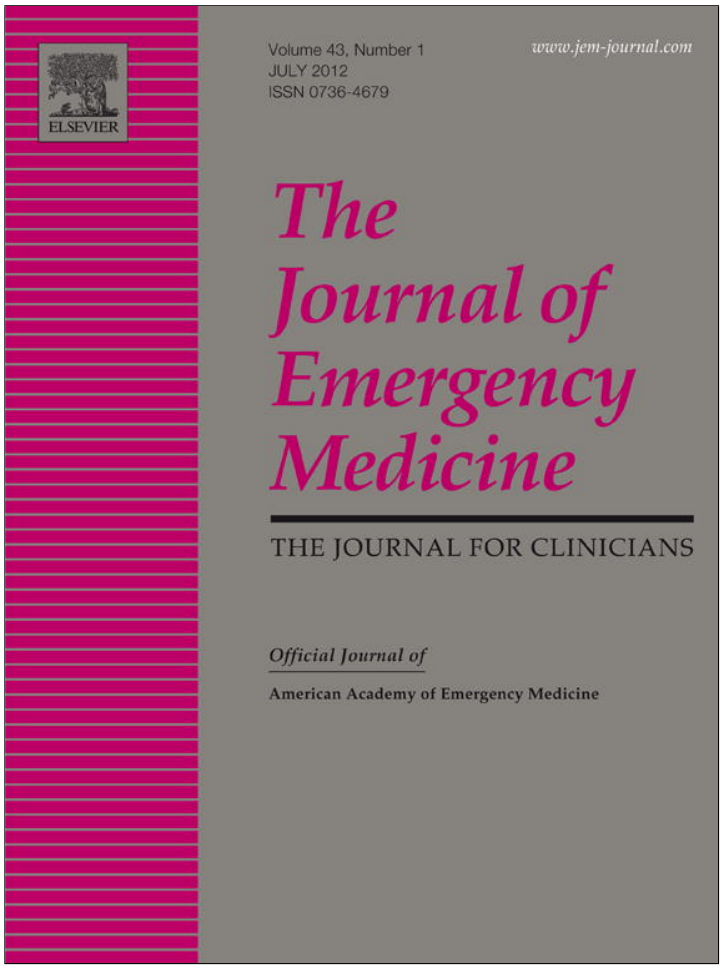

The Journal of Emergency Medicine, Vol. 43, No. 1, pp. 139–148, 2012

0736-4679/$ - see front matter

doi:10.1016/j.jemermed.2011.01.019

Administration of Emergency Medicine

INCIDENCE AND IMPACT OF PHYSICIAN AND NURSE DISRUPTIVE BEHAVIORS IN THE EMERGENCY DEPARTMENT

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☐ **Abstract—Background: Disruptive behaviors have been shown to have a significant negative impact on staff collaboration and clinical outcomes of patient care. Disruptive episodes are more likely to occur in high stress areas such as the Emergency Department (ED). Having the structure, process, and skills in place to effectively address this issue will lower the likelihood of preventable adverse events. Objectives: To assess the status of disruptive behaviors and staff relationships in the ED setting. Methods: A 23-question survey tool was distributed to a regional group of ED physicians, nurses, and staff members to assess their perceptions as to the incidence of discipline-specific occurrences, types and impact of disruptive behaviors on staff behaviors, communication efficiency, and patient outcomes of care. Results: A total of 370 surveys were received. Fifty-seven percent witnessed the disruptive behaviors by physicians, 52% witnessed the disruptive behaviors by nurses; 32.8% of the respondents felt that disruptive behavior could be linked to the occurrence of adverse events, 35.4% to medical errors, 24.7% to compromises in patient safety, 35.8% to poor quality, and 12.3% to patient mortality. Eighteen percent reported that they were aware of a specific adverse event that occurred as a direct result of disruptive behavior. Conclusion: Disruptive behaviors in the ED have a significant impact on team dynamics, communication efficiency, information flow, and task accountability, all of which can adversely impact patient care. EDs need to recognize the significance of disruptive behaviors and implement appropriate policies and protocols to address this issue.** © **2012 Elsevier Inc.**

☐ **Keywords—disruptive behavior; patient safety; staff communication; team collaboration; adverse events**

INTRODUCTION

Over the past 10 years there has been a growing amount of research documenting the frequency and impact of disruptive behaviors on staff relationships and clinical outcomes of care (1–5). Disruptive behavior is defined as any inappropriate behavior, confrontation, or conflict, ranging from verbal abuse (yelling, intimidation, condescending, berating, disrespectful, abusive behaviors) to physical or sexual harassment that can negatively impact work relationships, communication efficiency, information transfer, and the process and outcomes of care.

Disruptive events tend to occur more frequently in certain medical specialties (General Surgery, Cardiovascular Surgery, Cardiology, Neurosurgery, Orthopedics, Anesthesia, OB/GYN) and in the more stressful high intensity areas (Peri-operative, Intensive Care, Delivery) (4–10). The data have shown that it is usually only 3–5% of the medical staff that is truly disruptive, but these individuals can have a profound effect on the entire organization.

It's not just the physicians who exhibit disruptive behavior. Nurses, too, have been shown to display disruptive behavior that occurs just as frequently as with physicians (5). The difference is that physician disruptive behavior directly impacts patient care. When it occurs, it's overt, quickly unfolds during the course of treatment, and ends soon after. Nursing disruptive behavior takes on more of a passive/aggressive approach, with

Received: 11 April 2010; Final submission received: 13 July 2010;
Accepted: 7 January 2011

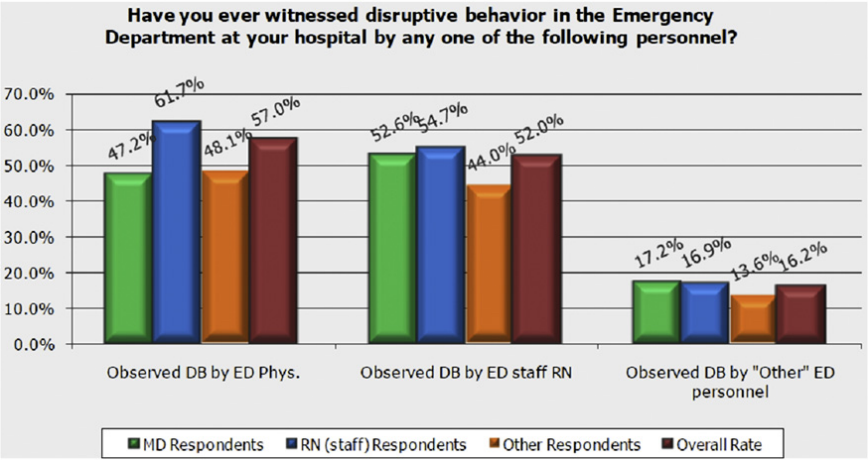

Figure 1. Disruptive behavior displayed by disciplines. DB = disruptive behavior.

behind-the-scenes undermining and subterfuge, with most of the activity being directed at other nurses. Some have applied the phrase "horizontal hostility" to describe its nature (11,12). In both cases, the incidents can adversely affect patient outcomes of care.

The Emergency Department (ED) represents a microcosm of all the things that can go wrong in the health care setting. Unscheduled, complex, acutely ill patients appear in surges, often without any supporting past medical history. Care is provided in a crowded, restricted space and there are multiple health care providers and other personnel involved in the process. The process often occurs at a frenzied pace and there is a strong need for effective interdisciplinary trust and collaboration between ambulance services, clerical staff, registration, triage, hospital staff, ancillary services, transportation, ED nurses and physicians, consultants, and attending physicians, as each plays a vital role in the process. When working relationships are impaired, communication gaps in both assessment and treatment can occur, which may result in unwanted negative patient outcomes. In an effort to assess the frequency and impact of disruptive behaviors in the ED, we conducted a multi-hospital ED survey to evaluate the frequency and circumstances contributing to disruptive behaviors and look for opportunities to improve overall care collaboration and coordination.

MATERIALS AND METHODS

We developed a customized 23-question web-based survey for ED physicians, nurses, and other staff employees. The survey was based on the original VHA West Coast survey utilized in other survey reports (1–4,6,9). Surveys were distributed in early 2009 to 27 EDs that were participants in the VHA Oklahoma/Arkansas ED Benchmarking Initiative. A total of 370 surveys were received from 20 individual EDs that elected to participate in the survey. The overall response rate was 38%. A total of 237 respondents listed their title as nurse, 44 listed their title as physician, 28 listed their titles as unit secretaries or clerks, 26 listed their title as ED technicians, 3 listed their title as Physician Assistants, 2 listed their title as Nurse Practitioners, and there were 30 respondents combined as "Other." Completed surveys were returned to VHA West Coast for analysis. The format for responses included yes-or-no questions, questions requiring a numerical grade based on a 10-point scale, and an open section for individual comments. Data were analyzed using SPSS statistical software (SPSS Inc., Chicago, IL). The data presented below summarize the aggregate results for surveys received from March 1, 2009 through November 30, 2009.

RESULTS

The major focus of the survey was to assess the frequency and impact of disruptive behaviors in the ED. Figure 1 summarizes the results of respondents who reported witnessing disruptive behavior in the ED by specific discipline. Fifty-seven percent of the respondents reported witnessing disruptive behaviors by ED physicians. Most of the witnessed behaviors were reported by the ED nurses (61.7%), followed by physicians witnessing it in other physicians (47.2%), and others (48.1%). Fifty-two percent of the respondents reported witnessing disruptive behaviors by nurses; 54.7% of the nurses witnessed the behaviors in other nurses, followed by physicians (52.6%) and others (44.0%). The frequency of disruptive behaviors noted by other staff was 16.2%.

Figure 2 describes the frequency and type of disruptive behaviors noted in the ED setting. The most frequent types of behaviors noted were yelling, disrespectful interaction, condescending behaviors, berating in front of staff and colleagues, and abusive language.

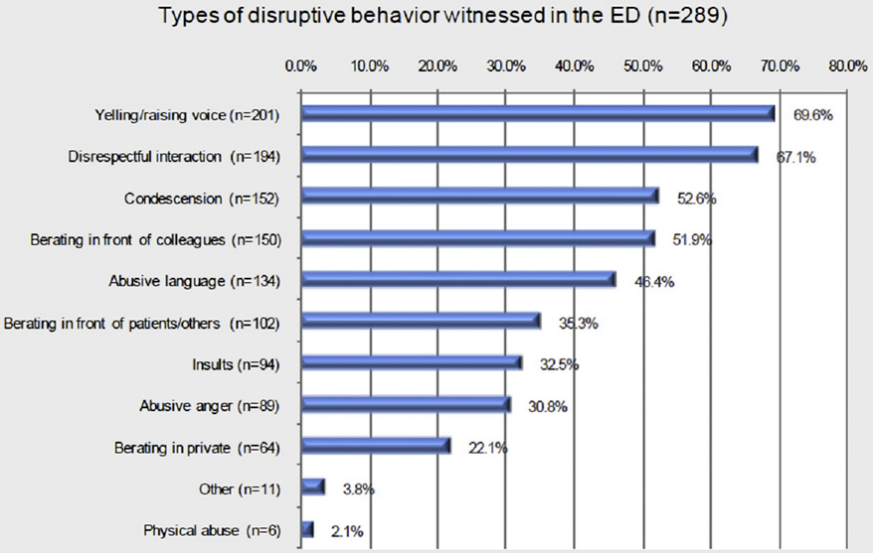

Figure 2. Types of disruptive behavior noted in the Emergency Department.

Figure 3 summarizes the results from the question asked about the contribution of deep-seated values and experiences that may present as barriers to effective communication. Personality was rated as the number one contributing factor (66.3%), followed by training influences (31.4%), gender differences (22.3%), generational (age) differences (22.1%), culture and ethnicity (16.5%), and other (10.8%). Most of the responses were similar for each discipline other than for the physician group, who ranked generational differences as more of a contributing factor than the other groups.

Figures 4 and 5 summarize the results from the question asked about the contribution of situational factors that may contribute to ineffective communication. Poor attitude and disruptive personality was the number one response (61.5%), followed by time delays (57.1%), inadequate staffing (40.0%), poor communication skills (40.2%), inappropriate tools or equipment (31.4%), unclear roles and responsibilities (29.1%), throughput delays (24.0%), and scheduling issues (15.5%). Most of the responses were similar for each of the disciplines, other than for time delays, where the nurses registered a greater concern than the physicians; inadequate staffing, where the physicians raised a higher level of concern than the nurses; poor communication skills and inappropriate tools or equipment, where the nurses expressed a greater concern; and unclear roles and responsibilities, where physicians raised a greater concern.

One of the pivotal questions in the survey was to ask respondents to rate the effects of disruptive behaviors on key psychological factors that may affect processing and performance. Respondents were asked to rank their response to disruptive behavior using a rating scale of never, rarely, sometimes, frequently, or constant, as to its effect on stimulating stress, frustration, loss of concentration, reduced collaboration, reduced information

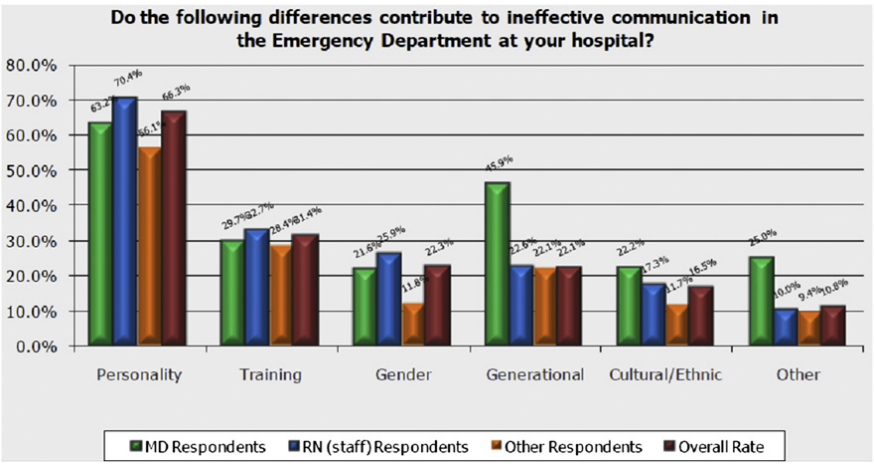

Figure 3. Deep-seated factors contributing to disruptive behavior.

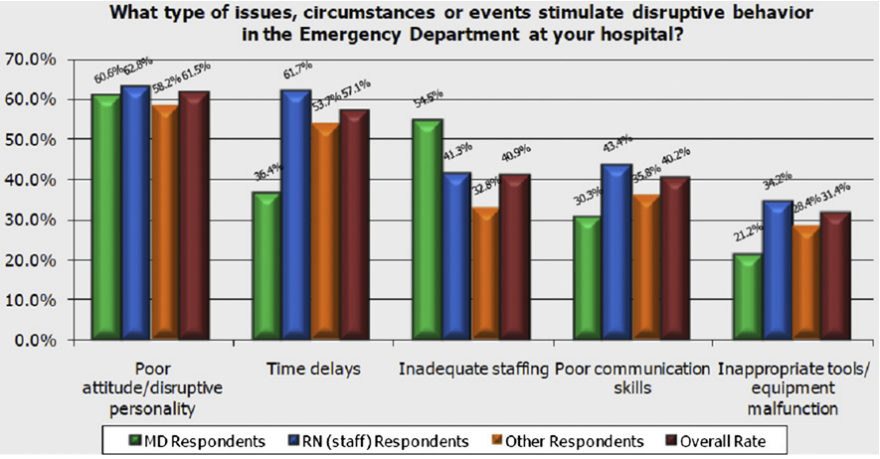

Figure 4. Situational factors contributing to disruptive behavior.

transfer, reduced communication, and impaired relationships. Using the sometimes, frequent, and constant responses as measures of significance, Figure 6 summarizes the combined results for each of these factors: 76.8% of the group felt stressed, 79.5% of the group felt frustration, 51.8% of the group felt that their ability to concentrate was impaired, 43.8% reported impaired collaboration between nurses and physicians, 42% reported impaired information flow, 55.6% reduced communication, and 46.7% impaired nurse-physician relationships.

The second pivotal question was to assess respondents' perceptions of the impact of disruptive behaviors on patient outcomes of care. Similar to the question above, respondents were asked to grade their perceptions of the linkage of disruptive behaviors to adverse events, errors, patient safety, quality, mortality, and satisfaction. Using the "sometimes," "frequent," and "constant" responses as measures of significance, Figure 7 summarizes the combined results for each of these factors: 32.8% of the respondents felt that disruptive behavior could be linked to the occurrence of adverse events, 35.4% to medical errors, 24.7% to compromises in patient safety, 35.8% to poor quality (35.8%), and 12.3% to patient mortality. The majority of the respondents felt that disruptive behaviors strongly affected nurse, physician, staff, and patient satisfaction. As to the question asking if they were aware of any specific adverse event that occurred due to disruptive behaviors, 13.0% of the group responded yes; 71.2% of the respondents felt that the adverse events could be prevented. Table 1 gives several examples of specific comments made by respondents as to their experiences with disruptive individuals.

DISCUSSION

Disruptive behavior has been shown to have a serious adverse effect on staff relationships, communication efficiency, and information flow, with a downstream effect on compromising patient outcomes of care. Previous studies

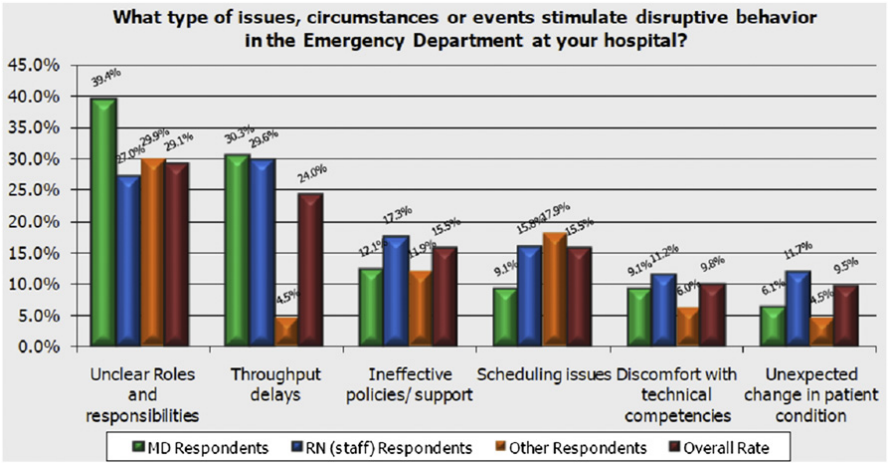

Figure 5. Situational factors contributing to disruptive behavior.

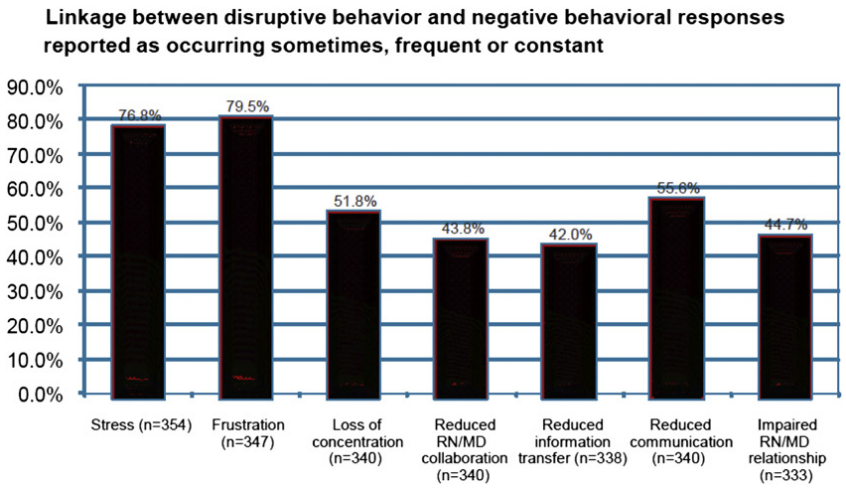

Figure 6. Impact on psychological factors.

have documented the frequency and severity of disruptive behavior in high stress areas such as the peri-operative services, intensive care services, and obstetrical services, but there have been only a few reported studies done on ED services (13,14). It is not surprising that the current study shows a similar pattern of disruptive events and consequences in the ED as in these other high stress areas.

The primary focus of addressing disruptive behaviors should be aimed more toward recognizing the causes of such behaviors, and whenever possible, taking the appropriate steps to minimize their recurrence. Table 2 presents a 10-step process put together from experiences gained from different hospitals that have taken steps to address the problem of disruptive behaviors; it can serve as a checklist of suggested strategies designed to address this problem.

The first step in the process is to raise the level of *awareness* as to the seriousness of the issue. It's unlikely that anyone begins the day with the intention of being disruptive; it just unfolds during the course of the day. Most individuals don't *recognize* that they are being disruptive or think that anything short of physical insult is a cause for concern. Results from the current survey reinforced the fact that most disruptive behaviors are manifested by intensity of tone and implied disrespect, and that all of these behaviors stimulate negative responses that can adversely impact staff satisfaction and patient care. The clinical significance for clinicians is to have them gain a better understanding of the downstream impact of their behaviors and what it can do in regard to its negative impact on staff relationships, employee turnover, patient satisfaction, team collaboration and communication, patient safety, and clinical outcomes of care; and take more accountability for their actions.

At the very outset, the organization needs to endorse and support a policy of zero tolerance for disruptive behaviors as part of a system-wide top-down, bottom-up *organizational commitment* to a culture of patient safety.

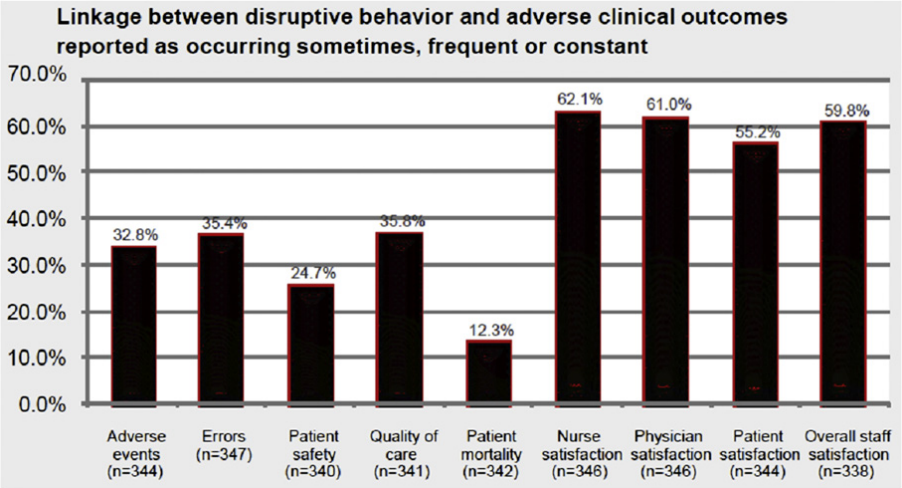

Figure 7. Impact on patient care.

Table 1. Comments

- "MDs become stressed due to patient overload and acuity. This decreases their patience and shortens their fuses where they do not handle questions from nurses, especially new ones, well at all."
- "Doctors refusing to listen to nurses regarding condition of patients."
- "Impaired nurse/physician relationships. If a physician doesn't like a nurse for whatever reason (perceived lack of skills, personality conflict, etc.). I believe it has an adverse effect on patient care due to lack of communication (like the physician or nurse not relaying information due to things listed above)."
- "Decrease in MD to RN communication that leads to longer stay for patients in the ER."
- "If the Dr. didn't act so hateful to staff they would be more willing to approach him and discuss patients and changes."
- "Talking about teams is one thing but providing the training to know what today's team is about is needed. It is not the Nurses versus the Doctors or the Admitting Clerk versus the medical staff and vice versa. Each person has the team (department they work for) but they are also a part of many teams. In the ER we may be in Admitting but we also are a part of the ER team and the goal is excellence in taking care of our patients. We have to get along and understand each other's roles and responsibilities. Staff need to understand the roles and responsibilities of management and be ready and open to try new things as change is inevitable."
- "A patient in respiratory distress had been intubated by the ED physician. The nurse at HOB was BMV ventilating the patient. MD left the room & immediate ED w/o providing ventilator or vent setting orders. This left the nurse 1:1 w/ the pat. to provide ventilation, this with ED full & available total staff (w/ that nurse) at 2 RN's & an LPN. When contacted by that nurse for vent & vent setting orders, the MD responded 'you can stand there & breathe him' (patient was to be admitted to the unit.) But, when confronted by the other (male nurse) about the inappropriateness of this directive r/t staff utilization & pt. safety, he then gave the vent orders."
- "Physician belittling nurse for episode out of her control. Physician had entered orders on wrong chart then had a yelling fit at the desk. Nurse ended up crying, not able to perform her duties well for a matter of minutes until she composed herself this impaired the relationship between them from now on."
- "Lack of confidence in the physician or nurse you are working with, leading to low morale. Poor patient satisfaction/concern."
- "Doctors quick to dc pts due to poor attitude and nurses hesitant to contact physicians due to abusive language and demeaning attitudes"
- "Staff not wanting to work with disruptive staff and unable to work to the best of their ability. Some nurses scared of Dr. because of yelling and attitude."
- "All Physician discipline issues must go before Medical Executive Committee. This is made up of Staff Physicians that repeatedly refuse to adequately address physician behaviors throughout the facility. Administration has repeatedly attempted to address these issues but physicians refuse to hold each other accountable and the Board has yet to force the issue."

If any individual does not abide by standards set by the organization, leadership needs to be ready and willing to take appropriate action. This process should be intertwined with all the quality improvement, patient safety, and risk-management programs at the organization. Having a *project champion* who is a well-respected member of the staff is helpful in driving the process forward.

Having a specific *disruptive behavior policy* is a mandatory step in the process. The policy needs to set criteria for appropriate behavior and establish a process for intervention when the standards are not adhered to. In January 2009, the Joint Commission initiated a new leadership standard as part of the accreditation protocol requiring hospitals to have a disruptive behavior policy in place and provide appropriate education to support its objectives. For the policy to be effective, it needs to be applied consistently across all disciplines and provide appropriate action for those who are not compliant.

Table 2. Recommended Strategies

1. Recognition and awareness
2. Cultural commitment/leadership endorsement
3. Policies and procedures
4. Clinical champions
5. Reporting process
6. General education
7. Internal assessment
8. Advanced education/training
   - ○ Personality styles
   - ○ Sensitivity training
   - ○ Diversity training
   - ○ Assertiveness training
   - ○ Anger management
   - ○ Stress management
   - ○ Conflict management
9. Communication/team collaboration tools
10. Intervention
    - ○ Early intervention
    - ○ Real-time intervention
    - ○ Post-event intervention

The *reporting* of disruptive incidents is a crucial part of the process. Traditional obstacles to reporting are the reluctance to report a fellow co-worker, the fear that reporting will lead to retaliation, or the previous experiences of reporting and never seeing any action or improvement in return. These barriers need to be addressed in the interests of providing best practice care. The reporting process itself needs to be well organized and consistently applied to assure that each complaint is handled appropriately and effectively. Our recommendation is to establish a multidisciplinary reporting committee whose responsibilities include reviewing each complaint, initiating an action plan, and following-up to ensure that there is a satisfactory solution. This multidisciplinary approach avoids problems with 1:1 interventions that may suffer from individual bias, established peer relationships, or potential conflicts of interest, and also has the advantage of utilizing a pooled skill set to make the appropriate recommendations for action and intervention.

Providing *general educational programs* will help all employees and staff gain a better appreciation of the frequency and impact of disruptive behaviors and the role that they play in the process. Having the organization perform an *internal assessment* through a survey tool, town hall meetings, focus groups, task forces, or informal input will help the organization get a better appreciation of the status of the staff's perceptions of behaviors and relationships and provide specific targeted areas for improvement. Educational programs should be provided to all staff involved in the health delivery process. Presentations should be given to the Board, clinical and administrative leadership (including Human Resources and Risk Management), Grand Rounds, Physician and Nursing Departmental meetings, Interns and Residents, and even the students (medical, nursing, pharmacy) who may be rotating through the health care facility. Better understanding leads to better collaboration.

Depending on the organizational culture, there are a series of *specialized education and training programs* that may be of particular benefit to the organization. In the end, individual values, attitudes, perceptions, and communication styles are the result of a complex set of life experiences that influence one's attitude, preference styles, and behavior. Offering programs that provide insight into relevant underlying issues will help promote a better understanding of how individuals receive, process, and act on information and provide learning tools and techniques designed to improve communication and collaboration efficiency. Table 3 gives an overview of factors affecting behaviors and communication styles.

Values and perceptions begin forming early in childhood and are molded through life's exposure and experiences. Looking at age and generation as a factor, generation gap preferences are set by the current events and parental attitudes that were prevalent during that time (15). Veterans and baby boomers, as a group, are hard workers, dedicated, loyal to the organization, do whatever it takes to accomplish the task, and stay at a job long term. Generation X and Y are more interested in technology, social structure, and work-life balance, will leave when their shift is over, and are more likely to move from job to job. When it comes to generational preferences, none of it is right or wrong, but getting a better understanding of each group's preferences will enable more effective ways of indoctrinating them into the work routine. Gender issues also influence behaviors.[16] Males are traditionally task oriented, thrive with having power and control, and when stressed, prefer to work independently. Females are usually more group oriented, are better at listening and sharing, and when stressed, tend to look for group consensus to support their view. Culture and ethnic diversity also play a role. With the increasing number of foreign-born physicians and staff entering the workforce, having a better understanding of their cultural and religious beliefs as to gender, hierarchy, power, and communication styles will help increase consciousness of appropriate and effective interaction styles. Differences in training also influence one's behavior. This is particularly true for physicians. Very early in their training, medical students have traditionally been subjected to demeaning criticism, which often results in low self-esteem and lack of self confidence. They learn to work independently, and are trained in technical and knowledge competency. This results in a very autocratic, dictatorial style of control, which is the antithesis of group collaboration. Taking into account all these factors as well as other life experiences, the resulting outcome is the individual's personality. The results from the current study reveal that personality issues was the number one barrier reported as contributing to ineffective communication. Providing more specialized educational programs and training seminars on personality styles, sensitivity training, diversity training, assertiveness training, and conflict management will help address these underlying issues.

On top of the more deeply seated influences are the mounting pressures of practicing in today's health care environment. Increasing complexity, environmental pressures, growing accountability, and pressure to reduce costs have led to increased levels of anger, frustration, stress, burnout, and depression, reaching a point where many health care professionals are retiring early or switching professions (16–20). Providing courses in stress management, anger management, and career counseling will help providers adjust reactions accordingly.

In regard to provoking factors, one of the key concerns raised in the survey had to do with technical and operational barriers. Time delays, throughput, staffing, and equipment problems were some of the key areas highlighted in the study as provoking a disruptive response. Organizational willingness to address these issues in

Table 3. Contributing Factors

- Deep seated:
  - Age (generation)
  - Gender
  - Culture and ethnicity
  - Family/life values and experiences
  - Biases
  - Training
  - Personality style
- Active:
  - Stress and frustration
  - Fatigue/burnout
  - Depression
  - Substance abuse
  - Emotional intelligence
- Situational:
  - Environmental
  - Provoked response

a constructive manner is a pivotal part of the physician or staff engagement process.

Improving *communication and team collaboration* is at the core of the entire process. Whereas disruptive individuals usually account for only a small percentage of the staff (3–5%), a much larger percentage of staff are poor communicators. Providing didactic training to improve communication skills will help improve information flow and task achievement. For the one-on-one conversations, utilizing a prepared script such as the SBAR tool (Situation/Background/Assessment/Recommendation) teaches individuals how to present and deliver the necessary information in a concise, well-organized format that will better enable the recipient to respond more appropriately to the requester's need (21). For those environments, such as the ED, that require more of a team approach to care management, specific team-building tools such as those utilized in the airline and racing industries will help promote effective team efficiencies. The basic components of these programs include gaining knowledge of everyone's role and responsibilities, promoting trust and respect, assuring competencies, promoting assertiveness, and stressing the value of post-event discussion and review (debriefing). One of the key successes we had was to have the ED nurses and physicians sit together in the same room where we (confidentially) presented the results and comments from the survey. This process stimulated a very proactive discussion around misassumptions and misperceptions that individuals had during an encounter that tended to impede the intent of the conversation.

The final step in the process is *intervention*. The spectrum and outcomes of the intervention are dependent upon awareness, sensitivity, perception of seriousness of the situation, and willingness to change.

The pre-event stage has the greatest opportunity for success. The goal is to prevent a disruptive event from occurring. Staff educational programs can raise levels of awareness and accountability, and more comprehensive training to enhance communication skills, team collaboration, and behavioral interactions will lessen the likelihood of a disruptive event occurring. Training in stress management, anger management, or conflict management techniques may help diffuse a tense situation when it does occur. At a deeper level is the recognition that many physicians are experiencing increasing levels of dissatisfaction, stress, frustration, stress, burnout, and even depression, which are affecting their willingness and capability to provide best practice care. Identifying such individuals and working with them through a supportive peer coaching or counseling model will help them adjust to the pressures of the surrounding environment. This can improve their home and work relationships, overall satisfaction, productivity and efficiency, and ultimately, improve outcomes of patient care. Looking at health care professionals as a precious limited resource and working with them early on in the process in a constructive proactive manner has a much greater chance for success than crisis intervention, which usually takes on more of a confrontational approach (22).

When you do have a crisis on hand, it is essential to intervene in real time. Here tools such as assertiveness training and team collaboration techniques become crucially important to prevent potential ill effects. In protracted tense situations, some organizations have implemented a "code white" call, where a selected group of trained individuals are paged to the sight of conflict to help diffuse a disruptive situation.

When an incident occurs, an informal post-event discussion will often ease the situation. In other instances, an incident report needs to be filed and a more formal evaluation is in order. The spectrum of disciplinary action runs the gamut from easy solutions gained from understanding and sensitivity, to specialized programs geared to improve behaviors from chronic offenders, and in some cases, the only workable alternative is suspension or termination.

A large percentage of individuals don't recognize that their actions are perceived as being disruptive, and once informed of the situation they adjust their reactions accordingly. Another group of individuals will benefit from specialized courses such as sensitivity or diversity training, stress management, or anger management. In some individuals, professional counseling may be in order. One must also consider the possibility of underlying drug or alcohol abuse and take appropriate steps in this regard. There are some individuals who are not amenable to change, and appropriate sanctions or termination may be the only course of action. When making that decision, the organization needs to recognize the risks of not taking action.

Limitations

This study has several limitations. Surveys were distributed to all members of the ED staff who consented to participate in the survey. There may be an assumption of selection bias in that only those individuals who experienced disruptive behaviors would take the initiative to fill out the survey. On the non-selection bias side, there were many responses that represented very favorable views of nurse-physician relationships. The second limitation is that the survey results were based on individual perceptions of events, which may be affected by individual bias or past experiences. The results are based on observational data, and although a strong relationship exists between disruptive behaviors, emotional distress, and adverse events, it is difficult to establish a direct cause-and-effect relationship. There are multiple factors contributing to human behaviors that are easier to describe

in more qualitative than quantitative terms. In many cases, the comment section helped to clarify individual observations. Results of the survey are very similar to other published studies using the same survey tool. More detailed studies assessing the direct impact of disruptive behaviors on human factors that affect communication flow, information transfer, and task accountability will help establish the direct cause-and-effect relationship between these variables.

CONCLUSION

As the primary portal of entry for the hospital, the ED represents the greatest potential for chaos and stress of all the departments in the hospital. Unscheduled appearances, acutely ill patients, limited history, and the need for communication and collaboration across multiple entities complicates the complexity and stress of the environment. Clinical staff working in the ED are under constant pressure to assemble all the parts to provide best patient care. Team communication and collaboration is essential to success. Assessing the impact of disruptive behaviors and implementing effective strategies that can reduce the incidence of such events or minimize both the short-term and long-term consequences of such events is in the best interest of all those who provide and receive medical care. Increasing provider awareness as to the consequences of disruptive behaviors and providing user-friendly education, tools, and techniques that promote effective communication and collaboration is the way to go.

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ARTICLE SUMMARY

1. Why is this topic important?

Disruptive behaviors have been shown to have an adverse impact on staff relationships, communication efficiency, information transfer, and team collaboration, which can lead to compromises in patient safety and quality of care.

2. What does this study attempt to show?

A multi-hospital survey was conducted to assess the frequency and impact of disruptive behaviors in the Emergency Department (ED) to evaluate the frequency, types, causes, and impact of disruptive behaviors on patient care in the ED setting.

3. What are the key findings?

Fifty-seven percent of the respondents reported witnessing disruptive behaviors by ED physicians; 52% of the respondents reported witnessing disruptive behaviors by nurses; 13% of the respondents reported that they were aware of an adverse event resulting from an incident involving disruptive behaviors. Multiple comments from the survey respondents provided specific examples of disruptive events causing compromises in patient care.

4. How is patient care impacted?

Disruptive behaviors can adversely affect staff interaction and communication, information transfer, team collaboration, and task accountability, which can lead to compromises in patient safety and clinical quality.