptive behavior on the part of clinicians as one of the most "stubborn and serious problems" (p. 115) negatively affecting the climate and culture of organizations. Recognizing the negative impact of DPB, the JCAHO (2008) created a new leadership standard to address disruptive behaviors in the healthcare environment (Rosenstein, 2011a).

After review of the existent literature on this topic, I found that most research conducted did not focus specifically on DPB and its role in nurse turnover. In addition, many researchers have stated that the existing literature on nurse turnover resulting from

DPB lacked in quality (see Flinkman et al., 2010; Goettler et al., 2011; Keller et al., 2020; Kimes et al., 2015; MacKusick & Minnick, 2010; Villafranca et al., 2017). Because the nursing shortage in the United States is expected to grow exponentially over the next several years, it is important to identify contributing factors to poor working environments to attempt to reduce the shortage (American Association of Colleges of Nursing, 2022; Snavely, 2016). The purpose of my research was to determine the impact of DPB on nurses' satisfaction and intent to leave their job, organization, or clinical practice.

In this section, I described my literature search strategy. I searched multiple databases and used multiple search terms. I then discussed the theoretical framework used for this research: AET. My discussion of the theory included the developers of AET, its propositions and major assumptions, how it has been previously applied to research, the rationale for its use in this research, and an explanation of how AET explains nurses' reaction to DPB and the decisions they make after experiencing DPB. I then turned my attention to the research literature on DPB. I did so to identify gaps in the literature that existed regarding DPB and its impact on nurses' satisfaction and intent to leave. I ended this chapter with a concise summary of the major themes in research conducted to date on DPB as well as a summary of what was and was not known about the impact of DPB and how this research filled an identified gap in the literature.

Literature Search Strategy

The databases used for the literature search included a simultaneous search of CINAHL and Medline for the dates between 2010 and 2020. Because I desired original

research on DPB, I chose to expand my search beyond the recommended span of 5 years. Articles from peer-reviewed journals were included in this literature review. Search terms used in the literature search were *DPB, disruptive behavior, nursing shortage* AND *economic impact, nurse attrition, intent to leave, patient safety, nurse* AND *job satisfaction, organizational commitment, work environment, theory, bullying, workplace bullying, incivility, job satisfaction, nurse turnover, communication,* and *collaboration.* These databases and search terms did not provide any research identifying an appropriate theory for research on DPB. A review of other available databases lead to a search of PsycArticles for the period of 2008-2018 where the search terms used included *workplace bullying, incivility, nurse job satisfaction,* and *theory* and provided peer-reviewed research articles and book chapters which included AET.

Theoretical Framework

AET was developed to explain how moods and emotions influence job performance and job satisfaction (Weiss & Cropanzano, 1996). AET builds on cognitive appraisal theory (CAT). According to CAT, employees strive to make meaning of workplace events and the employees' interpretation of the events determines the emotional reaction to the event (Redmond, 2007). CAT suggests that if employees appraise a workplace event in a positive way, they are more likely to experience positive emotions as a reaction to the event (Todorova et al., 2014). Likewise, if employees appraise the event in a negative way, they are more likely to respond to the event with negative emotions. Employees appraise or form an opinion of the event based on cognition or their knowledge resulting in a perception of the event. In addition,

employees' attitude or feelings about the event also affect their response to the event (Redmond, 2007). Going beyond the role of CAT, AET not only focuses on employee attitudes, cognitions and perceptions of events occurring in their work environment but also focuses on how they impact employees' emotional reactions, behavior, job performance and decisions. In addition to cognitive appraisal and the ascription of meaning, AET provides a more in-depth explanation of emotion in the workplace and adds the notion of time. Events happen over time resulting in continuous change to affect, and this change in affect continuously changes the influence affect has on behavior (Redmond, 2007). In the next section, AET's propositions are discussed and two different paths leading up to employees' behavioral response to workplace events will be described.

Propositions

Theorists use AET in an attempt to describe the cause or path to employee behavioral responses to an event in the workplace. It addresses the idea that behavior is either driven by emotion or reflective judgement (Redmond, 2007). First, an event can cause a direct, immediate, and automatic emotional response in the employee which is termed *affect-driven behavior*. This type of emotional response results in instantaneous or hasty decisions on the part of employees; for example, immediately quitting a job after a negative event such as a fight with their manager. In contrast, the second path is longer as employees cognitively evaluate the event through their knowledge and attitudes to appraise the event and determine the meaning of it. This type of behavioral response results in behavior on the part of the employee that is deliberate or *judgement-driven* in

response to the event (Redmond, 2007). Using the same example above, in judgement-driven behavior, the employee cognitively evaluates the event accounting for their attitude or feelings about the organization termed *organizational commitment.* This judgement-driven behavior could result in a different outcome than the affect-driven behavior and the employee may decide to stay with the organization. In addition to its propositions, AET makes five assumptions described in the next section.

Assumptions

The five assumptions that AET makes about the workplace and the constructs like cognitions and attitudes describe how an employee reacts to events that occur in the workplace (Redmond, 2007). The five assumptions include:

- AET assumes that job satisfaction and affect are not the same.
- AET assumes that affect contributes to job satisfaction.
- AET assumes that affect impacts job performance negatively.
- AET assumes that emotion draws on employee resources of cognitive processing, motivation and attention competing for these resources that are essential to maintaining good job performance.
- AET recognizes that events happen over time. This results in continuous change to affect which then results in continuous change of its influence on employee behavior (Redmond, 2007).

Application of AET in Research

AET has been used extensively in research to explain incivility in the workplace and how it affects employees as well as other constructs. Schilpzand et al., (2016) used

AET in research to explain the effects of uncivil behavior on employees' health and intention to leave via its impact on job satisfaction. AET has also been used to study how affective events experienced in the workplace impact job performance through the event's impact on employee job satisfaction (Carlson et al., 2011). In addition, AET has been used in research regarding work-family enrichment where research findings suggested that employees experienced positive moods or affect when their employer supports work-family enrichment events (Carlson et al., 2011). This positive mood in turn resulted in increased job satisfaction and improved job performance. Specific to healthcare, AET has been used to study avoidance behaviors and job withdrawal in emergency department nurses after experiencing violent behaviors by patients, patients' family members, physicians, and other nurses (Li et al., 2018). Finally, Gabriel et al. (2011) used AET to explain how nurses' inability to accomplish their daily tasks impacted their emotions, satisfaction, and well-being. Although, prior research was not specific to the impact of DPB on nurse turnover, researchers have studied the moderating effect of nurse-physician collegial relationships on nurse stress related to daily task accomplishment and suggested that collegiality may have a moderating effect on or buffer nurse stress.

Rationale for use of AET and Relatedness to the Study

After conducting an extensive review of the literature to identify a theoretical framework for this research on DPB, I found AET to be a theory frequently used in workplace incivility research (see Kabat-Farr, et al., 2018; Rapp, 2016).; Reich & Hershcovis, 2015). DPB in the healthcare environment could be construed as incivility.

Because I sought to determine the impact of DPB on nurses' job satisfaction and intent to leave their unit, job, organization, or the nursing profession, AET was considered an appropriate theory to use for this research. This theory was also appropriate as it has been used specifically for research on the impact of the healthcare environment on nurses. Gabriel et al. (2011) and Li et al. (2018) used AET in previous research in the healthcare environment to explain how nurses were impacted by their environment or events in their environment and to help explain the reasoning behind the decisions they made.

There was no consistent definition of DPB, and varied definitions were found in the literature (see Saxton et al., 2009). Many healthcare-related organizations have defined DPB. The American Medical Association (AMA, 2008) defined DPB as "personal conduct, verbal or physical that has the potential to negatively affect patient care or the ability to work with other members of the healthcare team" (p. 1). JCAHO (2008) defined DPB as "all behaviors that undermine a culture of safety" (p. 1). Disruptive physician behaviors occur on a continuum and were characterized as overt, aggressive, and uncivil behaviors or more passive, insidious behaviors (John & Heitt, 2018). In addition, Villafranca et al. (2017) defined disruptive behavior as "behavior that does not show others an adequate amount of respect and causes victims or witnesses to feel threatened" (p. 128). They also cited the United Nations Universal Declaration of Human Rights (1948) that includes "recognition of the inherent dignity in all people (Article 1); freedom from discrimination and arbitrary invasions of privacy (Article 3); freedom from degrading treatment (Article 5); and freedom from attacks upon honor and reputation (Article 12)" (Villafranca et al., 2017, p. 130).

Disruptive behaviors are associated with and can be categorized as uncivil or bullying behaviors (Felblinger, 2009). Although uncivil and bullying behaviors may seem synonymous, they have been defined differently in the literature. Incivility was defined as "rude, disruptive behavior that can result in distress and can progress to bullying and other threatening situations" (Schoville & Aebersold, 2020). It is characterized as psychological in nature, low-intensity, and inconsiderate behavior (Felblinger, 2009). This disruptive behavior, sometimes subtle and insidious, was associated with intent to harm the targeted person. It was the intent to harm that distinguished incivility from bullying. Felblinger (2009) described disruptive behaviors that were associated with incivility and these behaviors included:

> Rude comments, disrespectful verbal attacks, offensive or condescending language, lack of collaboration, disregard for interdisciplinary input about patient care, public criticism, subtle or overt verbal aggression, name calling, ethnic slurs, or jokes, sexual comments, yelling, screaming, attacking a person's integrity or professional reputation, patronizing others in any discipline and at any organizational level, requesting input from others when decisions are already made, superficial listening, blaming team members when something goes wrong, blaming others in front of a patient or patient's family member, lacking empathy, taking credit for someone else's idea or work, and withholding important information. (p. 14)

These disruptive, uncivil behaviors violate the, often unwritten, workplace norms of being respectful in all interactions with employees in all healthcare disciplines. If left

unaddressed, uncivil behavior can become the new norm (Felblinger, 2009), and it could eventually occur between healthcare employees and their patients negatively impacting patient safety (Rosenstein & O'Daniel, 2008). In addition, uncivil behaviors could escalate to increasingly dangerous behavior like purposely damaging medical equipment, slamming down the phone, and throwing surgical instruments which, if dirty, could expose workers to sickness through exposure to contaminated body fluids (Felblinger, 2009).

Bullying behaviors, in contrast to incivility, occur repeatedly and are long-term; for example, occurring at least twice weekly for as long as 6 months (Einarsen et al., 2009; Felblinger, 2009). Felblinger (2009) does not provide specific bullying behaviors; however, the American Nurses' Association (ANA, 2016) described disruptive, bullying behaviors as "hostile remarks, verbal attacks, threats, taunts, intimidation, and withholding of support." In bullying, the perpetrator has actual power over the individual or the power is just perceived by the victim. This power, whether real or perceived, makes the victim feel defenseless in defending themselves or stopping the abuse.

Previous research has been inconsistent when describing the prevalence of DPB. Leape and Fromson (2006) estimated that 3% to 5% of physicians displayed disruptive behavior. The results of another study found a 97% prevalence rate in physicians and nurses (Rosenstein & O'Daniel, 2008). In another study, 95% of physician executives admitted to regular encounters with DPB (Weber, 2004). Despite much research on the phenomenon of DPB and its impact, DPB persists in the healthcare environment despite organizational interventions to address it. Rosenstein (2002) conducted original survey

research with 2,500 respondents from 100 acute care hospitals in the United States and found that over 90% of the respondents reported witnessing DPB. Respondents were multidisciplinary and included nurses, physicians, and hospital administrators. The prevalence of DPB tended to be higher in certain high-intensity physician specialties and included surgeons, obstetricians, anesthesiologists, emergency physicians, and interventional cardiologists (Goettler et al., 2011; & Villafranca et al., 2017). DPB was also more prevalent in male physicians (Goettler et al., 2011).

Villafranca et al. (2018) recognized DPB as a frequent and serious problem in the operating room environment and conducted a review in which they defined DPB, its prevalence in the operating room as well as its consequences. They provided a discussion about its management and prevention in the operating room environment. The authors defined disruptive behavior as "any behavior that is: interpersonal (i.e., directed towards others or occurring in the presence of others); results in a perceived threat to victims and/or witnesses; and violates a reasonable person's standard of respectful behavior" (Villafranca et al., 2018, p. 366). The researchers expressed concern for the accuracy of previous research on prevalence especially since most research was from limited groups of clinicians (Villafranca et al., 2018). Therefore, they developed their own survey which measured 14 examples of disruptive behavior. The survey was distributed internationally to 7,465 operating room workers including nurses, certified nurse anesthetists, anesthesiologists, surgeons, technicians, and medical students. Almost all the 7,465 respondents, or 7,315 (98%), reported they had witnessed or experienced disruptive behavior in the 12 months preceding completion of the survey and the average clinician

experienced it 64 times in that year. This behavior was not unique to surgeons; all types of operating room professionals were complicit with the behaviors. Perpetrators of disruptive behavior were most frequently male surgeons and nurses in higher ranking positions and their targets were lower-ranked young inexperienced women, non-heterosexual nurses working in for-profit or private healthcare organizations. The United States and New Zealand had the highest rates of reported disruptive behaviors (Villafranca et al., 2018). Finally, Villafranca et al. (2018) surveyed a subsample of the study population from the United States and Canada for exposure to verbal threats, personal space invasion with the intent to intimidate, and physical assault. There were 1,314 respondents (44.5%, 95%, CI 42.7-46.3) who reported being exposed to one of the three abusive behaviors in the previous years. Verbal abuse was experienced by 372 respondents, personal space invasion by 528 respondents, and physical assault by 85 respondents. The study findings indicated that the prevalence of DPB was an international problem frequently experienced not only in U.S. operating rooms but also worldwide.

When discussing the prevalence of DPB, it is important to consider how it is defined and whether the label is being misused. Specifically, the frequency with which it occurs by a physician is important (Reynolds, 2012). Physicians will have bad days when their behavior may be disruptive, but care must be taken not to label them personally as disruptive. If they show a pattern of disruptive behavior over time, then it may be appropriate to label them as disruptive. However, a single incident of disruptive behavior

in a physician may need to be addressed depending on the egregiousness (Reynolds, 2012).

Healthcare administrators should understand the causal mechanisms of disruptive behavior in physicians. This would assist them to take a proactive and preventive approach rather than a reactionary approach when deleterious effects of DPB have already occurred (John & Heitt, 2018). Disruptive behaviors have been categorized as workplace logistics encompassing production pressure, workplace culture, working conditions, mismanagement, and administrative inefficiencies; intrapersonal including personality, values, psychological conditions, and transient states; broader contextual issues including societal issues, life experiences, education, family upbringing, and non-workplace relationships; and last, workplace relationships including personality clashes, hierarchies, perceptions of status, value conflicts, and tribalism (Villafranca et al., 2018). The researchers provided five personality traits that they called the "big five model" (Villafranca et al., 2018, p. 368) and included agreeableness, openness, conscientiousness, neuroticism, and extroversion which could be considered when determining the cause of DPB. For example, employees that displayed a low level of agreeableness were more likely to be rude, harsh, and callous toward coworkers and were also more likely to bully other employees (Villafranca et al., 2018). Additional personality characteristics included arrogance, egocentricity, inflexibility, and vindictiveness (Reynolds, 2012). DPB could also be caused by stress, overwork, fatigue, and burnout or even personality disorders (John & Heitt, 2018; Reynolds, 2012; Villafranca et al., 2017; Villafranca et al., 2018). Some physicians may suffer from

psychopathologies such as depression that result in abuse of alcohol and drugs although this has not occurred in a large percentage of physicians (John & Heitt, 2018). Character traits included insecurity, immaturity, and aggression and could have been a factor in DPB. Poor emotional intelligence, poor social skills, cultural and ethnic issues, and generation and gender bias may also contribute to DPB (John & Heitt, 2018). Disruptive physicians may have a need for power and control in relationships often using intimidation to gain control (Reynolds, 2012). Finally, it can be learned when observed in role models such as educators in their medical school program and then reinforced in the hospital culture where physicians observed that this behavior is tolerated (Villafranca et al., 2017; Villafranca et al., 2018). In summary, comprehensive knowledge about the causes of DPB and early recognition and intervention by administrators is essential to mitigate the negative impact of DPB on patients, nurses, and the organization.

Keller et al. (2020), conducted a systematic review of the literature looking to identify predictors and triggers of incivility within healthcare teams. Personality was cited frequently as a trigger. One study found that personality disorders were found more frequently in physicians being evaluated for disruptive behaviors than those evaluated for other types of behavior. In addition, disruptive or uncivil behaviors were more prevalent in male physicians. Females were the most frequent targets of disruptive behavior and team members with less experience were frequently targets of the perpetrator. Among diverse medical professionals, those with less power in the hierarchy including nurses, and scrub technicians, were more frequently targeted by the perpetrators of disruptive and uncivil behaviors. Keller at al. found that there are certain situations that may trigger

disruptive behavior. These situations included high workload, poor communication, lack of teamwork, patient safety concerns, poor performance, bearing heavy responsibility, fatigue, and personality conflicts. High workload was the most frequently mentioned trigger for disruptive and uncivil behaviors having been mentioned in ten studies. Poor collaboration and teamwork were the second most cited triggers and were mentioned in nine studies. Finally, the lack of leadership response to these behaviors and organizational culture are associated with disruptive behaviors. Disruptive behaviors were less likely to occur in Magnet designated organizations (Keller et al., 2020). Magnet designation signifies a healthy work environment in healthcare organizations (Graystone, 2018).

Despite its pervasiveness and the many ways in which it negatively affects healthcare organizations, DPB has been tolerated in the healthcare setting partly due to the fear that confronting the physician would result in the physician admitting their patients to a different healthcare organization and because of the physicians' position in the organizational hierarchy (Rosenstein, 2009). DPB negatively affects interdisciplinary communication, collaboration and patient care but also increases the risk of organizational liability and litigation increasing financial costs to the institution (John & Heitt, 2018; Suresh, 2019). The most important reason healthcare administrators must address DPB is to maintain the safety of the patients they serve and to ensure the provision of high-quality care. If ignored or left unaddressed, the financial costs to the organization are exponentially increased (Felblinger, 2009). The organization could incur costs associated with employee turnover, absenteeism to avoid disruptive behavior,

decreased employee commitment to the organization, decreased patient safety as evidenced by an increase in medication errors, adverse events, poor quality of care and poor emotional and physical health of employees (Felblinger, 2009). Patients are at their most vulnerable when hospitalized experiencing intense feelings of fear, loss and isolation which could be exacerbated when their caregivers are emotionally taxed or distracted due to experiencing DPB (Pfifferling, 2008).

Development of prevention and management strategies to deal with DPB in healthcare organizations is essential. Villafranca et al. (2018) presented a general framework for addressing disruptive behavior in the operating room environment which could be used throughout an organization. It is important for organizations to be proactive and therefore, this framework or prevention plan should preempt the categories of disruptive behavior of workplace logistics, intrapersonal, broader context, and workplace relationships described in more detail previously. For example, organizations should equip employees experiencing workplace stress with resources or skills needed to deal productively with the stress. Examples may include employee assistance programs to assist with stress management or even more extensive support for those employees who may suffer from a chronic psychological condition. Proactive interventions to help reduce disruptive behaviors due to interpersonal problems could include education using simulations of scenarios where disruptive behavior can be viewed along with the interventions that provided resolution. Another might be to change the organizational structure to be less hierarchical (Villafranca et al., 2018). Leadership should proactively work to change workplace logistics like short staffing to reduce stress through

manageable workloads. Broader social context is much more difficult for organizations to have an impact on, and organizations should provide support for employees experiencing family and financial issues outside the workplace (Villafranca et al., 2018).

Healthcare organizations may also create behavioral standards with which all healthcare disciplines must comply. This can be achieved through the creation of policies which define disruptive behavior and provide a list of behaviors considered disruptive (Villafranca et al., 2018). The organization should use contracts, bylaws, codes of ethics, professional standards, and professional oaths to articulate disruptive behavior, set standards for expected behaviors, and enforce those standards. Second, the organization must help clinicians to meet the standards through values education and teaching the value of professional behaviors starting in their respective medical education programs whether it be physician, nursing, or other healthcare disciplines. This education should then be continued throughout their career (Villafranca et al., 2018). Finally, organizational leaders could help prevent disruptive behavior through screening of potential applicants to prevent the hiring of clinicians who act disruptively. This screening, although controversial, could be achieved using tests that measure a potential hire's personality characteristics such as professionalism and empathy as well as tests to identify if one has personality traits that are associated with disruptive behavior (Villafranca et al., 2018).

It is important that organizational leadership recognize and address disruptive behavior no matter how minor to prevent escalation. The organization should have a system in place to monitor compliance with the organization's behavioral standards

(Villafranca, et al., 2018). There should be an explicit procedure to deal with identified events and corrective actions should be applied consistently and fairly across disciplines. Corrective actions should account for the magnitude or egregiousness of the disruptive behavior event as well as the frequency with which it occurs in the perpetrator and should be undertaken immediately. Villafranca et al. (2018) stressed that corrective actions and feedback should not be solely punitive but should exhibit compassion and consider the circumstances in which the behavior occurred. Finally, important to the success of identification of DPB and compliance with organizations' behavioral standards, the organization should have a just environment in which employees should be encouraged to report and feel safe reporting disruptive behavior.

When talking about consequences of disruptive behavior, Villafranca et al. (2018) provided two factors in which to consider: the victims or witnesses cognitive appraisal or interpretation of the disruptive behavior event and their behavioral response to the event. Consequences of the same disruptive behavior event can be different based on how the events are interpreted by those experiencing the event and how they respond to it. Villafranca et al. listed many possible negative consequences that impacted all involved including patients, clinicians, students, and institutions. Patient care can be negatively impacted by the undermining of communication and teamwork between healthcare professionals when the victim's response is passive such as avoidance; manipulative such as intentional miscommunication or lying, or maliciousness. Disruptive behavior can negatively impact technical performance of healthcare workers putting patient outcomes at risk. The well-being of healthcare professionals may be negatively impacted resulting

in increased stress, burnout, decreased self-esteem, and depression which could lead to decreased job satisfaction possibly leading to poor coping mechanisms where the healthcare professional may self-medicate eventually leading to substance abuse in some instances. Consequences to institutions may include decreased employee productivity, increased sick day utilization, decreased job commitment, and increased employee turnover. Additionally, replacement costs for nurses, liability, and litigation may result in significant financial expenditures. Finally, this behavior could be perpetuated in the organization when medical students observe this behavior occurring without consequences, therefore, seeing this behavior as normal and perpetuate the disruptive behavior (Villafranca et al., 2018).

DPB's Impact on Patient Safety and Outcomes.

A review of literature between 1994 and 2008 found patient safety to be a major challenge for U.S. healthcare organizations (Saxton et al., 2009). Disruptive behavior has been found to negatively impact patient safety (Dang et al., 2016; John & Heitt, 2018; Johnson & Benham-Hutchins, 2020; Layne et al., 2019; Rosenstein, 2011b; Saxton et al., 2009; Villafranca et al., 2017; Villafranca et al., 2018). Disruptive behavior was not unique to physicians as it occurred across all healthcare disciplines (John & Heitt, 2018). However, due to the relative power inherent in their position in the organization, disruptive behavior on the part of physicians tended to have a much greater impact on the organization.

The negative consequences of DPB are far-reaching. DPB has been identified as a barrier to effective communication in the nurse-physician relationship (Johnson &

Benham-Hutchins, 2020; Kimes et al., 2015; Thind, 2018; Villafranca et al., 2018) and true collaboration is a key component in achieving excellence in healthcare (Blake, 2013). According to Smetzer (2004), a 2003 survey at the Institute for Safe Medication Practices found 7% of medication errors were attributed to poor communication whereby nurses and pharmacists felt too intimidated to clarify medication orders with the ordering physician (Cohen & Smetzer, 2005). In 2013, the ISMP conducted additional research with similar findings with 11% of respondents being aware of a medication error directly attributed to disruptive behavior (ISMP, 2013). Dang et al. (2016) found that 114 (12.5%) of 909 respondents reported disruptive behavior events that resulted in patient harm. After experiencing DPB, nurses were left feeling belittled, disrespected, stressed and angry (JCAHO, 2008; Kimes et al., 2015; Pfifferling, 2008;). As previously mentioned, nurses impacted by DPB may engage in avoidance behavior like not calling the physician with abnormal clinical results (Cohen & Smetzer, 2005). DPB decreased nurse advocacy for their patients which threatened patient safety (Kimes et al., 2005). DPB has resulted in hostile work environments that undermine the provision of high-quality care, patient safety, and patient satisfaction (JCAHO, 2008; John & Heitt, 2018; Pfifferling, 2008).

Johnson and Benham-Hutchins (2020) conducted a systematic review of 14 research studies from 2012 through 2017 to determine the impact of nurse bullying on nursing practice areas and patient outcomes. They sought to identify themes related to bullying and nursing practice errors. They included only studies that looked at bullying among nurses but excluded physicians and those studies with the setting of clinics or hospitals.

Johnson and Benham-Hutchins (2020) identified four themes which included the influence of the work environment on nursing practice errors, individual-level connections between bullying and nursing practice errors, barriers to good teamwork, and impaired communication among healthcare professionals. The Practice Environment Scale-Nursing Work Index (PES-NWI) tool was used to evaluate the nurses' work environment. The review found that a negative work environment resulted in increases in central catheter-associated bloodstream infections, ventilator-associated pneumonia, and urinary tract infections. Those experiencing bullying felt depersonalized and this depersonalization was associated with increased reporting of negative patient outcomes which included patient falls, nosocomial infections, and medication errors. The review found a connection between organizational-level relationships, depersonalization of nurses, and negative patient outcomes. The review found that bullying was not unique to any one type of nursing unit but was very prevalent in operating rooms where staff members were three times more likely to be bullied than other members (p = .03, CI 95%). The review identified the psychosocial consequences of those who experienced bullying behaviors which included increased stress, somatic symptoms, frustration, low morale, absenteeism, and lack of concentration. One study found a correlation between verbal abuse and job stress (r = 0.17, p = .001) and intent to leave (r = 0.16, p = .001). Increased frequency and intensity of bullying behaviors was associated with emotional exhaustion in the target (p = .001). Finally, Johnson and Benham-Hutchins suggested that it was not the bullying behavior that resulted in medical errors but the psychological or

behavioral responses to bullying behavior that resulted in medical errors negatively impacting patient outcomes.

Additional themes identified by Johnson and Benham-Hutchins (2020) included teamwork and communication. Experiencing disruptive behaviors like bullying in healthcare was found to have a negative effect on teamwork specifically, resulting in avoidance behaviors on the part of the targets of this behavior. In one study, 25.6% of nurses experiencing bullying failed to ask for help lifting patients, 11.6% failed to ask for help with unfamiliar medical equipment, and 6.9% failed to get clarification of physician orders. When nurses were asked about patient safety culture, there was an association between serious surgical complications and the hospital safety culture subscale ($p = .002$, CI 95%), and the nursing statements "problems often occur in the exchange of information across hospital units" ($p = .006$, CI 95%) and "hospital units do not coordinate well with each other" ($p = .013$, CI 95%). Finally, the review found that a significant positive relationship existed between communication openness and patient safety grade ($r = 0.62$, $p = .0001$).

Walrath et al. (2013) conducted an organizational assessment using a descriptive survey design to determine the impact of disruptive behavior on patients in a 1013-bed urban medical center in the mid-Atlantic region of the United States. The study population (N=5710) included RNs (n=2759); nurse practitioners, certified nurse midwives, certified nurse anesthetists, and physician assistants (n=470); and medical school faculty, fellows, and house staff (MDs) (n=2481). There was a total of 1559 (27.3%) respondents (RNs-n=987, 35.8%; affiliates-n=76, 16.2%; MDs-n=496, 20%).

Harm was classified as temporary and included patient events that required intervention or prolonged hospitalization; permanent events such as wrong site wrong procedure events; and even life-sustaining interventions like intubation or emergency surgery (Walrath et al., 2013). The researchers found that 10.1% (n = 114/1131) of respondents in their study reported that patient harm had occurred. In contrast, 19.6% (n = 222/1131) of respondents were not sure that disruptive behavior resulted in harm to patients. Overall, the clinicians reported 189 incidences of harm to patients due to disruptive behavior. Some were reported to be temporary (77.2%, n = 146), permanent (10%, n = 19), and requiring life-sustaining interventions (12.7%, n = 24) (Walrath et al., 2013).

Dang et al. (2016) conducted a study using a cross-sectional descriptive design. The purpose of this study was to determine correlations between disruptive clinician behavior and patient outcomes as well as identification of mediating factors on those correlations. The organization was a Joint Commission accredited, Magnet designated urban academic center in the mid-Atlantic United States working to improve the culture of safety in the organization through continuous monitoring and assessment of the work environment. Dang et al. (2016) used the same study population as Walrath et al. (2013). The total population of the study was N=5710 and was comprised of registered nurses both clinical and administrative (RNs; n=2759); nurse practitioners, certified midwives, certified RN anesthetists, and physician assistants (clinical affiliates; n=470); and full-time clinical faculty, fellows, and house staff (MDs; n=2481). There was a 27.3% response rate or 1559 professionals completing the survey which included 736 (61.7%) registered nurses, 128.9%) 111 (9.3%) clinical affiliates, and 345 (28.9%) physicians.

Dang et al. (2016) found a substantial number or 90% of the respondents had experienced conflict with a clinician. The three domains of the disruptive behavior scale used were incivility, psychological aggression and violence measured on a 5-point Likert scale. Rude, disrespectful, self-centered, self-serving, egocentric, gossip, and passive aggressive behavior was experienced by 80% of the respondents. Physical violence was experienced by 12% of the respondents. Regarding patient outcomes, 27.3% of respondents attributed disruptive behavior to near miss events in their patients over the past year and 12.5% of the respondents reported that, over the past year, disruptive behavior resulted in harm to their patients. The behaviors experienced the most were conflict (mean 2.86; SD = 1.16); passive-aggressiveness (mean 2.85; SD = 1.31); and self-centeredness (mean 2.74; SD = 1.25). The behavior experienced the least was physical violence (mean 1.15; SD = 0.43).

Dang et al. (2016) explored the relationship between disruptive behavior and the response to that behavior. The most frequent positive responses to disruptive behavior included "I control my response by thinking through or analyzing disruptive behavior" and "I seek support from peers in response to disruptive behavior" (Dang et al., 2016). The most frequent negative responses included "respondents accommodated disruptive behavior" and "respondents accepted them." Specific to the three domains, there was an inverse relationship between the domain of psychological aggression and the use of desirable responses. For example, when psychological aggression was high the use of desirable responses was lower (β = -.177, $p < 0.01$). The RNs were found to use constructive responses more than clinical affiliates (β = -2.234, $p < 0.01$). In addition, the

results of this study found that those respondents who experienced more disruptive behavior used negative responses more and those respondents reporting less experience with disruptive behavior reported using positive responses more (Dang et al., 2016).

The severity of disruptive behavior and its impact on patient outcomes was studied (Dang et al., 2016). An increase in psychological aggression was associated with increased likelihood of near misses (odds ratio [OR], 1.072; 95% confidence interval [CI], 1.038-1.109) and harm to patients (OR, 1.114; CI, 1.059-1.171). As incivility increased, the likelihood of near misses increased (OR, 1.119; 95% CI 1.004-1.247). Positive or negative responses to behavior alone showed no relationship to the occurrence of a near miss event; however, disruptive behavior combined with positive responses resulted in an increased likelihood of near miss events. This finding holds true for harm to patients where the greater the positive responses to disruptive behavior, the greater the likelihood of harm to patients (OR, 1.059; 95% CI, 1.015-1.105). Therefore, the findings of this study did not support a mediating role of positive responses to disruptive behavior on the relationship between near misses and harm to patients (Dang et al., 2016).

Extensive research exists on the impact on patient safety resulting from disruptive behaviors among healthcare professionals. According to a 2022 annual sentinel event review by the JCAHO, communication failures continue to be the main contributing factor to sentinel events negatively impacting patient safety. JCAHO received 1, 442 reports of sentinel events with 20% of those resulting in death and 44% resulting in severe temporary harm. Poor communication among surgical teams was found to be the cause of 10% of paid surgical malpractice claims (Rosenstein, 2011b).

Felps et al. (2006) found that 64% of pharmacists failed to confirm questionable prescriptions to avoid disruptive physicians. Rosenstein and O'Daniel (2008) found that 40% of health care professionals had experienced intimidation which resulted in failure to report questionable medical practice and potential errors.

Medicine and nursing share the same goal of providing high-quality patient care; however, poor nurse-physician relationships have resulted in increased instances of preventable complications and increased mortality (Gunnarsdottir et al., 2009). Today's healthcare environment continues to increase in complexity requiring more collegial nurse-physician relationships and improved collaboration in order to provide safe, efficient, and effective patient care (Thind, 2018). This increase in complexity necessitates action on the part of healthcare leaders to create policies defining disruptive behaviors, setting behavioral standards or expectations holding all accountable to those behaviors and describing consequences for deviation from the expected behaviors with an explanation of the disciplinary process.

Implications for Social Change

It is critical that healthcare administrators develop strategies for dealing with DPB because it is a significant issue with grave consequences. Recent attention on it from accrediting organizations such as JCAHO has thrust it into the forefront, making it an unwise decision to look the other way as has been done in the past. (Rosenstein, 2009b; Rosenstein, 2015). Administrators must address the issue to prevent the negative impact on nurse satisfaction and nurse turnover. More importantly, administrators must address DPB to mitigate or eliminate its negative impact on quality of care provided and patient

safety (Rosenstein, 2009b). Addressing this issue may result in improved nurse-physician relationships with improved communication and collaboration that is so essential to provision of high-quality care and positive patient outcomes (Rosenstein, 2009).

First, commitment to alleviating this problem must come from the executive suite (Rosenstein, 2009b). The administrators and all employees should be provided with training on disruptive behavior, how it is defined and the many forms it takes along its continuum. Healthcare executives should be aware of the barriers to intervening with DPB. Also important is a thorough understanding of DPB and its impact on nurses, patient care and outcomes, and colleagues as well as the financial implications for the organization. More specialized training should follow to provide employees with the skills needed to effectively deal with the behavior if it occurs. This specialized education could include sensitivity, assertiveness, diversity, conflict management training (Rosenstein, 2009b). An assessment of the organization should be undertaken via survey to raise awareness of and assess the magnitude of the problem. Discussion of contributing factors and the roles and responsibilities of employees may increase accountability for behaviors. Implementation of strategies or tools to promote communication and collaboration in the organization are essential. Examples include the SBAR tool (Situation, Background, Assessment, Recommendations), informal gatherings, town hall meetings and multidisciplinary task forces. Policies and procedures should be created to provide set expectations for appropriate behavior in the organization as well as consequences for deviating from the expectations. Executive commitment is needed to circumvent barriers to the successful implementation of behavior policies and procedures,

consistency and follow through (Rosenstein, 2009b). All must be held to the standard of behavior irrespective of position or title in the organization. In addition, leadership should create and implement a formal process for reporting and reviewing of inappropriate behavioral occurrences which should include a core team with members from across the healthcare disciplines (Rosenstein, 2009b).

The goal in any organization should be to prevent disruptive behavior from occurring at all. When it does occur, hospital leaders can no longer afford to look the other way (Rosenstein, 2009b). “The risks of not addressing disruptive behaviors are much greater than the risk of avoidance” (Rosenstein, 2009b, p. 8). Disruptive behaviors on the part of even one physician can create a hostile work environment and have a devastating impact on the organization (Reynolds, 2012). Litigation is not uncommon (Reynolds, 2012). Healthcare executives can improve the chances of success in dealing with DPB in their organization through an awareness of barriers to intervention and removal of those barriers. Historically, there has been a lack of responsiveness to this problem on the part of executive leaders (Rosenstein, 2015). Second, the behavior is tolerated and accepted and third, there is a lack of structure and process including established, written policies and procedures to deal with inappropriate, disruptive behaviors. There are varied reasons for the barriers to intervention including the position of physicians in the organizational hierarchy and their revenue-generating capacity, a code of silence inherent in the culture of the organization, fear of retaliation and repercussions, and lack of a mechanism for reporting (Rosenstein, 2015).

The consequences are many if DPB is not dealt with successfully and may include decreased staff satisfaction and morale, increased employee turnover, compromised patient safety, poor patient satisfaction scores, negative hospital reputation and increased exposure to litigation (Rosenstein, 2015). Many of these consequences are associated with adverse events leading to economic loss in today's era of pay-for-performance (Rosenstein, 2011b). Determining the impact of DPB on nurses' job satisfaction and intent to leave and effectively addressing the issue could help to retain nurses currently working in the field as well as new nursing graduates. Retention of experienced and novice nurses may improve patient care and outcomes among the U.S. population. As the number of nurses actively employed increases, the nurse-to-patient ratio decreases with the direct result of safer patient care (Candiotti et al., 2012). As patient care improves, organizations may experience significant financial savings through reduction in medical errors. Healthcare organizations that are more stable financially have more funds enabling them to provide more of the needed services in the organizations' community. Successfully dealing with DPB would be a major step in the right direction toward a safer and more high-quality U.S. healthcare system.

Nursing Shortage

As the largest group of healthcare providers in the United States with 5.2 million members (American Association of Colleges of Nursing, 2023), nursing shortages can have a significant negative impact on the quality of care and patient outcomes. The United States has been plagued with cyclical nursing shortages for many years, but the coming shortage will be more severe at twice the rate of previous shortages (Jincer,

2016). The Bureau of Labor Statistics (BLS) (2013) estimated a shortage of one million nurses by 2024. Contributing factors to the shortage included the aging baby boomer generation which will impact the balance of supply and demand simultaneously increasing the demand for healthcare services and reducing the supply of nurses through retirement (Snavely 2016; Jincer, 2016). The 2017 National Nursing Workforce survey found that 50.9% of respondents were age 50 and older (National Council of State Boards of Nursing & National Forum of State Nursing Workforce Center, 2018). As the aging nursing populations retires, the supply of registered nurses will be 20% below the demand by 2020 (Sigma Theta Tau International, 2023, para 2). According to Sofer (2018), the percentage of full-time RNs 50 years of age and older increased from 26% in 2001 to 37% in 2015 and by 2030, an estimated 1 million RNs will have retired. Alarming is the fact that along with the mass exodus of RNs, the healthcare system will sustain a loss of 1.7 million years of accumulated experience and knowledge which could negatively impact quality of care (Buerhaus et al., 2017). Those baby boomer nurses that remained working or who returned to work during the 2007-2008 economic recession, an estimated 250,000 (Staiger et al., 2012), will be returning to pre-recession work status (Snavely, 2016) with an estimated 120,000 RNs leaving the workforce by 2015 (Staiger et al., 2012).

Also contributing to the nursing shortage is the lack of nursing school capacity to accept all applicants due to a shortage of nursing school faculty with a reported 2,166 full-time vacant faculty positions in 909 United States nursing schools in 2022 (American Association of Colleges of Nursing, 2022; Robeznieks, 2015; Snavely, 2016). In 2021,

91,938 qualified nursing school applicants were turned away (American Association of Colleges of Nursing, 2023). Due to the nature of nursing being a high stress and demanding profession with high burnout, the profession loses many to attrition. Approximately 30% to 50% of nurses leave the profession after only 3 years of clinical practice (Macusick & Minick, 2010) and there was an increase in turnover rate from 13.5% in 2011 to 17.2% in 2014 (Nursing Solutions, Inc., 2015). Finally, nearly 25% of all U.S. hospitals have reported a 10% or greater RN vacancy rate (Nursing Solutions, Inc., 2015). The coming nursing shortage will be much harder to address because of this faculty nursing shortage and the shortage in nursing school slots (Jincer, 2016; Roseznieks, 2015). An adequate nursing workforce is essential to the provision of high-quality care and optimum patient outcomes. Poor patient outcomes are an economic burden and financial risk to healthcare organizations especially in this era where insurance companies deny payment for adverse events due to poor-quality of care (Rosenstein, 2011b). An estimated 1.5 million preventable errors involving the administration of medications occur in U.S. hospitals each year with each event costing between $2000 and $5800 per hospitalization 7% of which are attributed to provider intimidation (Agency for Healthcare Research and Quality, 2010). About 1 in 31 hospitalized patients has a healthcare associated infection associated with their care costing the U.S. healthcare systems billions each year (Office of Disease Prevention and Health Promotion, 2018). Increases in ventilator-associated pneumonia, urinary tract, surgical, central line, and clostridium difficile infections are associated with higher patient-to-nurse ratios and cost the U.S. healthcare system between $28.4 and $33.8

billion each year (Cimiotti et al., 2012). Even more important is the impact on patient mortality with thousands of patients dying as a result of adverse events each year (Rosenstein, 2011b).

DPB and Nurses' Job Satisfaction

Research has shown that disruptive behavior has had a negative impact on nurses' job satisfaction, increasing absences and intent to leave their job or profession. Job satisfaction, work conditions, and nurse burnout were cited frequently in the literature as contributors to nurse turnover (Al Sabei et al., 2020; Alharbi et al., 2020; Hairr et al., 2014; Liu et al., 2016; & Trepanier et al., 2013).

Alharbi et al. (2020), examined the relationship between the nurses' work environment which included the IVs of nurse participation affairs, nurse manager ability, leadership and support of nurses, and collegial nurse-physician relationships and the DV job satisfaction. The researchers found nurse participation in hospital affairs to be positively correlated to jobs satisfaction (OR=2.27, $p < .05$, 95% CI [1.18, 4.38]). Nurse manager and leadership support for nurses were positively correlated with job satisfaction (OR=1.80, $p < .05$, 95% CI [1.07, 3.01]). The researchers found that collegial nurse-physician relationships were inversely associated with job satisfaction with positive relationships being associated with decreased job satisfaction (OR=0.42, $p < .01$, 95% CI, [0.23, 0.75]). This finding was unexpected, and the researchers attributed this to a possible suppression effect. In summary, nurses experienced less emotional exhaustion and higher job satisfaction when they perceived their work environments provided encouragement of nurse's contributions to organizational decisions and this resulted in

less inclination to leave their jobs (Alharbi et al., 2020). These results indicated that nurses wish to practice in work environments in which they have some control and autonomy otherwise, the risk of emotional exhaustion and decreased job satisfaction existed.

Al Sabei et al. (2020) conducted a study to determine predictors of nurse intent to leave, burnout, and nurses' perceived quality of care and to examine if job satisfaction moderated the relationship between the nurses' work environment and nurses' intent to leave. The researchers sent an online survey to 1400 nurses in Oman and 219 (15.6%) nurses completed the survey. Twelve participants did not meet eligibility criteria and their survey responses were excluded resulting in a study sample of n=207. Turnover intentions were higher in nurses who perceived a lack of support from their manager (t =2.06, p = .041), and lack of adequate staffing (t = 2.33, p = .021). Nurses' involvement in hospital affairs including being involved in managing affairs at the hospital and unit levels and in the operations of the hospital was associated with better engagement and less burnout, and emotional and physical exhaustion. Those nurses reporting greater participation in hospital affairs were 79% less likely to experience burnout (p = .02, 95% CI = 0.05-0.80). An inverse relationship existed between job satisfaction and nurses' turnover intention. An increase of one point in job satisfaction was associated with a 71% reduction in intent to leave (p = .001, 95% CI = 0.16-0.53). Al Sabei et al. used a "hierarchical moderated logistic regression analysis with interaction" (p. 98) to determine if job satisfaction had a moderating effect on the relationship between nurses' work environment and intent to leave. In Step 1, the researchers found

that work environment was not significantly associated with nurses' intent to leave (odds ratio [*OR*] = 1.23, *p* = .318, 95% CI = 0.66-0.51). In Step 2, the researchers found that there was an interaction effect between work environment and job satisfaction (OR = .89, *p* = 0.30, CI = .80-1.00). The level of satisfaction determined the strength and direction of the relationship between the work environment and intent to leave. When job satisfaction was high, better perceptions of the work environment were significantly associated with nurse intent to stay (*OR* = 0.29, *p* = .007, 95% CI = 0.79-0.96) and greater participation in hospital affairs was associated with decreased intent to leave (*OR* =0.47, *p* = .03, 95% CI = 0.23-0.98).

Dang et al. (2016) studied the impact of disruptive behavior on job satisfaction and physical symptoms of those experiencing disruptive behavior. As psychological aggression increased job satisfaction decreased ($\beta = .008$; $p < 0.05$). When respondents reported using positive responses, they also reported decreased job satisfaction ($\beta = -.003$; $p < 0.05$). When including both disruptive behavior and responses to it, only psychological aggression was associated with decreased job satisfaction. The findings of this research indicated that there was an inverse relationship between psychological aggression and job satisfaction. The study findings indicated that disruptive behavior was associated with decreased job satisfaction with a mean of 3.34.

Dang et al. (2016) studied the impact of disruptive behavior on the targets as well as how the target's responses to the behavior impacted the experience of physical symptoms in the targets. As psychological aggression increased physical symptoms increased ($\beta = .017$; $p < 0.05$). An inverse relationship existed between the use of

constructive responses and physical symptoms (Dang et al., 2016). As the use of constructive responses to disruptive behavior increased, physical symptoms decreased ($\beta = -.008$; $p < 0.05$). Like the findings with psychological aggression and job satisfaction, when including both the behavior and responses to the behavior, only psychological aggression was found to have a statistically significant relationship with the experience of physical symptoms (Dang et al., 2016). Overall, the study's findings did not support a significant correlation between disruptive behavior and physical symptoms in the targets of that behavior as evidenced by a mean of 2.27 for physical symptoms.

The newly licensed registered nurse (NLRN) population is an important population to focus on because 13% leave their position within 1 year (Bontrager et al., 2016; & Hickson, 2013). Determining the factors associated with job satisfaction and retention in this nursing population is essential and could have a positive impact on the nursing shortage in the short- and long-term due to their longevity enabling them to outlast the coming nursing shortage. Bontrager et al. (2016) conducted a quantitative, cross-sectional study using the descriptive design to determine the impact of the preceptor role and group cohesion on the NLRNs' satisfaction and intent to stay. A convenience sample of 210 NLRNS were sent a survey with 84 NLRNs (40% response rate) completing the survey. Bontrager et al. found a correlation between preceptor role effectiveness and group cohesion and satisfaction and intent to stay. As the NLRNs' perception of preceptor role effectiveness and group cohesion increased, their job satisfaction and intent to stay increased. Job satisfaction was an independent predictor of intent to stay. Important to note is the positive impact of the effective preceptor on the

NLRNs' ability to communicate openly and participate in constructive communication. This is important because communication and collaboration among health professionals is key to positive patient outcomes (Blake, 2013). Finally, an effective preceptorship and increased group cohesion created a supportive environment with decreased frustration and increased ability of the NLRNs' to be independent in practice. This supportive work environment also assisted with adaptation into the clinical nursing role and culture (Bontrager et al., 2016).

Retention of mid-career and newly hired nurses has been identified as a problem (Yarbrough et al., 2017). Yarbrough et al. (2017) conducted research to investigate the relationship between professional values, career development, job satisfaction and intent to stay in both mid-career, newly hired nurses as well as early-career nurses. A convenience sample of 67 nurses from one facility in a large multi-site system was used. Findings from this study indicated that both job satisfaction ($r = 0.39$, $p = 0.003$) and career development ($r = 0.29$, $p = 0.037$) are positively correlated with nursing retention. Nurses with 5 or more years of experience scored higher on retention ($U = 14.5$, $p = 0.041$) and job satisfaction ($U = 18.5$, $p = 0.005$) than early career nursing with less than 5 years of experience. Although professional values did not significantly correlate with retention in either mid-career or early-career nurses, the perception of a conflict in the values of the nurse and the organization could adversely affect nurse retention (Yarbrough et al., 2017). Those nurses with support in their personal life scored significantly higher on retention ($U = 214.5$, $p = 0.006$) and job satisfaction ($U = 339.5$, $p = 0.006$) than those nurses who were the sole support of themselves. This represented a

secondary and non-modifiable risk factor associated with nurse retention. A small sub-sample or five of the mid-career nurse respondents agreed to answer questions about their perception of retention but only two provided detailed information. Important to the mid-career nurses, career development initiatives such as a good orientation adequately preparing nurses for practice, opportunities for continuing education including tuition reimbursement, and reimbursement for certification exams were associated with higher job satisfaction and retention. The primary reason they chose to stay in their position was a positive work environment (Yarbrough et al., 2017).

Unruh et al. (2016) conducted research on newly licensed registered nurses (NLRNs) to determine what personal and work factors affected the perception of work-family conflict (WFC) and if these perceptions affected job satisfaction and intent to leave their job or the profession. Intent to leave the job and profession both had four items on the survey and were rated on 5-point scales ranging from strongly disagree to strongly agree. In 2008, a survey was mailed to a random selection of 3027 NLRNs in Florida. A total of 533 surveys were returned for an 18% response rate. The final sample size was N=503 as those respondents not currently employed in nursing were excluded. Survey instruments used had been tested in previous studies. WFC was experienced one or more times per week in 30% to 40% of respondents. About half of NLRNs felt their orientation was fairly to extremely good and adequate orientation was associated with perceptions of job control, reduced job difficulties, reduced job demands which was associated with decreased WFC. Personal characteristics included in the study were age, gender, health, marital status, children in the home, and race. The researchers found no

direct effect of these personal characteristics on a job demands, difficulties or satisfaction. Work characteristics like 12-hour shifts, higher patient loads, were associated with the perception of higher job demands, job difficulties and less control all increasing WFC. As WFC increased, the intent to leave the job and profession increased. These findings were consistent with previous research. Unexpectedly, the research showed that WFC did not directly affect job satisfaction which contrasted with previous research. WFC indirectly affected job satisfaction through the NLRNs perception of the job (Unruh et al., 2016).

DPB and Nurses' Intent to Leave

Nurse retention is another major challenge facing healthcare organizations (Saxton et al., 2009). Turnover of nurses in U.S. hospitals was estimated to be 16.5% and was expensive costing $44,380 to $63,400 per nurse and an estimated annual financial loss of $4.21 to $6.02 million for hospitals (Yarbrough et al., 2017). Intent to leave and nurses' satisfaction with their job were two variables identified as predictors of actual nurse turnover and retention rates (Han et al., 2015) underscoring the importance of identifying contributors to nurse satisfaction to identify opportunities to positively impact nurse satisfaction in the hopes of increasing retention. Han et al. conducted a cross-sectional secondary data analysis of a 2004 Nurses' Worklife and Health Study to determine the relationship between nurses' job satisfaction and four elements of nursing working conditions: physical and psychological demands, autonomy in clinical practice (Han et al., 2015, Hickson, 2015), supervisor and peer support, and work schedule. The study included 1641 currently employed nurses with 60% working in hospitals. The

sample demographics included an average age of 46.4, was 95% female and 86% white. Fifty-one percent of the respondents were Bachelors-prepared or higher. The job satisfaction and intention to stay among respondents was 75%. The satisfaction among nurses working in ambulatory clinics or home health agencies/hospice/assisted living facilities was higher than that of nurses employed at hospitals. All working condition variables were significantly related to job satisfaction. As the level of psychological demand increased, the level of nurse satisfaction decreased. Lower levels of job autonomy were associated with lower levels of nurse job satisfaction. Those nurses who worked long hours had lower rates of job dissatisfaction. Job satisfaction was lower in those nurses who reported lower levels of peer and supervisor support. Intention to leave their job was significantly associated with jobs with greater physical and psychological demands, longer hours, less autonomy, and lower peer and supervisor support. The findings indicated that autonomy and support are important to nurses and when lacking, were significantly associated with intent to leave (Han et al., 2015).

Alharbi et al. (2020), examined the relationship between the nurses' work environment which included the IVs of nurse participation affairs, nurse manager ability, leadership and support of nurses, and collegial nurse-physician relationships and the DV intent to leave. The researchers used logistic regression to examine the unique relationship between each DV and IVs and found that the only IV that was correlated with intent to leave was nurse participation in hospital affairs ($OR = 0.52$, $p < .05$, 95% CI [0.28, 0.95]). The researchers then used the causal steps approach and found that emotional exhaustion ($OR = 1.03$, $p < .01$, 95% CI [1.01, 1.05]) and job satisfaction (*OR*

= 0.57, $p < .01$, 95% CI [0.34, 0.93]) mediated the effects of nurse participation in hospital affairs on intent to leave and were significantly associated with intent to leave. These findings suggested that those nurses with increased autonomy and control over their work environments were less inclined to leave their jobs.

Al Sabei et al. (2020), conducted research to determine what factors contributed to nurse turnover intention, burnout, and nurses' perception of the quality of care among nurses in Oman. In addition, the researchers sought to determine if job satisfaction had a mediating effect on the relationship between the nurses' work environment and nurses' turnover intention. The study sample consisted of 207 nurses working in a hospital in Muscat, Oman. The components of the work environment included nurse participation in hospital affairs, nursing foundation for quality of care, nurse manager ability, leadership, and support of nurses, adequate staffing and resources, and collegial nurse-physician relationships. The researchers found that for each point in job satisfaction, nurse intent to leave went down 71% (p <.001, 95% CI = 0.16-0.53). Greater nurse participation in hospital affairs resulted in a decrease in the odds of burnout by 79% ($p < .02$, 95% CI = 0.05-0.80). Al Sabei et al. used the causal steps approach and found that, in Step 1, work environment was not a significant predictor of nurse turnover intentions (OR = 1.23, p = .318, 95% CI = 0.66-.51). In Step 2, the work environment and job satisfaction had a significant effect on nurse intent to leave (OR = .89, p = .030, CI = 0.80-1.00). Better perceptions of the work environment were significantly correlated to a reduction in nurses' intent to leave only when job satisfaction was high (OR = 0.29, p = .007, 95% CI = 0.79-0.96). Greater nurse participation in hospital affairs was associated with a

reduction in intent to leave only when job satisfaction was high (*OR* = 0.47, *p* = .03, 95% CI = 0.23-0.98). The study findings highlighted the need for nurses to be involved in hospital affairs and operations, possibly increasing job engagement, enhancing autonomy and reducing burnout which may lower nurses' intent to leave.

Walrath et al. (2013) conducted an organizational assessment to determine the impact of disruptive behavior on the organization, its staff, and its patients. This included determination of the impact on intent to change jobs or leave the organization in RNs MDs. They found that 35% (n = 243/692) of RNs admitted to intent to leave their current hospital and 10% (n = 68/692) admitted to intent to resign. Approximately 20% (n = 67/326) of MDs admitted to the intent to change positions and/or residency programs. Finally, 5% of clinical faculty intended to resign due to experiencing disruptive behavior (Walrath et al., 2013). The findings of this study were in congruence with previous research findings that disruptive behavior negatively impacted job satisfaction, morale, and working relationships whether it was a member of the same or another healthcare discipline.

Bullying has been a persistent problem in the nursing profession for many years (Sauer & McCoy, 2018), and bullying has been defined in diverse ways. The American Nurses' Association (ANA, 2015) defined bullying as "nonverbal actions such as eye-rolling, ignoring, and walking away when approached" (p. 219) and verbal examples of bullying included "snide or derogatory comments, yelling, or teasing a co-worker." Nurse bullying was associated with mental or psychological distress in which the victim experienced elevated levels of stress, burnout, a loss of loyalty and sense of commitment

to their employer (Einarsen & Nielsen, 2015; Giorgi et al., 2016; Sauer & McCoy, 2016). It resulted in increased nurse absenteeism and turnover with the unintended consequence of increased financial costs to the healthcare organization (Wilson et al., 2011). The negative impact of nurse bullying does not stop with the victim but also may result in poor communication between other members of the healthcare team which may jeopardize patient safety (JCAHO, 2022).

Sauer and McCoy (2018) conducted a cross-sectional descriptive study to determine the extent of bullying in various workplace settings and the impact it had on nurses' intent to leave their unit or the organization. The Negative Acts Questionnaire Revised (NAQR) was used to measure bullying and included work-related, person-related, and physically intimidating bullying. The Perceived Stress Scale (PSS) was also used. The names and emails of currently licensed registered nurses from one southeastern state in the United States were obtained from the state board of nursing and an online web survey was sent to 2,250 randomly selected registered nurses. A total of 345 nurses completed the survey for a response rate of 15.3% and 309 nurses had non-missing data. The researchers found that 124 or 40% of the 309 respondents had been bullied in the past 6 months. Nineteen percent (n=66) of the respondents had NAQR scores of 45 or above which indicated they had experienced severe bullying. Two-thirds (68%) of the respondents reported witnessing their co-workers being bullied. Sixteen percent (n=49) were likely to stay with their employer but change units and 17.5% of the respondents reported they were likely or very likely to leave their current employer. Sixty-six respondents (22.8%) experienced severe bullying as evidenced by NAQR scores greater

than 45. Those who experienced a higher severity of bullying were significantly more likely to leave their unit/department ($p < 0.001$) and their employer ($p < 0.001$). There was a higher percentage of nurses with intentions to leave their employer than nurses with intentions to transfer within the organization (Sauer & McCoy, 2018).

DPB is not unique to U.S. healthcare but rather a ubiquitous problem researched in many countries. Simon et al. (2010) conducted a study utilizing secondary analysis of the German data collected in the European Nurses' Early Exit Study with the intent of investigating the variables associated with intent to leave nursing (ITLprof) and those associated with intent to leave the organization (ITLorg). The sample size consisted of 2119 registered nurses from 71 departments from 16 hospitals. Approximately 18% of the nurses considered leaving the profession while 15% considered leaving the organization. The results of the study indicated that professional commitment, job satisfaction, burnout, and age were the variables most associated with both ITLprof and ITLorg (Simon et al., 2010).

Previous research supported the correlation between job satisfaction and professional commitment with leaving intentions in general (Irvine & Evans, 1995; Lu, Lin, Wu, Hsieh & Chang, 2002; Lynn & Redman, 2005). The experience of registered nurse burnout is positively correlated with both ITLprof and ITLorg (Alharbi et al., 2020; Shader et al., 2001; Shimizu et al., 2005; Simon et al., 2010). The quality of the nurses' leadership team is positively associated with actual turnover, and this has been previously documented in research (Griffeth et al., 2000). Intent to leave the organization was

associated with leadership quality and city size while intent to leave the profession was associated with marital status, hours worked per week, and work-family conflict.

Yurumezoglu and Kocaman (2016) conducted a descriptive cross-sectional study to determine predictors of nurse intent to leave the organization and the profession. The sample included 799 nurses at 16 hospitals across Turkey. They found job dissatisfaction among nurses significantly correlated with intent to leave the organization and profession more frequently. In addition, they found that positive perceptions of the collegiality of nurse-physician relationships were associated with a decrease in nurses' intent to leave their organization (Yurumezoglu & Kocaman, 2016).

Disruptive behavior toward nurses is not unique to physicians. Horizontal violence or nurse to nurse violence is a prevalent and serious problem in healthcare organizations (Armmer & Ball, 2015). It may be in the form of "bullying, professional terrorism, interpersonal conflict, workplace violence, aggression, intergroup conflict, lateral violence, and dysfunctional nurse to nurse relationships" (Armmer & Ball, 2015, p. 92). Armmer and Ball (2015) conducted research using a descriptive, correlational design to determine if a correlation existed between horizontal violence and intent to leave. A randomized sample of 300 staff nurses from a medical facility in the Midwest were mailed questionnaires including demographic, Briles' Sabotage Savvy (BSSQ) and Michigan Organizational Assessment questionnaires. The survey response rate was 36% (108) and only 104 of the surveys were able to be used for data analysis due to incompleteness. A high percentage (69.2%) of respondents reported being reprimanded or confronted in the presence of others, not being acknowledged (59.6%), job information

being withheld or respondent bypassed (40.4%), and not given important messages (57.7%). The results of this study supported a correlation between horizontal violence and intent to leave as 28.8% of the respondents reported intent to leave. This was especially true in younger nurses. Nurses with longer length of employment with their employer were less likely to leave (Armmer & Ball, 2015).

Summary and Conclusions

DPB has been a pervasive and serious problem in healthcare organizations for many years (Sanchez, 2014). Problematic for researchers of this topic, is the fact that there is no consistent definition of DPB in the literature (Saxton et al., 2009). It occurs on a continuum and can be overt or very subtle and difficult to identify (John & Heitt, 2018; Walrath et al., 2013). One commonality among the definitions of disruptive behavior in general is the perception that this behavior undermines patient care (Johnson & Benham-Hutchins, 2020; Layne et al., 2019; Villafranca et al., 2017; Villafranca et al., 2018). For various reasons, as described previously, this behavior has been tolerated and allowed to continue despite research findings proving its negative impact on patients, nursing staff, and organizational climate (Dang et al., 2016; Giorgi et al., 2016; Gunnarsdottir et al., 2009; Rosenstein, 2015; Rosenstein, 2011b; Rosenstein, 2009; Rosenstein & O'Daniel, 2008; Walrath et al., 2013).

Research conducted by Saxton et al. (2009) has shown that a high percentage of healthcare professionals were aware of instances of patient errors and harm that may have been a result of disruptive behavior. The impact of disruptive behavior on the RN and physician relationship and communication has been cited as contributor to negative

patient outcomes (Kimes et al., 2015; Layne et al., 2019; Rosenstein, 2009; Rosenstein & O'Daniel, 2008; Sanchez, 2014; Saxton et al., 2009; Thind, 2018). Specifically, its negative impact on inter-disciplinary communication has resulted in medication errors due to nurses and pharmacists exhibiting avoidance behaviors including failing to call the physician to clarify medication orders (Cohen & Smetzer, 2005; ISMP, 2013; Johnson & Benham-Hutchins, 2020; Rosenstein & O'Daniel, 2008; Saxton et al., 2009). Nurses' ability to concentrate on tasks and to think critically has also been negatively impacted (Johnson & Benham-Hutchins 2020; Saxton et al., 2009).

Important to consider is the impact of DPB on nurses' job satisfaction and intent to leave. Research has shown a relationship between DPB, decreased nurse satisfaction, poor morale, and nurse turnover (Rosenstein, 2002). However, there is a paucity of quality research focusing on DPB and its impact on nurses' intent to leave (Flinkman et al., 2010; Goettler et al., 2011; Kimes et al., 2015; MacKusick & Minnick, 2010). In addition, much of the research on this topic is lacking in quality (Flinkman et al., 2010). Much of the data in existing research is obtained from studies with significant limitations in their methodological approach including sampling frames, statistical methods, and survey tools (Villafranca et al., 2017). In addition, Keller et al. (2020) conducted a systematic review of research published between 2002 and January 2020 on incivility in healthcare. The researchers used the Medical Education Research Study Quality Instrument (MERSQI) to assess the quality of studies reviewed and found that overall, the quality of the studies was low, however, the more research reviewed had higher MERSQI scores indicating an increase in quality. Identified methodological limitations

included the reliance solely on participant perceptions, the same disruptive behavior event was reported by multiple professionals, most questionnaire studies had low response rates and a lack of complex statistical analyses of the study data (Keller et al., 2020). Some of this research focused on disruptive clinician behavior and findings indicated that it decreased nurse satisfaction and increased intent to leave (Dang et al., 2016; Walrath et al., 2013). However, DPB is the focus of this research project. The intent of this research is to expand the knowledge of disruptive behavior on the part of physicians regarding its impact on nurse job satisfaction and intent to leave.

A severe nursing shortage is on the horizon making it essential for administrators to understand what contributes to poor job satisfaction and nurse turnover in experienced as well as novice nurses (American Association of Colleges of Nursing, 2022; Armmer & Ball, 2015; MacKusick and Minick, 2010; Snavely, 2016). Replacing nurses is costly for healthcare organizations and efforts to retain them are critical (Yarbrough et al., 2017; Wilson et al., 2011). Nurse retention is not only critical to prevent the financial burden of replacement costs but more importantly for the maintenance of an adequate nursing workforce enabling safer, higher quality patient care.

A previous survey tool called the JH-DCBS for Hospital Settings was created and used by Dang et al. (2016) and was considered appropriate to be used for my research project. This tool is discussed in more detail in Chapter 3. In addition, a detailed description of the study's research design and methodology is provided.

Chapter 3: Research Methodology

A review of the literature identified a gap of quality research on DPB and whether it has an impact on nurse satisfaction and intent to leave the job, organization, or clinical practice. The purpose of this quantitative research was to survey a sample of U.S. nurses to determine if there was a correlational relationship between DPB, nurse satisfaction, and intent to leave their job, organization, or profession.

In this chapter, I provide a description of the research design and my rationale for the chosen design. An in-depth description of the research methodology is provided and includes a definition of the target population and population size, sampling and sampling procedures, and the procedures used to recruit study participants and collect data are provided. I discuss the survey instrument I used including its reliability and validity as well as threats to the validity of the study findings. Finally, a review of ethical procedures specific to Institutional Review Board (IRB) approval, informed consent, and confidentiality is provided.

Research Design and Rationale

For this research I used a nonexperimental, correlational, and quantitative research design to explore the relationship between DPB (IV) and the DVs of nurses' job satisfaction, intent to leave their job or organization, and intent to leave clinical practice. In addition, survey research was appropriate for this study because it allowed the study participants to self-report (see Cox, 2016) on their experiences with the IV and how those experiences impacted their job satisfaction and intent to leave (DVs). One method of survey research I used in this study was a web-based survey questionnaire. One

advantage of this survey research method was the ability for the data collected to be exported into the SPSS data analysis software preventing the need for manual data entry and saving much time (Cox, 2016). The data needed for this study was most appropriately collected via a survey instrument because the study sought to collect data specific to the respondents' experience with the DPB, the IV. A correlational design was appropriate because the study's purpose was to explore the correlation between DPB and the DVs of nurse job satisfaction and intent to leave. A quantitative design was appropriate because numerically quantifying the registered nurses' experience with DPB was desired.

Methodology

Population

NCSBN (2019) estimated that there were 4,692,502 licensed registered nurses in the United States as of December 31, 2018; however, as of May 2018, only an estimated 2,951,960 registered nurses were actively practicing in the United States with approximately 1,698,700 of those nurses practicing in the hospital setting (U.S. Bureau of Labor Statistics, 2019). The target population of interest for this study was registered nurses currently practicing in U.S. hospitals and having membership in the AACN, AORN, or AMSN.

Sampling and Sampling Procedures

The target population for participation in this research was nurses of any age actively employed in the hospital setting with membership in national nursing organizations including the AACN, AORN, and the AMSN. The AACN and AORN were

chosen because disruptive behavior is more prevalent in these high-stress healthcare settings (see Villafranca et al., 2017; Villafranca et al., 2018). The AMSN was included to expand the opportunity for participation to medical-surgical nurses to capture data for other physician specialties. Inclusion of RNs from varied professional nursing associations was an attempt to make the findings of this research more generalizable and to possibly improve statistical significance (see Polit & Beck, 2008). The AACN has 143,000 members but they do not allow surveys to be sent to their members' email accounts (M. Altman, personal communication, May 2022). Another option was list rental, but paper surveys would have needed to have been sent to member addresses with self-addressed, stamped envelopes for return which would have been too costly. Another option was to request to join the AACN Ambassadors Facebook group which has 1,100 members (M. Altman, personal communication, May, 2022). The AACN Ambassadors Facebook page was the chosen sampling method for the AACN. When contacted, it was found that only AACN ambassadors could use this page. The actual method by which the AACN members were recruited was by postcard via the U.S. Postal Service (See Appendix E). The AORN has 40,000 members with no limitations to how many members I could contact (M.A. Anderson, personal communication, January 13, 2020). The AMSN has approximately 12,500 members with no limitations as to the number of members who could receive the survey (D. Olthoff, personal communication, April 2022). Therefore, all AORN and AMSN members who had an email address on file with their respective professional organizations received the survey via email.

Using these organizations and their members provided a convenience sample of potentially thousands of registered nurses for this research. Convenience sampling is a form of nonprobability sampling used in quantitative research (Polit & Beck, 2008). One problem with this type of sampling is that this method may not provide a representative sample making it difficult to make inferences from the findings for nurses and physicians in the aggregate (Warner, 2013). Using more than one organization should have helped mitigate this concern.

A power analysis is required in quantitative research to determine the sample size needed for the research findings to be valid (Polit & Beck, 2008). As sample size gets larger, representativeness of the population increases. Three key factors to consider when performing a power analysis are significance or alpha level, effect size, and power level (McCrum-Gardner, 2010). The significance or alpha level for this research was .05, which means that the chance of making a Type I error (the null hypothesis is rejected when it is true) occurring was 5%. Specific to this research, there was a 5% chance that the null hypotheses would be rejected when it was true that there is no statistically significant relationship between DPB and nurses' intent to leave their job, organization, or the profession. The power level used was .80 which means that there is an 80% chance of not making a Type II error (the null hypothesis is not rejected when the alternative hypothesis is true). An alpha of .05 and power of .80 are the minimum acceptable levels for these values in research and this was the basis for choosing those levels (McCrum-Gardner, 2010). In addition, only two of the 31 studies included an integrative review of nurses' intention to leave the profession. Both studies used an alpha of .05 and power of

.80 (see Nogueras, 2006; Zurmehly et al., 2009) According to Burkholder (n.d.), most of the time researchers assume a small or medium effect size. Noqueras (2006) assumed a small effect size while Zurmehly et al. (2009) assumed a moderate effect size. Using Cohen's *d*, researchers can use effect sizes of 0.2, 0.3, 0.4, 0.5. The effect size I chose for this research was 0.2. Using G* Power (version 3.1.9.4) analysis, the required sample size was calculated to be 194 assuming a significance of 0.05, power of 0.80, and an effect size of 0.2.

One disadvantage of survey research is the low response rates typical of this method of collecting data for research (Cox, 2016). Low response rates can limit the generalizability of research and the validity of the findings could be called into question. Additional participants above the calculated sample size of 194 were needed. Previous research on DPB resulted in response rates of approximately 27% (see Dang et al., 2016; Walrath et al., 2013).

Procedures for Recruitment, Participation, and Data Collection

The AACN and AORN were contacted via their websites' "*Contact Us*" link and the AMSN via email at amsn@amsn.org to request their members' participation in this research. The AORN and AMSN have thousands of members and a link to the JH-DCBS was sent to all members with an email address on file. To maintain member privacy and confidentiality, the organizations would not provide member information including email addresses. Once IRB approval was obtained, a link to the survey was provided to the AORN for distribution via email to their members using the online survey tool, SurveyMonkey. The email provided a detailed description of the research including the

independent and dependent variables, the purpose of the research, requirements for participation, and assurance of the maintenance of their privacy and confidentiality (Appendix D). The members were informed of the voluntary status of participation in the research. Participant consent was implied upon completion of the survey. Participants could exit the survey at any time. Once the participants completed the survey (Appendix B) and clicked on submit, their participation was complete with no further participation required and were considered exited from the study. After contacting the AMSN, the organization was no longer allowing surveys to be sent to email. The method of recruitment for AMSN members then changed to providing a link to the survey and description of the survey via their research page and their community hub on the AMSN website. For the AACN, a postcard (Appendix E) was mailed to a list of 1,000 members. The postcard introduced me and provided a brief statement about the topic of the research and brief inclusion criteria. There was a QR code on the front of the postcard that brought the member to the survey on SurveyMonkey. There was a brief statement on the front of the postcard referring the member to a red QR code on the reverse of the postcard that would bring the member to a detailed description of the study. A statement was provided indicating participation in the research was voluntary and that completion of the survey implied consent and that AACN members could exit the survey at any time. Initially, the participants would be asked to provide their member identification number to ensure no member submitted more than one survey, but this was later taken off the survey per the IRB review to maintain confidentiality. There was no follow-up requirement.

Permission to use the JH-DCBS (Appendix A) was obtained from Dang. The survey contains five subscales with 47 questions but only those subscales with questions specific to this research were included. Demographic information requested included gender, racial/ethnic group, professional role, years in current professional role, and hospital practice setting (inpatient/intermediate, intensive care, operating room etc.). In the letter of permission received, it stated that it is allowable to modify demographic variables and therefore, age range of the participant, years of practice as a RN, their membership organization, and Magnet status of the organization were requested. Ethnicity and race were removed from the demographic section. Additional data collected included various types of unprofessional behavior, the frequency with which the behavior occurred, identification of the role of the unprofessional person, how long the participant had experienced disruptive behavior by the person, and how long the person had been acting unprofessionally. For the purposes of this research, the subscales "Trigger(s) of Unprofessional Behavior," "Response to Unprofessional Behavior," and "Reason for Not Addressing Unprofessional Behavior" were not used. Finally, the subscale "Impact of Unprofessional Behavior" was used to determine the participants' perception of how the unprofessional behavior impacted nurses and patients including the level of harm.

Instrumentation and Operationalization of Constructs

In 2012, Dang et al. (2015) developed the JH-DCBS out of concern for the impact of disruptive clinician behavior on patient safety, staff retention, economic health outcomes, the lack of attention to this pervasive problem and implementation of preventive strategies to reduce it. There is a lack of instruments measuring the causes and

impact of disruptive clinician behavior (Dang et al., 2015). Therefore, the JH-DCBS was developed to "fill the methodological gaps in the science and meet the urgent challenge of advancing patient safety and promoting healthy work environments in clinical settings" (Dang et al., 2015, p. 470). This instrument was useful for capturing information needed to answer the research questions for DPB and nurses' intent to leave their job, organization, or the profession and to determine the impact of DPB on nurses' job satisfaction. The instrument was modified slightly to include "leave the profession" as a choice in Question 19. Dang granted permission to exclude some subscales and their corresponding questions as the data collected by these subscales lacked relevance to this research.

The JH-DCBS was pilot tested in a 1,013-bed urban academic medical center in the United States using a cross-sectional survey design (Dang et al., 2015). The survey was sent via a recruitment email to the work addresses of 5,710 clinicians with a response rate of 1,559 or 27%. Incomplete surveys were excluded resulting in analysis of data from a total of 1,198 surveys. The developers tested construct validity. The Cronbach α values for each of the subscales included .91 for disruptive behavior, .92 for triggers, .79 for response to disruptive behavior, .85 for not addressing disruptive behavior, and .89 for impact of disruptive behavior. These values indicated good internal consistency for the subscales. The unidimentionality of the subscales was tested using factor analysis. The Eigenvalues for the five subscales were 3.2 to 5.95. These values indicated that the subscales could be treated as unidimensional scales. Construct validity was tested using 915 nurses from the study who answered questions in the Negative Acts Questionnaire

(NAQ). There was a statistically significant correlation between the scores of the NAQ and the JH-DCBS (γ=.67, P<.01). This indicated the scale has convergent validity.

A version of the JH-DCBS was used by Walrath et al. (2013) and Dang et al. (2016) in the same population in a 1,013-bed mid-Atlantic urban academic medical center. The population was *N*=5,700 and included registered nurses, nurse practitioners, certified midwives, certified nurse anesthetists, physician assistants, physicians, and fellows (Walrath et al., 2013). The initial survey contained 105 items and the authors used exploratory factor analysis to reduce the number of items in the survey. The final survey contained 62 items. The reliability of the survey was good with a Cronbach α of .93 and the range of Cronbach α for the subscales ranged from .72 to .92 (Walrath et al., 2013). This same 62 item was survey used by Dang et al. (2016).

For this research, the IV was DPB, and the DVs included nurses' intention to leave their job, organization, or the profession. An additional DV was nurse job satisfaction. The JH-DPBS (Appendix B) included specific behaviors in Questions 9 through 15 and included conflict; condescending language, dress down, and power play; intimidation, threats, and harassment; passive aggressive behavior; physical violence, professional disregard; and being rude and disrespectful. The survey provided multiple examples of each type of behavior.

The first section of the JH-DPBS included descriptive demographic variables including professional organization membership, age range, gender, years of practice, highest level of education, Magnet designation, practice setting, and professional role held. The responses for these variables were numbered consecutively. The organizational

membership identification number was deleted from the survey to improve confidentiality. The participants were asked to choose an age range which are ordinal and categorical variables. The age ranges were coded as follows: (1) 20-29, (2) 30-39, (3) 40-49, (4) 50-59, and (5) 60-69. Gender is both binary and categorical and was coded as (1) Male and (2) Female. The last question determined if the employing organization held Magnet designation, a binary variable, and the available responses were (1) Yes and (2) No. In total, there were seven control variables.

The first subscale was "Unprofessional Behavior" and consisted of seven questions (Questions 9-15) on seven types of disruptive behaviors. In total, there were seven IVs representing seven types of disruptive behavior. It provided data on the frequency with which those behaviors occurred. A 5-point Likert scale was used for the responses and the responses were coded as (0) Never, (1) Rarely, (2) Monthly, (3) Weekly, and (4) Daily. The nurses were asked to recall firsthand experiences with unprofessional behaviors over the last year when answering questions about the frequency of these behaviors. Next was the subscale "Impact of Unprofessional Behavior" and provided data on how the disruptive behavior impacted the nurses' morale, working relationships and job satisfaction; its physical and emotional impact; and whether the disruptive behavior causes ethical dilemmas for the nurses. The questions on morale, working relationship, physical and emotional impact, and ethical dilemmas were excluded as the information gleaned from them would not be relevant to this research. For this study, the questions focused on the impact of unprofessional behavior on nurses' job satisfaction, and intent to leave their job, unit, organization, or the nursing profession.

The nurses were asked to answer these questions about the impact on nurses' job satisfaction and intent to leave based on personal experiences with unprofessional behavior over the past year. The variables measuring DPB were operationalized as binary variables and coded as (0) Strongly Disagree; (0) Disagree; (1) Agree (1) Strongly Agree.

The original question asking the participants whether they had considered leaving their job or organization the past year was rewritten with three separate questions asking specifically if they had considered leaving their job/unit or organization. In addition, a question was added specific to consideration of leaving the profession as the original survey did not include this. This subscale provided the data on the participants' intent to leave their job/unit, department, organization or profession and this data were analyzed to help answer the research questions posed. The variables measuring nurse satisfaction and intent to leave the organization/profession were operationalized as binary variables and coded as (0) Strongly Disagree; (0) Disagree; (1) Agree (1) Strongly Agree. In total, there were four DVs. See Table 1 below for a description of the study variables.

Table 1

Description of Study Variables

Short Name	Description	Variable Type
Independent Variables-Disruptive Behavior (How often the participant experienced the disruptive/unprofessional behavior)	(0) Never (1) Rarely (2) Monthly (3) Weekly (4) Daily	Ordinal
Conflict	Contentious interactions and/or unresolved disputes between and among team members)	Ordinal
Condescending Language	Public humiliation, put down, insulted; ridiculed, embarrassed, demeaned, berated; criticized in front of staff/patients; pulling rank; dominating or controlling by range or position; withholding information at your expense.	Ordinal
Intimidation/Threats/Harassment	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	Ordinal
Passive Aggressive	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 pages or other requests	Ordinal
Physical Violence	Grabbing, shoving, pushing; hitting, slamming, fighting, throwing objects	Ordinal
Professional Disregard	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	Ordinal

Short Name	Description	Variable Type
Rude/Disrespectful	Lack of courtesy; sarcasm; discourteous tone; yelling; raised voice; not listening, ignoring, turning away; hanging up phone during conversations; engaging in malicious gossip; ex	Ordinal
Dependent Variables: Impact of Disruptive/Unprofessional Behavior		
Job Satisfaction	(0) Strongly disagree (0) Disagree (1) Agree (1) Strongly agree	Binary
Considering Leaving Job/Unit	(0) Strongly disagree (0) Disagree (1) Agree (1) Strongly agree	Binary
Considering Leaving Organization	(0) Strongly disagree (0) Disagree (1) Agree (1) Strongly agree	Binary
Considering Leaving Nursing Profession	(0) Strongly disagree (0) Disagree (1) Agree (1) Strongly agree	Binary
Control Variables		
Age Range	(1) 20-29; (2) 30-39; (3) 40-49; (4) 50-59; (5) 60-69	Ordinal
Gender	(1) Male; (2) Female	Binary/Categorical
Current Practice Setting	(1) Surgical ICU; (2) Medical ICU; (3) OR, PACU; (4) Med/Surg; (5) PCU; (6) Specialty/Procedure: ED, Cath Lab, EP, L&D, Endo, Radiology	Demographic
Facility Magnet Designation	(1) No; (2) Yes	Binary/Categorical

Data Analysis Plan

SPSS version 27 was used to analyze the data obtained from the JH-DCBS. Surveys with missing data or values were excluded from the research. Descriptive statistics were used to describe the characteristics of the sample population and to analyze the data. Frequency distributions were used to analyze the data and were presented in graph form based on level of measurement. Nominal level measurement of gender was presented in tables. Data gleaned from survey questions using Likert-type scales is ordinal level measurement and were presented in tables. Correlation coefficients were reported in a table format correlation matrix.

The research questions for this study were as follows:

RQ1: What is the relationship between DPB and nurses' intent to leave the job or organization adjusting for age, gender, setting, and Magnet status?

H_o1*:* No statistically significant relationship exists between DPB and nurses' intent to leave the job or organization.

H_a1: A statistically significant relationship exists between DPB and nurses' intent to leave the job or organization.

RQ2*:* What is the relationship between DPB and nurses' intent to leave the nursing profession adjusting for age, gender, setting and Magnet status?

H_o2*:* No statistically significant relationship exists between DPB and nurses' intent to leave the nursing profession.

H_a2: A statistically significant relationship exists between DPB and nurses' intent to leave the nursing profession.

RQ3*:* What is the relationship between DPB and nurses' job satisfaction adjusting for age, gender, setting, and Magnet status?

H_o3: No statistically significant relationship exists between DPB and nurses' job satisfaction.

H_a3: A statistically significant relationship exists between DPB and nurses' job satisfaction.

Multiple logistic regression (MLR) is a statistical test used by researchers when there are multiple independent or predictor variables (Warner, 2013). MLR was used for all three research questions to determine the relationship between the IVs and DVs and test the hypotheses. It was an appropriate statistical test for this research because MLR is used in research where there are more than two independent or predictor variables. In addition, MLR is flexible in that it allows the researcher to use different types of variables including ordinal and categorical which are being used in this research (Stoltzfus, 2011). In this research, there were seven different types of disruptive behavior or independent/predictor variables including conflict; condescending language, dress down, and power play; intimidation, threats, and harassment; passive aggressive behavior; physical violence, professional disregard; and being rude and disrespectful. Multiple logistic regression was used to determine if a statistically significant relationship existed between the IVs and the DVs of intent to leave the job, organization and profession, and nurse job satisfaction. The benefit of using MLR was its ability to reveal the unique contribution of each of the predictor variables to the DVs (Stoltzfus, 2011). This analysis attempted to determine the impact of each behavior or IV individually on

the DVs to identify which IV had the strongest correlation to the DVs. A p value of $p <$ .05 was considered statistically significant.

There are four assumptions of multiple logistic regression that must be met (Salkind, 2010). The first assumption is that the data will be collected by independent random sampling This research used convenience sampling of registered nurses from the United States that are members of the AACN, AORN, or AMSN. This assumption was partially met in that each of the participants answered questions to the survey and the data would be independent of other participant data. Second, it is assumed that there is a linear relationship between the independent and DVs. For this research, it was assumed that as nurses experience DPB, there would be an increase in the DVs of intent to leave the job, organization, or profession and job satisfaction will go down. Third, MLR assumes that the distribution of the DV is normal around each of the values of the IVs. Finally, the fourth assumption is the homoscedasticity assumption where at each value of each of the IVs, the variance in predicting Y needs to be consistent (Salkind, 2010).

Threats to Validity

There are threats to validity that can be attributed to the use of survey research. Study participants receiving surveys via email need to be able to interpret the survey questions. If they are not sure of questions and have no opportunity to clarify the meaning of survey questions the accuracy of the data may suffer (Cox, 2016). A low response rate can negatively impact the validity of the study results (Cos, 2016). A low response rate can also negatively impact the generalizability of the study's findings to the registered nurse population. Generalizability was already threatened due to convenience sampling

used for this study. Those taking the time to complete the survey may have experienced DPB and may not have been able to answer the survey items in an objective manner which may have increased susceptibility of selection bias. Although not likely due to how the survey was distributed, there was potential for more than one respondent reporting on the same disruptive behavior event (Dang et al., 2016).

Threats related to the survey instrument follow. The JH-DCBS survey allows for choosing from many professional disciplines, the person exhibiting disruptive behavior. There is potential for the survey to change participant focus to other healthcare personnel behavior reducing survey data specific to disruptive behavior on the part of physicians. To mitigate this threat, many of the interdisciplinary roles of those exhibiting disruptive behavior had been deleted and the only roles remaining included attending/staff physician, fellow physician, resident physician, and intern. A concern from the literature about disruptive behavior research using the JH-DCBS described the title of the survey as a possible limitation of the study impacting study results. The terms "disruptive behavior" may have connotations that impacted how the participants answered the questions (Walrath et al., 2013). The title was changed to "*Survey of Unprofessional Behaviors: Triggers, Responses, Impacts"* (Walrath et al., 2013, p. 120). The survey provided for this research maintained the original title as provided earlier in this chapter.

Ethical Procedures

Walden University's IRB approval process was followed starting with completion of Form A: Description of Data Sources and Partner Sites. Once the IRB provided the preliminary feedback, a written response addressing all identified ethical issues was

provided until the University's ethical standards for research were met. An IRB application was completed, and the Proposal submitted for approval. IRB approval to move forward with data collection along with the IRB number 02-08-22-0390940 was received via email on February 8, 2022. Requests from the AACN, AORN, and AMSN were obliged. The AACN, AORN, and AMSN had agreed to have its members participate in this research and requested a copy of the IRB approval for the study, a copy of the research abstract describing the study, the tool that would be used along with a copy of the authorization to use it, and a completed application which were provided to all organizations. The privacy and confidentiality of study participants was maintained. The link to the survey was sent to AORN and AMSN participants via email by their respective organizations maintaining participant anonymity. Consent to participate was implied with completion of the survey. The email provided a description of the research including its purpose and a statement that the study was optional and a statement that they understood they could exit the survey at any time.

The JH-DCBS (Appendix B) was revised, and the revisions followed all conditions stated in the permission letter (Appendix A) from Dr. Deborah Dang. Data collected were de-identified and anonymous. The study did not ask for the participants' member ID numbers and there was no personally identifiable information. The data was stored in a password protected file and will be kept for the maximum allowable time. The data file will then be destroyed except for the raw data provided to John's Hopkins per Dr. Dang's request. As requested, the de-identified raw data collected by the survey will

be provided to the John's Hopkins study team via a password protected file for inclusion in its database.

Summary

This chapter detailed the methodology for my research. A description of the population used for this research on DPB and its impact on the DVs of nurses' intent to leave their job, organization, or profession and nurses' job satisfaction was included. Procedures for the recruitment of participants, informed consent, data collection, and a description of inclusion criteria were provided. An introduction of the JH-DCBS was included and a discussion providing the reliability and validity of the survey instrument was provided. Statistical tests used for data analysis were described. Threats to the validity of the findings of this research were discussed as well as the procedures to ensure the study would be conducted in an ethical manner. In Chapter 4, the results of the survey are discussed and a discussion detailing the study's findings is provided.

Chapter 4 Results

DPB has been identified in the literature for many years but has not been extensively studied as an IV in research on nurse turnover intentions. The purpose of this research is to determine the impact of seven different types of DPB on nurses' intent to leave their job, unit, organization, or nursing profession. In addition, I sought to determine the impact of DPB on nurses' job satisfaction . In this Chapter, I present a detailed report of the data collection methods. This includes timeframes for completion of the JH-DCBS. Descriptive and demographic characteristics of the participants are provided. Finally, a discussion of the representativeness of the sample is included.

I used the following research questions and hypotheses for my study:

RQ1: What is the relationship between DPB and nurses' intent to leave the job/unit or organization adjusting for age, gender, setting, and Magnet status?

$H_0$1: No statistically significant relationship exists between DPB and nurses' intent to leave the job or organization.

$H_1$1: A statistically significant relationship exists between DPB and nurses' intent to leave the job or organization.

RQ2: What is the relationship between DPB and nurses' intent to leave the nursing profession adjusting for age, gender, setting and Magnet status?

$H_0$2: No statistically significant relationship exists between DPB and nurses' intent to leave the nursing profession.

$H_1$2: A statistically significant relationship exists between DPB and nurses' intent to leave the nursing profession.

RQ3: What is the relationship between DPB and nurses' job satisfaction adjusting for age, gender, setting, and Magnet status?

$H_0$3: No statistically significant relationship exists between DPB and nurses' job satisfaction.

$H_1$3: A statistically significant relationship exists between DPB and nurses' job satisfaction.

Data Collection

The JH-DCBS was the data collection tool I used for this research and was distributed to RNs in U.S. hospitals who were members of the AACN, AORN, and AMSN. The time the survey was available to the members was dependent on the organization and how quickly the organization completed their internal process to set up the research.

AORN members were solicited via an email from AORN which contained a description of the study including inclusion criteria (See Appendix D) and a link to the survey. The AORN has 40,000 members. The first email disseminating the survey was sent on June 1, 2022. A reminder email was sent on June 14, 2022. The survey was available to AORN members from June 1, 2022, through July 15, 2022. AORN members accounted for 322 (58.9%) of the survey responses (See Table 2). The response rate could not be determined as the AORN representative could not provide the total number of members who received the survey.

The AMSN would no longer distribute requests for participation in research via AMSN member emails which was the original method stated in the Chapter 3

methodology section. Therefore, the method of solicitation for AMSN member participation was via the AMSN e-news, website's "Participate in Open Research Page," and their Community Hub Breakroom with an estimated 2000 members. The survey was available to AMSN members from May 9, 2022, to July 15, 2022. AMSN members accounted for 115 survey responses with a response rate of 5.75% (See Table 2). addresses.

Initially, the AACN members were to be solicited via the AACN Ambassadors' Facebook page, but this was a private page with no allowance to post the survey. Therefore, AACN members were solicited through a rental of list of 1,000 member names and addresses, creating a recruitment postcard (See Appendix E), and sending it to the members via the U.S. postal service. The front of the postcard included a brief description of the survey and a QR code to scan that brought the participants to the survey on the survey monkey site. An additional QR code was included on the reverse side of the postcard to take participants to a detailed description of the study. An AACN research assistant used the study's inclusion criteria to create a list of members that met criteria and the list was populated with 18,000 members. The 1,000 members and addresses purchased were from the rental list. The postcards were mailed on June 13, 2022, and access to complete the survey remained available until July 15, 2022, when the survey was closed. AACN members accounted for 107 or 19.6% of the survey responses with a response rate of 10.7% (See Table 2).

The target population of interest for this study was registered nurses currently practicing in U.S. hospitals and holding membership in the AACN, AORN, and AMSN.

According to the U.S. Bureau of Labor Statistics (2019), approximately 1,698,700 nurses practice in U.S. hospitals. The survey was provided to AACN members via a list rental of 1,000 names and addresses with a low response rate of 10.7%, which is typical of survey research (Cox, 2016). The survey was posted on the AMSN website in their Community Hub in the Breakroom which has approximately 2,000 members and had a very low response rate of 5.75%. The survey was distributed to AORN members via their email address, but a response rate was unable to be determined. The AORN has 40,000 members. The results of this research are not representative of the 1,698,700 nurses working in U.S. hospitals. The results are not representative of the total population of the AACN, AMSN, or AORN populations. The results of this research are not generalizable to the general nursing population.

Descriptive Statistics

Analyses of baseline descriptive data were conducted on demographic information including professional organization membership, age, gender, years in professional role, highest level of education, Magnet designation, practice setting, and professional role (See Table 2). The total number of survey respondents was 547. A total of 26 participant responses had missing data. The data analyses in Chapter 4 were based on a total of 547 responses (N=547). Participants held membership in the AACN, AORN, and AMSN with the total number of respondents being 107 (19.6%), 322 (58.9%), and 115 (21%), respectively. Demographic information for the responding participants is shown in Table 2.

Table 2

Demographics: Frequencies and Percentages

Characteristics	Number	Percentage
Professional Organization		
AACN	107	19.6
AORN	322	58.9
AMSN	115	21
Age Range		
20 to 29	47	8.6
30 to 39	110	20.1
40 to 49	119	21.8
50 to 59	163	29.8
60 to 69	107	19.6
Gender		
Male	39	7.1
Female	507	92.7
Years in Professional Role		
Less than 5	78	14.3
5 to 10	90	16.5
11 to 20	121	22.1
21 to 30	115	21
31 to 40	91	16.6
41 or greater	52	9.5
Education Level		
AAS	75	13.7
BSN	315	57.6
MSN	136	24.9
Doctorate	19	3.5
Magnet Designation		
No	312	57
Yes	235	43
Current Practice Setting		
Surgical ICU	31	5.7
Medical ICU	48	8.8
OR/PACU	328	60
MED/SURG	111	20.3
Specialty Area	28	5.1
Professional Role		
Nurse Leader	162	29.6
Advanced Practice Nurse	38	6.9
Charge/Preceptor	89	16.3
Staff Nurse	257	47

The means and standard deviations for the independent, dependent and control variables are presented in Table 3. The response ranges for the seven types of disruptive behaviors or IVs ranged from 1 to 5. The response ranges for the control variables varied with age being 1 to 5; gender being 1 or 2; Magnet status being 1 or 2; and current practice setting being 1 to 6. The responses for decreased job satisfaction, leaving the job or unit, leaving the organization, and leaving the nursing profession were dichotomous and were 0 (generally disagree; completely disagree) and 1 (generally agree; completely disagree). The means and standard deviations for the IVs and DVs are shown in Table 3.

Table 3

Independent, Dependent, and Control Variables (Mean, Standard Deviation, Minimum, and Maximum

	N	Minimum	Maximum	Mean	*SD*
Independent Variables					
Conflict	531	1	5	2.94	1.026
Condescending Language/Dress Down/Power Play	531	1	5	2.88	1.141
Intimidation/Threats/ Harassment	530	1	5	2.02	1.085
Passive Aggressive Behavior	531	1	5	2.96	1.240
Physical Violence	531	1	4	1.34	.598
Professional Disregard	530	1	5	2.85	1.130
Rude/Disrespectful	531	1	5	2.98	1.232
Dependent Variables					
Decreases Job Satisfaction	525	0	1	.89	.314
Leave Job/Unit	525	0	1	.59	.491
Leave Organization	525	0	1	.53	.500
Leave Nursing Profession	526	0	1	.34	.473
Control Variables					
Age	546	1	5	3.32	1.237
Gender	546	1	2	1.93	.258
Magnet Status	547	1	2	1.43	.495
Current Practice Setting	546	1	6	4.05	1.003
Valid *N* (listwise)	522				

A Pearson correlation was performed to determine the strength of the relationship between the DVs of intent to leave the job/unit, intent to leave the organization, intent to leave the nursing profession, and decreased nurses' job satisfaction and the seven types of DPBs or IVs (see Table 4). According to Chen and Popovich (2011), a Pearson correlation coefficient of 0.1 indicates a small or weak correlation, 0.3 or above indicates a moderate correlation, and 0.5 or above indicates a large or strong correlation between two variables. They stressed that a small correlation does not necessarily indicate that the relationship is not important (Chen & Popovich, 2011). All Pearson correlation coefficients were significant at the 0.01 level (two-tailed) for all IVs and all seven types of DPBs.

The Pearson product correlations for intent to leave the job or unit and the seven types of DPBs were varied. When asked whether experiencing disruptive behavior in general caused consideration to leave the job or unit, 59% of respondents either agreed (32%) or strongly agreed (27%). When looking at the correlation for individual types of disruptive behavior, not all were significantly correlated with intent to leave the job or unit. Condescending language (.425, p <.001) and rude, disrespectful behavior (.404, p <.001) showed the highest correlation. Additional correlations include conflict (r = .354, p <.001); intimidation, threats, and harassment (r = .312, p <.001); passive aggressive behavior (r = .341, p <.001); physical violence (r = .259, p <.001); professional disregard (r = .341, p <.001). Physical violence had the weakest correlation (r = .259, p <.001) to leaving the job or unit when compared to the other types of disruptive behaviors. This may be due to the very low incidence of physical violence with 1.7% of respondents

experiencing physical violence weekly and 1.5% experiencing physical violence monthly. These data show DPBs experienced by nurses in general are associated with intent to leave the job or unit but the contribution of each type of behavior varies with some more strongly correlated than others. The result of this Pearson product correlation supports the alternate hypothesis that there is a statistically significant relationship between DPBs and nurses' intent to leave the job or unit (see Table 4).

The Pearson product correlation of intent to leave the organization and the seven types of DPBs were varied. When asked whether experiencing disruptive behavior in general caused consideration to leave the organization, 53% of respondents either agreed (29%) or strongly agreed (24%). When looking at the correlation for individual types of disruptive behavior, not all were significantly correlated with intent to leave the job or unit (See Table 4). The types of disruptive behaviors with the highest correlations were conflict (r = .401, p <.001) and condescending language (r = .415, p <.001). Additional correlations include intimidation, threats, and harassment (r = .359, p <.001); passive aggressive behavior (r = .359, p <.001); physical violence (r = .291, p <.001); professional disregard (r = .342, p <.001); rude and disrespectful (r = .369, p <.001). Physical violence had the weakest correlation (r = .291, low positive) to leaving the organization when compared to the other disruptive behaviors. These data show DPBs experienced by nurses in general are associated with intent to leave the organization but the contribution of each type of behavior varies with some more strongly correlated than others. The result of this Pearson product correlation supports the alternate hypothesis

that there is a statistically significant relationship between DPBs and nurses' intent to leave the organization (see Table 4).

The Pearson product correlation for intent to leave the nursing profession and DPBs was varied (See Table 4). When asked whether experiencing disruptive behavior in general caused consideration to leave the nursing profession, 34% of respondents either agreed (20%) or strongly agreed (14%). The Pearson correlations were lower for intent to leave the profession when compared to the correlations for the other DVs. The Pearson correlations include conflict (r = .322, p <.001); condescending language (r = .345, p <.001); intimidation, threats, and harassment (r = .320, p <.001); passive aggressive behavior (r = .358, p <.001); physical violence (r = .283, p <.001); professional disregard (r = .316, p <.001); rude and disrespectful (r = .349, p <.001). Physical violence had the weakest correlation (r = .283, <.001) to leaving the nursing profession when compared to the other disruptive behaviors. These data show DPBs experienced by nurses in general are associated with a moderately strong correlation with intent to leave the profession but the contribution of each type of behavior varies with some more strongly correlated than others. The result of this Pearson product correlation supports the alternate hypothesis that there is a statistically significant relationship between DPBs and nurses' intent to leave the profession.

The Pearson product correlation for decreased job satisfaction and DPBs were varied and all weakly positive and statistically significant (See Table 4). When asked whether experiencing disruptive behavior in general decreased job satisfaction, 89% of respondents either agreed (46%) or strongly agreed (43%). Pearson correlations include

conflict (r = .158, p <.001); condescending language (r = 214, p <.001); intimidation, threats, and harassment (r = .130, p <.003); passive aggressive behavior (r = .219, p <.001); physical violence (r = .090, p <.039); professional disregard (r = .191, p <.001); rude and disrespectful (r = .195, p <.001). Physical violence had the weakest correlation (r = .090) to decreased job satisfaction when compared to the other disruptive behaviors. These data show DPBs experienced by nurses in general are associated with decreased job satisfaction for nurses but all Pearson correlations for the seven types of disruptive behaviors are weakly positive. The result of this Pearson product correlation supports the null hypothesis that there is not a statistically significant relationship between DPBs and decreased nurses' job satisfaction.

Table 4

Correlation Analysis

	Conflict	Condescend Language	Intimidat. Threats Harass.	Passive Aggressive Behavior	Physical Violence	Profess. Disregard	Rude Disresp.
Intent to Leave Job/Unit							
Pearson Correlation	.354**	.425**	.312**	.341**	.259**	341**	.404**
Signif.	< .001	< .001	< .001	< .001	< .001	< .001	< .001
Intent to Leave Organization							
Pearson Correlation	.401**	.415**	.359**	.359**	.291**	.342**	.369**
Signif.	< .001	< .001	< .001	< .001	< .001	< .001	< .001
Intent to Leave Nursing Profession							
Pearson Correlation	.322**	.345**	.320**	.358**	.283**	.316**	.349**
Signif.	< .001	< .001	< .001	< .001	< .001	< .001	< .001
Decreased Job Satisfaction							
Pearson Correlation	.158**	.214**	.130**	.219**	.090*	.191**	.195**
Signif.	< .001	< .001	< .003	< .001	< .039	< .001	< .001

**. Correlation is significant at the 0.01 level (2-tailed).

*. Correlation is significant at the 0.05 level (2-tailed).

Reliability Statistics – Independent Variables

A Cronbach's alpha (α) was conducted for the seven items containing the types of DPB which are the IVs. Cronbach's α measures the internal consistency or reliability of surveys or questionnaires with ranges from 0 to 1 (Polit & Beck, 2008). The higher the number the more reliable the survey or questionnaire. The overall Cronbach's α for the IVs was .890. The Cronbach's α for the disruptive behaviors indicates good internal consistency and reliability of the IVs scale. The Cronbach's α, if the item is deleted, for conflict; condescending language; intimidation, threats, and harassment; passive aggressive behavior; physical violence; professional disregard; and rude and disrespectful

behavior were .87, .86, .88, .87, .90, .87 and .86, respectively (see Table 5). Therefore, the internal consistency and reliability remain very good with any item deletions.

Table 5

Reliability Analysis: Independent Variables with Item Deletions

	Item-Total Statistics				
	Scale Mean if Item Deleted	Scale Variance if Item Deleted	Corrected Item-Total Correlation	Squared Multiple Correlation	Cronbach's Alpha if Item Deleted
Conflict	15.02	26.251	.708	.519	.872
Condescending Language, Dress Down, Power Play	15.09	24.320	.810	.674	.858
Intimidation, Threats, Harassment	15.95	26.299	.656	.462	.878
Passive Aggressive Behavior	15.00	24.263	.732	.553	.869
Physical Violence	16.62	31.379	.454	.253	.899
Professional Disregard	15.11	25.514	.697	.503	.873
Rude, Disrespectful	14.98	23.982	.766	.622	.864

Results

Research Question 1

Multiple logistic regression analysis was performed to determine the relationship between the seven types of DPB, the independent or predictor variables, and nurses' intent to leave their job, unit (the dependent or outcome variables). The dependent or outcome variable intent to leave was coded as 0 = Strongly Disagree; Disagree and 1 = Agree; Strongly Agree. The multiple logistic regression procedure in SPSS was used to perform the analysis. Data from 547 survey responses was included in this analysis.

A test of the full model (with the seven types of DPB as the predictor variables) compared with a constant-only model or null model was statistically significant, $X^2(11) =$

143.195, p = <.001. This indicated that there was a significant improvement in model fit as compared to the null model. The strength of the association between the DPBs and the DV of intent to leave their job or unit was somewhat strong with Nagelkerke's R^2 = .324 indicating that 32% of the change in intent to leave can be attributed to DPB. The Hosmer and Lemeshow test was performed which resulted in Chi-square of 5.192 with a significance of .737. The results of this test indicated that the model adequately described the data, and the model was a good fit because a significance level of >0.05 in the Hosmer and Lemeshow test indicates that the model is a good fit for the data.

The multiple logistic regression coefficients, Wald statistics, and the estimated change in odds of nurses leaving their job or unit due to experiencing DPB, along with a 95% CI, are presented in Table 6. Variables in the equation included the seven IVs of conflict; condescending language, dress down, and power play; intimidation, threats, and harassment; passive aggressive behavior; physical violence; professional disregard; and rude and disrespectful behavior. Control variables included age, gender, Magnet designation, and current practice setting.

The only predictor variables that were found to be significantly associated with intent to leave were condescending language, dress down, and power play which were combined into one predictor variable in the survey (p = .018), and physical violence (p = .036; see Table 6). The predictor variable, condescending language, dress down, power play, in the multiple logistic regression analysis was found to contribute to the model. The unstandardized Beta weight for the constant; B = -2.530, SE =1.018, $Wald$ = 6.182, p = .013. The unstandardized Beta weight for condescending language, dress down, power

play was *B* = .369, *SE* = .155, *Wald* = 5.637, *p* = .018. The estimated odds ratio favored an increase of 44.6% (*Exp*(*B*) =1.446, 95% CI 1.066, 1.960) for intent to leave the job or unit for every one unit increase in the predictor variable of condescending language, dress down, and power powerplay. The unstandardized Beta weight for the predictor variable of physical violence was *B* = .519, *SE* = .247, *Wald* = 4.413, *p* = .036. The estimated odds ratio favored an increase of 68% (*Exp*(*B*) = 1.681, 95% CI 1.035, 2.728) for intent to leave the job or unit for every one unit increase in physical violence (see Table 6). The control variable of age was statistically significant. The unstandardized B weight for the control variable of age was *B* = -.310, *SE* = .091, *Wald* = 11.743, *p* = <.001. The estimated odds ratio favored a decrease of 27% (*Exp*(*B*) = .733, 95% C I.614, .876) for every one unit increase in the control variable of age. The results of this multiple logistic regression accept the alternate hypothesis to be true and reject the null hypothesis.

Table 6

Multiple Logistic Regression: Intent to Leave Job or Unit

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B) Lower	Upper
Step 1[a]								
Conflict	.169	.144	1.376	1	.241	1.185	.893	1.572
Condescending Language, Dress Down, Power Play	.369	.155	5.637	1	.018	1.446	1.066	1.960
Intimidation, Threats, Harassment	.186	.145	1.642	1	.200	1.204	.906	1.600
Passive Aggressive Behavior	-.020	.124	.026	1	.872	.980	.769	1.250
Physical Violence	.519	.247	4.413	1	.036	1.681	1.035	2.728
Professional Disregard	.169	.129	1.719	1	.190	1.184	.920	1.524
Rude, Disrespectful	.212	.133	2.524	1	.112	1.236	.952	1.605
Control Variables								
Age	-.310	.091	11.743	1	<.001	.733	.614	.876
Gender	.653	.394	2.742	1	.098	1.920	.887	4.157
Magnet Designation	-.295	.212	1.940	1	.164	.744	.491	1.128
Current Practice Setting	-.099	.099	.992	1	.319	.906	.746	1.100
Constant	-2.530	1.018	6.182	1	.013	.080		

a. Variable(s) entered on Step 1: Conflict, Condescending Language/Dress Down/Power Play, Intimidation, Threats, Harassment, Passive Aggressive Behavior, Physical Violence, Professional Disregard, Rude/Disrespectful, Age Range, Gender, Magnet Designation, Current Practice Setting

Leaving the Organization

A multiple logistic regression analysis was performed to determine the relationship between the seven types of DPB, the independent or predictor variables, and nurses' intent to leave their organization (the dependent or outcome variable). The dependent or outcome variable intent to leave the organization was coded as 0 = Strongly Disagree; Disagree and 1 = Agree; Strongly Agree. The multiple logistic regression

procedure in SPSS was used to perform the analysis. Data from 547 survey responses were included in this analysis.

A test of the full model (with the seven types of DPB as the predictor variables) compared with a constant-only model or null model was statistically significant, $X^2(11) = 147.176$, $p = <.001$. This indicated that there is a significant improvement in model fit as compared to the null model. The strength of the association between the predictor variables and the DV of intent to leave their organizations was somewhat strong with a Nagelkerke's $R^2 = .328$ indicating that 33% of the change in intent to leave their organization can be attributed to DPB. The Hosmer and Lemeshow test was performed which resulted in Chi-square of 4.792 with a significance of .780. The results of this test indicated that the model adequately described the data, and the model was a good fit because a significance level of >0.05 in the Hosmer and Lemeshow test indicates that the model is a good fit for the data.

The multiple logistic regression coefficients, Wald statistics, and the estimated change in odds of nurses leaving their organization [DV] due to experiencing DPB, along with a 95% confidence interval, are presented in Table 7 below. Variables in the equation included the seven IVs of conflict; condescending language, dress down, and power play; intimidation, threats, and harassment; passive aggressive behavior; physical violence; professional disregard; and rude and disrespectful behavior. Control variables included age, gender, Magnet designation, and current practice setting.

The predictor variables that were found to be significantly associated with intent to leave the organization were conflict ($p = .009$), intimidation, threats and harassment

which were combined into one predictor variable (p = .017) and physical violence (p = .012; see Table 7). In the multiple logistic regression analysis, these predictor variables were found to contribute to the model. The unstandardized Beta weight for the constant; B = -2.437, SE =1.007, $Wald$ = 5.859, p = .015. The unstandardized Beta weight for conflict was B = .368, SE = .140, $Wald$ = 6.896, p = .009. The estimated odds ratio favored an increase of 44.5% ($Exp(B)$ =1.445, 95% CI 1.098, 1.902) for intent to leave the organization for every one unit increase in the predictor variable of conflict. The unstandardized Beta weight for intimidation, threats, and harassment was B = .327, SE = .138, $Wald$ = 5.653, p =.017. The estimated odds ratio favored an increase of 38.7% ($Exp(B)$ = 1.387, 95% CI 1.059, 1.817) for intent to leave the organization for every one unit increase in intimidation, threats, and harassment. The unstandardized Beta weight for physical violence was B = .595, SE = .236, Wald = 6.353, p = .012. The estimated odds ratio favored an increase of 81.2% ($Exp(B)$ = 1.812, 95% confidence interval 1.141, 2.877) for intent to leave the organization for every one unit increase in physical violence (see Table 7). The control variables of age (p = .020) and Magnet designation (p =.009) were statistically significant. The unstandardized Beta weight for age was B = -.204, SE = .088, $Wald$ = 5.393, p = .020). The estimated odds ratio favored a decrease of 18% ($Exp(B)$ = .816, 95% CI .687, .969) for intent to leave the organization for every one unit increase in the control variable age. The unstandardized Beta weight for Magnet designation was B = -.548, SE = .210, $Wald$ = 6.799, p = .009). The estimated odds ratio favored a decrease of 42% ($Exp(B)$ = .578, 95% CI .383, .873) for intent to leave the organization for every one unit increase in the control variable Magnet designation. The

results of this multiple logistic regression accept the alternate hypothesis to be true and reject the null hypothesis.

Table 7

Multiple Logistic Regression: Intent to Leave the Organization

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B) Lower	Upper
Step 1[a]								
Conflict	.368	.140	6.896	1	.009	1.445	1.098	1.902
Condescending. Language, Dress Down, Power Play	.217	.151	2.068	1	.150	1.242	.924	1.668
Intimidation, Threats, Harassment	.327	.138	5.653	1	.017	1.387	1.059	1.817
Passive Aggressive Behavior	.079	.119	.442	1	.506	1.083	.857	1.368
Physical Violence	.595	.236	6.353	1	.012	1.812	1.141	2.877
Professional Disregard	.158	.125	1.582	1	.208	1.171	.916	1.497
Rude Disrespectful	.003	.134	.001	1	.982	1.003	.771	1.305
Control Variables								
Age	-.204	.088	5.393	1	.020	.816	.687	.969
Gender	.207	.391	.281	1	.596	1.231	.572	2.648
Magnet Designation	-.548	.210	6.799	1	.009	.578	.383	.873
Current Practice Setting	-.034	.100	.117	1	.732	.966	.795	1.175
Constant	-2.437	1.007	5.859	1	.015	.087		

a. Variable(s) entered on Step 1: Conflict, Condescending Language/Dress Down/Power Play, Intimidation, Threats, Harassment, Passive Aggressive Behavior, Physical Violence, Professional Disregard, Rude/Disrespectful, Age Range, Gender, Magnet Designation, Current Practice Setting

Research Question 2

A multiple logistic regression analysis was performed to determine the relationship between the seven types of DPB, the independent or predictor variables, and nurses' intent to leave the profession (the dependent or outcome variable). The dependent or outcome variable intent to leave the profession was coded as 0 = Strongly Disagree; Disagree and 1 = Agree; Strongly Agree. The multiple logistic regression procedure in SPSS was used to perform the analysis. Data from 547 survey responses were included in this analysis.

A test of the full model (with the seven types of DPB as the predictor variables) compared with a constant-only model or null model was statistically significant, $X^2(11) = 114.665$, $p = <.001$. This indicated that there is a significant improvement in model fit as compared to the null model. The strength of the association between the predictor variables and the DV of intent to leave their profession was somewhat weak with Nagelkerke's $R^2 = .273$ indicating that 27% of the change in intent to leave the profession can be attributed to DPB. The Hosmer and Lemeshow test was performed which resulted in Chi-square of 10.065 with a significance of .261. The results of this test indicated that the model adequately described the data, and the model was a good fit because a significance level of >0.05 in the Hosmer and Lemeshow test indicates that the model is a good fit for the data.

The multiple logistic regression coefficients, Wald statistics, and the estimated change in odds of nurses leaving the profession [DV] due to experiencing DPB, along with a 95% confidence interval, are presented in Table 8. Variables in the equation

included the seven IVs of conflict; condescending language, dress down, and power play; intimidation, threats, and harassment; passive aggressive behavior; physical violence; professional disregard; and rude and disrespectful behavior. Control variables included age, gender, Magnet designation, and current practice setting.

The predictor variables that were found to be significantly associated with intent to leave the profession were passive aggressive behavior (p = .015) and physical violence (p = .009; see Table 8). In the multiple logistic regression analysis, these predictor variables were found to contribute to the model. The unstandardized Beta weight for the constant; B = -1.737, SE =1.010, $Wald$ = 2.955, p = .086. The unstandardized Beta weight for passive aggressive behavior was B = .298, SE = .123, $Wald$ = 5.886, p = .015. The estimated odds ratio favored an increase of 34.8% ($Exp(B)$ =1.348, 95% CI 1.059, 1.715) for intent to leave the profession for every one unit increase in the predictor variable of passive aggressive behavior. The unstandardized Beta weight for physical violence was B = .513, SE = .197, $Wald$ = 6.741, p =.009. The estimated odds ratio favored an increase of 67% ($Exp(B)$ = 1.670, 95% CI 1.134, 2.458) for intent to leave the profession for every one unit increase in physical violence (Table 8). The control variables of age (p = .04) and current practice setting (p =.008) were statistically significant. The unstandardized Beta weight for age was B = -.184, SE = .09, $Wald$ = 4.208, p = .04). The estimated odds ratio favored a decrease of 17% ($Exp(B)$ = .832, 95% CI .698, .992) for every one unit increase in the control variable age. The unstandardized Beta weight for current practice setting was B = -.286, SE = .107, $Wald$ = 7.146, p = .008). The estimated odds ratio favored a decrease of 25% ($Exp(B)$ = .751, 95% CI .609,

.927) in intent to leave the profession for every one unit increase in the control variable of current practice setting. The results of this multiple logistic regression accept the alternate hypothesis to be true and reject the null hypothesis.

Table 8

Multiple Logistic Regression: Intent to Leave the Profession

							95% C.I. for EXP(B)	
	B	S.E.	Wald	df	Sig.	Exp(B)	Lower	Upper
Step 1[a]								
Conflict	.139	.144	.930	1	.335	1.149	.867	1.523
Condescending Language, Dress Down, Power Play	-.034	.155	.048	1	.827	.967	.713	1.310
Intimidation, Threats, Harassment	.174	.124	1.948	1	.163	1.190	.932	1.518
Passive Aggressive Behavior	.298	.123	5.886	1	.015	1.348	1.059	1.715
Physical Violence	.513	.197	6.741	1	.009	1.670	1.134	2.458
Professional Disregard	.125	.127	.965	1	.326	1.133	.883	1.453
Rude, Disrespectful	.179	.136	1.722	1	.189	1.196	.915	1.563
Control Variables								
Age	-.184	.090	4.208	1	.040	.832	.698	.992
Gender	-.002	.399	.000	1	.996	.998	.456	2.181
Magnet Designation	-.314	.218	2.076	1	.150	.731	.477	1.120
Current Practice Setting	-.286	.107	7.146	1	.008	.751	.609	.927
Constant	-1.737	1.010	2.955	1	.086	.176		

a. Variable(s) entered on Step 1: Conflict, Condescending Language/Dress Down/Power Play, Intimidation, Threats, Harassment, Passive Aggressive Behavior, Physical Violence, Professional Disregard, Rude/Disrespectful, Age Range, Gender, Magnet Designation, Current Practice Setting

Research Question 3

A multiple logistic regression analysis was performed to determine the relationship between the seven types of DPB, the independent or predictor variables, and nurses' job satisfaction (the dependent or outcome variable). The dependent or outcome variable nurse's job satisfaction was coded as 0 = Strongly Disagree; Disagree and 1 = Agree; Strongly Agree. The multiple logistic regression procedure in SPSS was used to perform the analysis. Data from 547 survey responses were included in this analysis.

A test of the full model (with the seven types of DPB as the predictor variables) compared with a constant-only model or null model was statistically significant, $X^2(11) = 36.632$, $p = <.001$. This indicated that there is a significant improvement in model fit as compared to the null model. The strength of the association between the predictor variables and the DV of nurses' job satisfaction was weak with Nagelkerke's $R^2 = .135$ indicating that 14% of the change in nurses' job satisfaction can be attributed to DPB. The Hosmer and Lemeshow test was performed which resulted in Chi-square of 8.199 with a significance of .414. The results of this test indicated that the model adequately described the data, and the model was a good fit because a significance level of >0.05 in the Hosmer and Lemeshow test indicates that the model is a good fit for the data.

The multiple logistic regression coefficients, Wald statistics, and the estimated change in odds of nurses' job satisfaction [DV] due to experiencing DPB, along with a 95% confidence interval, are presented in Table 9. Variables in the equation included the seven IVs of conflict; condescending language, dress down, and power play; intimidation, threats, and harassment; passive aggressive behavior; physical violence;

professional disregard; and rude and disrespectful behavior. Control variables included age, gender, Magnet designation, and current practice setting.

There were no predictor variables found to be significantly associated with the outcome variable of nurses' job satisfaction. The only predictor variable coming close to significance was passive aggressive behavior (p = .055; see Table 9). The independent, dependent, and control variables did not contribute to the model. The results of this multiple logistic regression found the null hypothesis to be true and accepted the null hypothesis. The alternate hypothesis was rejected. Therefore, there was no statistically significant relationship between the independent and control variables and nurses' job satisfaction.

Table 9

Multiple Logistic Regression: Job Satisfaction

	B	S.E.	Wald	df	Sig.	Exp(B)	95% C.I. for EXP(B) Lower	Upper
Step 1[a]								
Conflict	-.073	.207	.122	1	.726	.930	.620	1.396
Condescending Language, Dress Down, Power Play	.382	.237	2.590	1	.108	1.465	.920	2.333
Intimidation, Threats, Harassment	-.080	.232	.119	1	.730	.923	.586	1.454
Passive Aggressive Behavior	.364	.190	3.693	1	.055	1.440	.993	2.088
Physical Violence	.015	.357	.002	1	.966	1.015	.504	2.045
Professional Disregard	.201	.199	1.016	1	.313	1.223	.827	1.807
Rude Disrespectful	.025	.199	.015	1	.902	1.025	.693	1.515
Control Variables								
Age	-.172	.130	1.768	1	.184	.842	.653	1.085
Gender	.250	.533	.220	1	.639	1.285	.452	3.654
Magnet Designation	-.055	.299	.034	1	.853	.946	.526	1.701
Current Practice Setting	.020	.132	.023	1	.878	1.020	.787	1.323
Constant	.024	1.369	.000	1	.986	1.024		

a. Variable(s) entered on Step 1: Conflict, Condescending Language/Dress Down/Power Play, Intimidation, Threats, Harassment, Passive Aggressive Behavior, Physical Violence, Professional Disregard, Rude/Disrespectful, Age Range, Gender, Magnet Designation, Current Practice Setting

Summary

A total of 547 survey responses were collected from registered nurses who were members of the AACN, AORN, and AMSN. Multiple logistic regression analyses were conducted to determine the relationship between the predictor variables (7 types of disruptive behaviors; see Table 1) and the DVs of intent to leave the job/unit, organization, or the nursing profession and nurses' job satisfaction. The Wald test was used to determine the statistical significance and confidence interval was used to estimate the odds ratios of the independent and DVs.

The first multiple logistic regression which addressed research question 1 sought to determine if a statistically significant relationship existed between the seven types of DPBs (see Table 6) and the DV of intent to leave the job, unit or organization. A substantial portion of the survey participants (59%) agreed or strongly agreed that DPBs they experienced caused them to consider leaving their job or unit and a Nagelkerke's R^2 = .32 indicated that 32% of the change in intent to leave can be attributed to experiencing DPBs. Two of the disruptive behaviors or predictor variables were found to be statistically significant with intent to leave the job or unit. As condescending language, dress down, and power play increased by one unit, intent to leave the job or unit increased by 44.6%. As physical violence increased by one unit, intent to leave the job or unit increased by 68%. The control variable of age was statistically significant and as age increased by one unit, intent to leave the job or unit decreased by 73%. The regression analysis indicated a relationship exists between DPBs and intent to leave the job or unit resulting in acceptance of the alternative hypothesis and rejection of the null hypothesis.

Multiple logistic regression was used to determine if a relationship existed between the seven types of disruptive behavior and intent to leave the organization (see Table 7). When specifically asked if experiencing DPB causes the nurses to consider leaving the organization, 53% of the survey participants chose agreed or strongly agreed and a Nagelkerke's R^2 = .33 indicated that 33% of the change in intent to leave the organization can be attributed to DPB. The DPBs or predictor variables found to be significantly associated with intent to leave the organization included conflict; intimidation, threats, and harassment combined into one variable; and physical violence.

For every 1 unit increase in conflict, there was a 44.5% increase in intent to leave the organization. For every 1 unit increase in intimidation, threats, and harassment, there was an increase of 38.7% in intent to leave the organization. For every 1 unit increase in physical violence, there was an 81% increase in intent to leave the organization. The regression analysis indicated a relationship exists between DPBs and intent to leave the organization resulting in acceptance of the alternative hypothesis and rejection of the null hypothesis. The control variables of age and Magnet designation were found to be statistically significant. For every 1 unit increase in age, there was an 82% decrease in intent to leave the organization. For every 1 unit increase in Magnet status, there was a 58% decrease in intent to leave the organization. The regression analysis indicated that a relationship exists between DPBs and intent to leave the organization, therefore the alternative hypothesis was accepted, and the null hypothesis was rejected.

A regression analysis relative to research questions 2 was performed to determine if a relationship exists between DPBs and intent to leave the profession (see Table 8). When specifically asked if experiencing DPB caused them to consider leaving the nursing profession, 34% of the survey participants chose to agree or strongly agree. Nagelkerke's $R^2 = .27$ indicated that 27% of the change in intent to leave the nursing profession can be attributed to experiencing DPB. The DPBs significantly associated with intent to leave the profession included passive aggressive behavior and physical violence. Every 1 unit increase in passive aggressive behavior is associated with a 34.8% increase in intent to leave the profession. Every 1 unit increase in physical violence is associated with a 67% increase in intent to leave the profession. The control variables of age and

practice setting were statistically significant. A 1-unit increase in age was associated with an 83% decrease in intent to leave the profession. A 1-unit increase in practice setting was associated with a 75% decrease in intent to leave the nursing profession. The regression analysis indicated a relationship exists between DPBs and intent to leave the nursing profession resulting in acceptance of the alternative hypothesis and rejection of the null hypothesis.

A regression analysis relative to research question 3 was performed to determine if a relationship exists between DPBs and nurses' job satisfaction (see Table 9). When asked if experiencing DPB decreased their job satisfaction, 89% agreed or strongly agreed. There were no specific predictor variables identified to be statistically significant or associated with a decrease in nurses' job satisfaction. The null hypothesis was accepted, and the alternative hypothesis rejected.

Chapter 5 includes an analysis and interpretation of the findings of the multiple logistic regressions. The limitations of the study are discussed and recommendations for future research are provided. Implications for social change and recommended practices are discussed.

Chapter 5 Discussion, Recommendations, and Conclusions

The purpose of this quantitative study was to determine if a relationship exists between DPBs and nurses' intent to leave their job, unit, organization, or the nursing profession and to determine if experiencing these behaviors decreases nurses' job satisfaction. I used the quantitative method to quantify the prevalence of DPB as experienced by the nurse study participants. A correlational design was used to examine if a relationship exists between the seven types of DPB and nurses' intent to leave the job, unit, organization, or the nursing profession and to determine if DPBs were associated with decreased nurses' job satisfaction. As the nursing shortage is expected to worsen (AACN, 2022), it is essential to determine contributing factors to nurses' intent to leave and nurses' job satisfaction. This research was conducted to determine if DPBs contribute to nurses' intent to leave and decrease job satisfaction.

A significant percentage of the survey respondents either agreed (32%) or strongly agreed (27%) that DPB caused them to consider leaving their job or unit. The results of the first multiple logistic regression indicated that condescending language, dress down, and power play (which were combined into one predictor variable) and physical violence were found to be significantly associated with intent to leave the job or unit. When answering how frequently they experienced physical violence, physical violence was not experienced frequently; 1.5% of respondents chose monthly, 1.7% chose weekly, and 26% chose rarely. This multiple regression analysis indicated that those few that experienced physical violence were more likely to leave their job or unit. The control variable of age was found to be significantly associated with intent to leave

the job or unit. As the control variable of age increased by one unit, intent to leave the job or unit decreased by 27%. Approximately half of the survey respondents (53%) either agreed (29%) or strongly agreed (24%) that DPBs caused them to consider leaving their organization.

The results of the second multiple logistic regression indicated that the predictor variables of conflict; intimidation, threats, and harassment (which were combined into one predictor variable); and physical violence were found to be significantly associated with intent to leave the organization. This multiple regression analysis indicated that those few who experienced physical violence were more likely to leave the organization. The control variables of age and Magnet designation were found to be significantly associated with intent to leave the organization. As age increased one unit, intent to leave the organization decreased by 18%. As Magnet increased by one unit, intent to leave the organization decreased by 42%. The alternate hypothesis was found to be true. There was a relationship between DPB and nurses' intent to leave their job, unit, or organization.

A smaller percentage of survey respondents agreed (20%) or strongly agreed (14%) that DPBs caused them to consider leaving the nursing profession. The third multiple logistic regression indicated that passive aggressive behavior and physical violence were significantly associated with nurses' intent to leave the organization. This multiple regression analysis indicated that those few who experienced physical violence were more likely to leave the nursing profession. The control variables of age and current practice setting were significantly associated with intent to leave the profession. As age increased by one unit, intent to leave the profession decreased by 17%. As practice

setting increased by one unit, the intent to leave the profession decreased by 25%. The alternate hypothesis was found to be true. There was a relationship between DPBs and intent to leave the profession.

A sizable percentage of the survey respondents either agreed (46%) or strongly agreed (43%) that DPBs decreased their job satisfaction. The fourth multiple logistic regression indicated that none of the predictor or control variables were found to be significantly associated with nurses' job satisfaction. The null hypothesis was accepted. Although 89% of the survey respondents agreed or strongly agreed that DPBs decreased their job satisfaction, none of the DPBs were identified specifically or independently associated with decreased job satisfaction.

Interpretation of the Findings

Intent to Leave

The findings of this research indicated that a relationship exists between DPB and intent to leave the job or unit. DPBs were a factor in intent to leave the job or unit with 59% of the respondents agreeing and strongly agreeing that DPB caused them to consider leaving the job or unit. The predictor variables found to be associated with intent to leave the job or unit were condescending language, dress down, and power play (combined into one predictor variable) (p = .018) and physical violence (p = .036). These results were congruent with the results of Sauer and McCoy (2018) who found that bullying was associated with nurses' intent to leave their unit. In my study, there was a lower percentage of respondents with intentions to leave their organization than intentions to leave their unit. These findings were inconsistent with Sauer and McCoy's research as

59% have considered leaving their job or unit but 53% have considered leaving their organization. The control variable of age was found to be significant (p = <.001). As the age of the respondent increased, intent to leave decreased.

The findings of this research indicated that a relationship exists between DPBs and the intent to leave the organization. DPBs were a factor in intent to leave the organization with 53% of the respondents agreeing and strongly agreeing that DPBs caused them to consider leaving. The predictor variables found to be associated with intent to leave the organization were conflict (p = .009), intimidation, threats, and harassment (combined into one variable) (p = .017) and physical violence (p = .012). These results were congruent with the results of Sauer and McCoy (2018) who found that bullying was associated with nurses' intent to leave their employer. There was a higher percentage of nurses with intentions to leave their employer than to transfer to another unit within the organization. Sauer and McCoy's (2018) results were inconsistent with this current research as 59% of the respondents considered leaving their unit while a smaller percentage (53%) considered leaving their organization. The control variables of age (p = .020) and Magnet designation (p = .009) were significant. As age increased, the intent to leave the organization decreased. Those respondents working in Magnet organizations were less likely to leave the organization.

The findings of this research indicated that a relationship exists between DPB and the intent to leave the nursing profession. The predictor variables associated with intent to leave the nursing profession were passive aggressive behavior (p = 0.15), and physical

violence (p = .009). The control variable of age was significant (p = .04). As age increased, the intent to leave the nursing profession decreased.

There were many similarities in the findings of my research with the existing research in literature. Conflict and passive aggressive behavior had the highest rate of occurrence with 59% of respondents reporting experiencing conflict monthly, weekly, or daily and 58% reporting experiencing passive aggressive behavior monthly, weekly, or daily. Physical violence was the least disruptive behavior reported at 3% of respondents. Dang et al.'s (2016) research found the experience of conflict (90%), and passive aggressive behavior (80%) to be more common and physical violence (12%) was least common. The total number of respondents in Dang et al.'s study was 1,559 and the percentages of respondents experiencing these behaviors was higher in Dang et al.'s research.

Nurses' Job Satisfaction

There were no specific types of disruptive behavior found to decrease nurses' job dissatisfaction. However, the raw data indicated that 89% of the respondents agreed or strongly agreed that their job satisfaction decreased when they experienced disruptive behaviors on the part of physicians. The findings of this research were congruent with the findings of Dang et al. (2016) who found disruptive behavior to be associated with decreased job satisfaction. Dang et al. found psychological aggression to be associated with decreased job satisfaction. This research was in congruence with Walrath et al. (2013) who found that disruptive behavior negatively impacts job satisfaction, morale, and working relationships. Al Sabei et al. (2020) found that job satisfaction had a

moderating effect on the relationship between the nurses' work environment and intent to leave. When job satisfaction was high, better perceptions of the work environment were associated with nurse intent to stay ($OR = 0.47$, $p = .03$).

The findings of my research contrasted with the findings of Alharbi et al. (2020), who found that nurse-physician collegial relationships were inversely associated with nurses' job satisfaction with positive relationships being associated with decreased job satisfaction. This was an unexpected finding. The researchers attributed this to a possible suppression effect (Alharbi et al., 2020).

Age was an important control variable in my research. As age increased by one unit, the odds ratio favored a decrease of 27% for intent to leave the job or unit and a decrease of 17% for intent to leave the organization. Younger nurses were more likely to leave the job, unit, or organization. A particularly important segment of the nursing population is the younger nurses. These findings are consistent with previous research. As high as 13% of newly licensed registered nurses leave their position within 1 year (Bontrager et al., 2016; Hickson, 2013). Retention of this segment of the nursing population has been identified as a problem (Yarbrough et al., 2017). The findings of Yarbrough et al. (2017) indicated that a positive work environment was associated with intent to stay in these nurses. Unruh et al. (2016) found that as work-family conflict increased, intent to leave the job and profession increased. The findings of this new and existing research underscore the need to determine what contributes to intent to leave in these new nurses especially with the persistent nursing shortage.

Theoretical Context

AET, developed by Weiss and Cropanzano (1996), was the theoretical foundation used for this research. This theory builds on CAT which assumes that employees strive to make meaning of events in the workplace and the employee' interpretation of events determines the emotional reaction to the event (Redmond, 2007). AET attempts to describe two pathways for behavioral responses to incivility events in the workplace. These pathways include an affect-driven pathway characteristic of instantaneous or hasty decisions or a judgement-driven behavior pathway where the target of incivility deliberates and cognitively evaluates the event accounting for their attitudes or feelings about the organization also termed organizational commitment. How humans act and the decisions made occur in the context of emotion and the emotional state impacts cognitive processes and human behavior. AET has been used in myriad healthcare research to explain the impact of uncivil behavior on healthcare employees' health and intent to leave due to its impact on, not their affective or emotional state, but on the affective process of job satisfaction with various aspects of their role.

In my research, there were no specific types of DPB found to decrease nurses' job satisfaction, however, 89% of the respondents agreed or strongly agreed that experiencing DPB decreased their job satisfaction. DPB was found to be a factor in intent to leave the job or unit with 59% of respondents agreeing or strongly agreeing that DPB cause them to consider leaving their job agreeing or strongly agreeing that DPB caused them to consider leaving the organization. The percentage of respondents with intention to leave the profession was smaller at 34%. In one study conducted by Al Sabei et al.

(2020), job satisfaction had a moderating effect on the relationship between the nurses' work environment and intent to leave. Al Sabei et al. found high job satisfaction and better perceptions of the work environment to be associated with intent to stay.

It is difficult to determine which pathway, affect-driven or judgement-driven, the respondents used to appraise the events they experienced. The degree of organizational commitment one may have could have an impact on their cognitive appraisal of the event and impact their decision on intent to leave or stay. The severity of the behavior could also have an impact. Although physical violence toward nurses was not a frequently experienced DPB, when it was experienced, it was significantly associated with intent to leave the job, unit, organization, and the profession. Age was found to be a significant factor in intent to leave the job, unit, organization, and the profession. The findings of this research indicated that as age increased, intent to stay increased which could be a function of organizational commitment in older generations such as the baby boomer generation. This may possibly indicate that older generation nurses used the judgement-driven pathway after experiencing DPB and decided to stay. Nurses between the ages of 25 and 34 tend to stay at their organization an average of 2.8 years (O'Hara et al., 2019) and 30% and 57% of younger nurses intend to leave their current role within 1 year and 2 years respectively (Ulep, 2018). These statistics present a dilemma that creates challenges for nurse leaders as they try to ascertain how to retain the younger generation (McClain et al., 2022). Current research identifies collegial relationships and healthy work environments as essential to the retention of nurses, especially younger generation nurses (McClain et al., 2022).

Limitations of the Study

Low response rates to survey research are quite common (Cox, 2016). The response rates for my survey were low for the members of the American Association of Critical Care Nurses and the Academy of Medical Surgical Nurses at 10.7% and 5.75% respectively. The response rate for the members of the Association of Operating Room Nurses was unable to be determined because the AORN representative could not provide the total number of members who received the survey. There was a total of 547 survey respondents in a total U.S. practicing nursing population of 1,698,700 (U.S. Bureau of Labor Statistics, 2019). The low response rates and the limitation of survey participation to three specific nursing specialties limited the representativeness and generalizability of the study findings to the entire U.S. nursing population.

Self-report surveys are susceptible to bias (Cox, 2016). The respondents may have unintentionally misreported information due to the inability to clarify the survey questions. Those who had experienced DPB may intentionally misreport information or complete the survey more than once using a computer with different IP addresses. This is possible due to the removal of the organization member identification number to increase privacy and confidentiality of the survey participants. The respondents may also have trouble recalling the event and how it made them feel due to the impact the experience had on them. These factors may have skewed the data and negatively impacted the accuracy of the study's findings.

Recommendations

According to Buerhaus et al. (2017), between now and 2030, 1 million nurses are expected to retire, contributing to the nursing shortage. Future research should focus specifically on the younger generation of nurses to determine what contributes to their job satisfaction as well as job dissatisfaction. My research should be conducted more large scale with recruitment of higher numbers of nurses and including all nursing specialties. Researching reasons for new nurse turnover should be a priority for nurse executives over the coming years to allow for the creation of and sustainability of an adequate nursing workforce to ensure safe, high-quality patient care. Results of my research may be used to guide the creation and implementation of policies and procedures that should address identified opportunities for improvement.

Development of prevention and management strategies to deal with disruptive behaviors is essential. One example of a strategy could be to create an educational program to be included in a transition to nursing orientation program and new physician orientation and should include behavioral expectations or standards, the impact of nurse-to-nurse or physician-to-nurse disrespect and violence on patient safety but also on the individual nurses and the healthcare organization. This program should be required for all nurses and physicians upon hiring. Research to determine the effectiveness of this education on nurses, physicians, patients, and the work environment should be conducted.

Implications

DPB has grave consequences especially because research has shown that it has resulted in preventable complications and increased mortality in patients (Thind, 2018). DPB has had a negative impact on nurses' job satisfaction and has contributed to nurse turnover (Al Sabei et al., 2020; Alharbi et al., 2020). The findings of my research indicate a need to address disruptive behaviors. Healthcare executives need to take disruptive behaviors seriously and prioritize the creation and implementation of prevention and management strategies. Despite its' negative consequences for patients and healthcare organizations, disruptive physician behavior continues to occur (Fibuch & Robertson, 2019). If left unaddressed, this serious problem will persist.

Reducing the prevalence of disruptive behaviors in healthcare would have a far-reaching positive impact for many. Nurses and physicians may have more respectful and collegial working relationships resulting in safer, higher quality care for patients and better patient outcomes. A more pleasant work environment and mutually respectful relationships may result in a reduction in nurse turnover. Improved patient outcomes and a reduction in nurse turnover would benefit the financial status of the healthcare organizations. When healthcare organizations are financially stable, they are more able to keep services rather than closing service lines. This would benefit the U.S. population because the availability of a variety of services may improve the health of the entire population.

Conclusion

In my study, the relationship between DPB and nurses' intent to leave the job, unit, organization, or the profession was evaluated. The relationship between DPB and job satisfaction was evaluated. I found that condescending language, dress down, and powerplay (all one predictor variable) and physical violence are associated with nurses' intent to leave their job or unit. I found that conflict; intimidation, threats, and harassment (as one predictor variable) and physical violence are associated with nurses' intent to leave their organization. Passive aggressive behavior and physical violence are associated with nurses' intent to leave the profession. I found that none of the predictor variables are associated with a decrease in nurses' job satisfaction; however, 89% of the survey respondents agreed or strongly agreed that DPB decreases their job satisfaction. Increasing age was associated with a decrease in intent to leave their job, unit, organization, or the profession.

A healthcare system that provides safe, high-quality care is a right for all U.S. citizens. Nurses and all healthcare disciplines deserve to work in a healthy environment where all healthcare workers can thrive and develop professionally. This is imperative for quality patient outcomes. Healthcare executives should and must address this serious problem. This problem will not resolve until healthcare leaders create policies and interventions to address it. Looking the other way is no longer an option. "The culture of any organization is shaped by the worst behavior the leader is willing to tolerate" Gruenert and Whitaker (2015).

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Appendix A: Permission Letter for Use of the JH-DCBS

June 24, 2018

Lisa Losito, RN, MS

Dear Ms. Losito

We are pleased that you are interested in using *The Johns Hopkins Disruptive Clinician Behavior Survey*© (*JH_DCBS*©) and grant permission to administer it to the professional staff at Walden University Dissertation Research. We can provide the survey either in paper form or transfer it electronically via Qualtrics to a specific User ID that you provide.

You are welcome to modify the following four (4) sections of the *JH_DCBS*© so that it reflects Walden University's dissertation research demographics, professional roles and/or IRB requirements and instructions:

1. First page (including instruction)
2. Participant demographics
3. Question 14 (insert list of roles/job titles appropriate for your organization)
4. Final "Thank You" page.

As part of the permission to use the survey, we ask that you provide the Johns Hopkins' study team your de-identified raw data for inclusion in its database.

Our Legal Department has requested the following copyright, permission and disclaimer language appear on the title of the first page whether the pages are distributed manually or electronically:

This work is intended for use to assist hospital and healthcare audiences; however, Johns Hopkins makes no representations or warranties concerning the content or clinical efficacy of this work, its accuracy or completeness. Johns Hopkins is not responsible for any errors or omissions or for any bias, liability or damage resulting from the use of this work. This work is not intended to be a substitute for professional judgment, advice, or individual root cause analysis.

I hope that our survey instrument is able to contribute to your work. If the stipulations for use are acceptable, please sign below to indicate your agreement and return the agreement to our Study Coordinator, Brianna Ferrell, by email () or fax ().

Best regards,

Deborah Dang, PhD, RN, NEA-BC
Director of Nursing
Practice, Education and Research
Johns Hopkins Hospital

I agree to the terms stipulated in this permission letter.

Lisa M. Losito, RN, MS June 24, 2018

(Signature) (Date)

Lisa M. Losito, RN, MS

Walden University

PhD Candidate

☐ I would like the survey to be sent to me as:

☐ PDF Paper document to email please.

Appendix B: Disruptive Clinician Behavior Survey

Introduction

You are invited to participate in a research study on disruptive physician behavior (DPB).

The purpose of the study is to determine the impact of experiencing DPB on nurses' job satisfaction and intent to leave their job, organization, or profession. It is hoped that the results of this study will inform healthcare leaders and encourage the development of policies and education to reduce the incidence of disruptive behavior while improving patient outcomes and providing for a healthier work environment for nurses.

- This survey takes about 15 minutes to complete. Your participation is voluntary. If you choose not to participate, it will not affect your employment status at your organization.
- Your responses are anonymous and are not linked to any personal identifying information.
- Your responses are confidential. Access is restricted to the research team.
- The potential risks of participating are minimal and include possible psychological distress as you think about and answer survey questions about a difficult event you experienced in your work environment.
- The benefit of participating is the opportunity to contribute to improving patient outcomes and the nursing work environment.

If you have any questions about your rights as a research participant, or if you think that you have not been treated fairly, you may call the Walden University Research Participant Advocate at 612-312-1210.

Your completing this survey will serve as your consent to be in this research study.

INSTRUCTIONS:

Respond to each question or statement according to the

instructions provided. You may decline to answer any questions.

Welcome to My Survey

This survey focuses specifically on DPBs and its impact on you the nurse. There are 19 questions, and the survey should take 5 to 10 minutes to complete. Thank you for your participation.

DEMOGRAPHICS

The following questions request information about your background.

1. What is your Professional Organization?

- ◯ American Association of Critical Care Nurses
- ◯ Association of periOperative Registered Nurses
- ◯ Academy of Medical Surgical Nurses

2. What is your age range?

- ◯ 20 - 29
- ◯ 30 - 39
- ◯ 40 - 49
- ◯ 50 - 59
- ◯ 60 - 69

3. What is your gender?

- ◯ Male
- ◯ Female

4. How many years have you been employed in your professional role (as a registered nurse)?

- ◯ < 5 years
- ◯ 5 - 10 years
- ◯ 11 - 20 years
- ◯ 21 - 30 years
- ◯ 31 - 40 years
- ◯ 41 or > years

5. What is your highest Education Level

- ◯ AAS
- ◯ BSN
- ◯ MSN
- ◯ Doctorate

6. Does your organization hold Magnet Designation?

- ◯ No
- ◯ Yes

7. What is your current practice setting?

- ◯ Surgical Intensive Care
- ◯ Medical Intensive Care
- ◯ Operating Room/Post Anesthesia Care Unit
- ◯ MedSurg Inpatient
- ◯ Progressive Care Unit
- ◯ Specialty/Procedure Area (ED, Cath Lab, EP Lab, Labor & Delivery, Endoscopy, Radiology)

8. What is your professional role?

- ◯ Nurse Leader (Nurse Manager, Assistant Nurse Manager, Shift Coordinator)
- ◯ Advanced Practice Nurse (Case Manager, Nurse Educator, Clinical Nurse Specialist
- ◯ Charge Nurse/Preceptor
- ◯ Staff Nurse (Registered Nurse (RN)

UNPROFESSIONAL BEHAVIOR

In the past year, consider unprofessional behavior you have personally experienced by physicians at all levels including attending, fellow, intern, or resident etc.

Please check the frequency of occurrence

9. **Conflict**
(ex. contentious interactions, and/or unresolved disputes between and among team members).

- ◯ Never
- ◯ Rarely
- ◯ Monthly
- ◯ Weekly
- ◯ Daily

10. **Condescending Language / Dress Down / Power Play**
(ex. being publically humiliated, put down, insulted, ridiculed, embarrassed, demeaned, berated, criticized in front of staff/patients, pulling rank, dominating or controlling by range or position, withholding information at your expense)

- ◯ Never
- ◯ Rarely
- ◯ Monthly
- ◯ Weekly
- ◯ Daily

11. **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 "rid you" at work; "do this or else"; hazing)

- ◯ Never
- ◯ Rarely
- ◯ Monthly
- ◯ Weekly
- ◯ Daily

12. **Passive Aggressive Behavior**
(ex. physician co-workers intentionally not taking patient report when requested, 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 pages or other requests)

- ◯ Never
- ◯ Rarely
- ◯ Monthly
- ◯ Weekly
- ◯ Daily

13. **Physical Violence**
(ex. grabbing, shoving, pushing, hitting, slamming, fighting, throwing objects)

- ◯ Never
- ◯ Rarely
- ◯ Monthly
- ◯ Weekly
- ◯ Daily

14. **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)

- ◯ Never
- ◯ Rarely
- ◯ Monthly
- ◯ Weekly
- ◯ Daily

15. **Rude /Disrespectful**
(ex. lack of courtesy, sarcasm discourteous tone, yelling, raising one's voice, not listening, ignoring, turning away hanging up phone during conversations, engaging in malicious gossip, exclusion by cliques)

- ◯ Never
- ◯ Rarely
- ◯ Monthly
- ◯ Weekly
- ◯ Daily

IMPACT OF UNPROFESSIONAL BEHAVIOR

The following statements focus on the impact of unprofessional behaviors you have experienced *by physicians* (all levels attending, fellow, intern, resident) on you, your work environment, job satisfaction and intent to leave.

Please check your level of agreement with each statement.

16. Unprofessional behavior I have experienced by physicians decreases my job satisfaction.

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Agree
- ◯ Strongly Agree

17. Unprofessional behaviors I have experienced by physicians have caused me to consider leaving my job/unit

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Agree
- ◯ Strongly Agree

18. Unprofessional behaviors I have experienced by physicians have caused me to consider leaving my organization

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Agree
- ◯ Strongly Agree

19. Unprofessional behaviors I have experienced by physicians have caused me to consider leaving the nursing profession

- ◯ Strongly Disagree
- ◯ Disagree
- ◯ Agree
- ◯ Strongly Agree

THANK YOUR FOR RESPONDING TO THIS SURVEY. YOUR PARTICIPATION IS GREATLY APPRECIATED

Appendix C: Letters of Cooperation

From: Marian Altman
Sent: Thursday, August 1, 2019 4:28 PM
To: Lisa M. Losito <
Subject: [External] AACN and research

Warning: This email originated from the Internet!

DO NOT CLICK links if the sender is unknown, and NEVER provide your password.

Hello Lisa
Your inquiry regarding AACN supporting research was forwarded to me.
Yes, we are able to assist you. Below you will find a list of the required documentation. Once I receive your completed packet, I will review your study to ensure that it is congruent with AACN's mission, vision and values. If so, I will inform you and we will post the study on our Participate in Research page on our website. https://www.aacn.org/nursing-excellence/research-studies

In addition, we will post information about your study and others on the above mentioned AACN webpage as space allows in the electronic newsletter.

We also offer the opportunity for membership list rental for members' snail mail addresses (not email). If you are interested in this please contact listrental@aacn.org.

Please let me know if you have any additional questions. I look forward to learning more about your research study.

Required documentation:

A copy of the IRB approval for the study.

A copy of the research abstract describing the study and what you are hoping to find.

The tool you will be using; additionally, if it has a copyright holder we need a letter/email giving you permission to use or adapt for use.

We request that you please submit a ***complete application.***

Regards

Marian

Marian Altman PhD, RN CNS-BC, CCRN-K
Clinical Practice Specialist

From: Mary Steffens
Sent: Monday, January 13, 2020 1:45 PM
To: Lisa M. Losito
Subject: [External] RE: Process for Sending Link for my Research

Warning: This email originated from the Internet!

DO NOT CLICK links if the sender is unknown, and NEVER provide your password.

Hi Lisa,

I found out the steps you need to take...they are all outlined here on our website:

https://www.amsn.org/practice-resources/research/conduct-research-study

Please check out all the tabs on this site. Then, when you are ready and have IRB approval, you *would* click on "resea survey application" and submit your survey. HOWEVER, we are in the process of changing the URL for this applicatio some time between now and the end of January (we are moving to another online application portal). So, before you apply using the link on the website, **please email me and let me know you are ready to submit your application.** Th will confirm the right link to use.

When your survey is reviewed and approved by our research committee team, we'll let you know. We then send invitations to our members to take the survey from here at AMSN. I believe the survey links go out every two we but I can confirm a date with you once we receive your application.

If you have any further questions right now, please let me know and I can give you a call tomorrow or later on thi

Thank you Lisa!

Mary

Mary Steffens
Manager, Professional Practice
Academy of Medical-Surgical Nurses (AMSN)
P.O. Box 56 | Pitman, NJ 08080

The AMSN PRISM Award® provides special recognition to medical-surgical units that model exemplary professiona practice. For more information go to https://www.amsn.org/practice-resources/amsn-prism-award.

From: Mary Alice Anderson
Sent: Monday, January 13, 2020 4:23 PM
To: Lisa M. Losito
Cc: Lisa Spruce
Subject: [External] Re: AORN Membership Survey

Warning: This email originated from the Internet!

DO NOT CLICK links if the sender is unknown, and NEVER provide your password.

Dear Lisa,

Here are the guidelines for submitting applications to survey the AORN membership. As we discussed, you do not need to be a member of AORN and there are about 40,000 members.

Applications are due the 1st of the month and will be submitted to our committee liaison for initial screening. Once it's approved, your application will go to the National Research Committee for review. This typically takes 4-6 weeks and we may potentially ask for additional information during this time.

If approved by the committee, I will connect you with our staff to disseminate your survey via email to our members.

Please let me know if I can provide additional information or clarification regarding the application. I've attached Dr. Lisa Spruce to this email as well.

Sincerely,

Mary Alice Anderson, MSN, RN, CNOR
Perioperative Practice Specialist
Association of periOperative Registered Nurses (AORN)
2170 S Parker Rd, Suite 400
Denver, CO 80231-5711

Appendix D: Email Invitation for Recruitment in Study

You are invited to take part in a research study about disruptive physician behavior and its impact on nurses' job satisfaction and intent to leave. The study seeks 194 volunteers who are registered nurses working in U.S. hospitals, are members of the American Association of Critical Care Nurses, the Academy of Medical Surgical Nurses, or the Association of periOperative Registered Nurses.

This study is being conducted by a researcher named Lisa Losito who is a student and PhD Candidate at Walden University. The purpose of this study is to determine how disruptive physician behavior impacts nurses' job satisfaction or intent to leave their job, organization or the nursing profession.

This study will involve you completing the following steps:

- consent to participate
- completion of an anonymous, one-time, online survey (15 minutes). After completion, no further participation would be required.

The survey is a modified version of Dr. Deborah Dang's John's Hopkins Disruptive Clinician Survey (JH-DCBS) which includes only those questions specific to my research. There are 3 sections and a total of 19 questions.

Here are some sample questions**:**

UNPROFESSIONAL BEHAVIOR

In the past year, consider unprofessional behavior you have personally experienced by physicians including attending, staff, fellow, resident, and interns. Examples of the behaviors are in parentheses.

- Rude/Disrespectful Behavior
- Condescending Language / Dress Down / Power Play
- Answers: Never, Rarely, Monthly, Daily, Weekly

Participation is completely voluntary and you may exit the survey at any time. Your decision to participate or not will be respected. The survey responses will remain confidential and your anonymity guaranteed as the researcher will not have access to any participant names. In addition, this data will be secured on a password protected external drive.

Participation in this study could involve some minimal psychological discomfort brought on by recalling of stressful events you may have experienced in your work environment. The voluntary nature of this research and the ability to exit at any time should minimize the risk to your wellbeing.

The benefit of this study is to contribute to a positive change in nurses' work environment. The aim of this study is affect social change improving the healthcare work environment in healthcare organizations. Once analysis is complete, the results of this research will be shared through publication of this dissertation.

If you have any questions with regard to this research, you may contact me at . . .. In addition, you may contact Walden University's Research Participant Advocate at 612-312-1210.

The AMSN and AORN have agreed to provide this email invitation containing a link to the survey to you via your email address and will not be providing this researcher with any contact or identifying information. The AACN does not provide member email addresses or contact their members requesting participation in research. Therefore, recruitment of AACN members will be by postcard via the U.S. States Post Office,. Completion of this survey by clicking on the link below implies your consent

to participate in this research.

Please click on the link below to start the survey:

https://www.surveymonkely.com

Thank you so much for your participation.

Lisa Losito, RN, MS, CCRN-K, CHFN-K
PhD Candidate

Appendix E: Postcard Invitation for AACN Members

Study on Disruptive Physician Behavior, Nurse Satisfaction and Intent to Leave

My name is Lisa Losito, an RN and PhD candidate at Walden University. I am passionate about the nurses' work environment. If you are an RN working in a U.S. hospital in any ICU, Cath Lab, EP, IR, or PACU and you are a member of the AACN, please consider taking my 3-5 minute, 19-question survey.

QR Code to Survey

Please scan QR code to the left which will take you to the survey.

For detailed information about this study, you may scan the red QR code on the reverse side of this card.

Study on Disruptive Physician Behavior, Nurse Satisfaction and Intent to Leave.

Scan for Study Description

PDF FILE