Causes and impacts of disruptive behavior (db) in healthcare

Introduction

Persons may be fascinated to study and work in the nursing occupation because it is trustworthy and esteemed; though, the reputation of nursing is at risk as nurses are vulnerable to violence at their work more than other professions (Carter 2000 cited in Norris 2003). Indeed, nursing profession is four times more dangerous than most other careers (Gallant, R 2008). Nurses deliver care for displeased patients and families, whether they are mentally or emotionally ill, or they are offenders. They also need to deal with staffs and other healthcare members within the organization who evoke distress and nervousness. Lateral violence (LV) in health organizations has come to be so widespread and troublesome that it has gained the concern of the policy makers, managers and the healthcare organizations.

During the past years LV has gained special attention in organization research. According to National Council on Compensation Insurance (NCCI) in 2006, 60% of workplace assaults are presented and intensified in health organizations, social facilities, and personal care employments. Investigators have reported alarming findings about the negative consequences related to disruptive behavior (DB) for the individuals, the health organizations, and the patients. As for the impacts on the organization, DB has been reported to be associated with higher turnover and intent to quit the organization, higher absenteeism, and decreased commitment and productivity (Hoel, Einarsen & Cooper 2003). In addition, victim bullying has been reported to experience stress, job dissatisfaction, psychological and physical illness, and possible expulsion from the Job (Hoel & Cooper 2000, Keashly & Jagatic 2003 cited in

Hoel et al. 2003, Vartia 2001) while patient bullying has been reported to result in reduced safety and quality of care (reference).

Although LV is considered a global epidemic (International council of nursing (ICN) (2007) and has long been a concern among healthcare providers, it has frequently gone uninhibited, or even pernicious, accepted as part of the organization. Thus, leaving these behaviors unaddressed, health organization quietly maintained and reinforced them. Fortunately, DB has lately come under better scrutiny. The American Medical Association (AMA) (2002) has commented: " Personal conduct, whether verbal or physical, that affects or that potentially may affect patient care negatively constitutes DBs. The American Association of Critical Care Nurses (AACN) in 2005 has noted that the presence of DB is negatively impacting the collaboration among healthcare workers, which is principal to instituting and supporting a productive work environment. Furthermore, Alspach (2007) stated that LV in nursing is insidious, costly, disgusting and affects patient care. These behaviors urge TJC in 2008 to warrant the healthcare organizations of the safety risk caused by intimidating behaviors and asked them to increase their awareness of the individuals and organizational risk resulting from these behaviors.

Those exposed to DB can live through stress, frustration, and psychomatic disorders. Sadly, Griffin (2004) found that 60 % of newly appointed nurses quit their work within six months of service upon exposure to LV, 20% leave the nursing profession forever. While, Veltman (2007) stated that DBs pushed the nurses to leave a particular job, and this drain on resources further affect patient care. In order to address this threat TJC (2009)

introduced a leadership standard requiring that facilities looking for accreditation must formulate policies to tackle DBs in healthcare organizations.

Now all Healthcare givers should be charged with understanding and addressing this needed culture change within health organizations. In this paper, the causes and impacts of DB for both patients and healthcare workers will be reviewed. Strategies to address and combat DBs among healthcare givers will be discussed. LV, DB and bullying are the terms that I will be using throughout this assignment.

Laying the foundation

Several terms have been used in nursing research to describe the negative behaviors of nurses in health services. These include LV, bullying, relational aggression, intimidation, horizontal hostility, horizontal violence, sabotage, verbal abuse, psychological abuse, oppression and interactive workplace trauma. (Alspach 2007, Dellasega 2009, Longo & Sherman 2007, Lutgen-Sandivk 2007, Rocker 2008, Rowell 2005, Rosenstein & O'Daniel 2008, Stanley 2007, The Joint Commission(TJC) 2008) . Griffin (2004) identified the most common ten features of DB in the nursing literature (Duffy1995; Farrell1997, 1999, McCall 1996, cited in Stanley 2007): non-verbal innuendo, verbal affront, undermining activities, withholding information, sabotage, infighting, scapegoating, backstabbing, failure to respect privacy, and broken confidences. These kinds of DBs may be perpetuated by healthcare providers, patients or their families.

High jobs pressure such as nursing tends to create stresses that are often released when further stressors are added. The discharge of the unbearable stress can result in LV. Irrespective of the initiating stress, no one merits to be abused. When LV erupts, everyone is influenced (Rowel 2010). Some researchers argued that nurses are an oppressed group who intern contributes to the oppressive behaviors indicative of LV (Stanley et al. 2007). Moreover, oppression, vulgarity, and sexual harassment are key elements of LV (Lutgen-Sandivk 2006). But these issues are not the only means that DB may manifest itself in personal communications. Norris (2010) added that hostility may take the form of apparent detesting, patronizing language, annoyance with questions from neophyte nurses or unlicensed employees, disparaging, impoliteness, concealing information, and even temper tantrums.

DB is used to depict the workplace negative behaviors that may affect the health status of patient (TJC 2008). Dellasega (2009) refers LV to the act of intimidating, degrading that result in physical, psychological or emotional injury on a colleague or group while Rosenstein and Q'Daniel (2008) described LV as any unsuitable conduct, conflict, or confrontation ranging from verbal abuse to bodily or sexual harassment. According to Piper (2003) DB is any aggressive behavior that may endanger the stability of patient, unit, and the ability of the organization to achieve its mission. The ICN (2007) defined bullying as a behavior that dishonors, demeans, or otherwise shows disrespect for the dignity and value of an individual. Habitually, the fundamental cause of DP turns around " communication mishaps" (Ratner 2006, cited in Rowel 2010) or intentional obnoxious behaviors.

Sheridan-Leos (2008) stated that the term LV has been used for more than 25 years in the nursing literature and described it as an act of antagonism that occurs between nursing colleagues within an organizational hierarchy. DB may be obvious or subtle. Farrell (2001, cited by Leiper 2005) uses the terms active or passive to categorize DP while the TJC uses the terms overt or covert. Active or overt actions range from intimidating body language designed to discomfort another or others to overtly criticizing a colleague in the presence of others, shouting at others and even physical attack (Leiper 2005, Longo & Sherman 2007). Passive, covert aggression may take the form of gossiping, cover-up information needed to perform the job, or demonstrating unhelpful approaches during routine doings.

Griffin (2004) found that many experienced nurses are not acquainted with the term LV and thought new nurses were making up the term. Likewise, many forms of DB may be so delicate that certain actions are considered nothing more than a personality conflict between two persons. Jackson (2002) contends that DB is an axiomatic phenomenon in health organizations and is recognized by many organizational cultures as a part of doing business. However, when asked precisely about personal experiences with DB, most healthcare providers confess that they know it when they see it, and many acknowledge exposure to some sort of experience with it during their professional life (Alspach, 2007). Owing to the seriousness and continuity of the side effects of LV on patient outcomes, a great attention has been paid to this topic in the literature. Here are some examples of reported cases:

In a study conducted by the joint program and reported by the international council of nurses (ICN) (2007). Researchers found that the most common forms of LV are Verbal abuse, bullying and sexual harassment where verbal abuse ranks the highest among them. Verbal abuse had been experienced by 39. 5% in Brazil, 32. 2% in Bulgaria, in Portugal, 52% in the health center complex and 27. 4%in the hospitals, 40. 9% in Lebanon, and up to 67% in Australia. Additionally, bullying has been suffered by 30. 9% in Bulgaria, 20. 6% in South Africa, 10. 7% in Thailand, in Portugal , 23% in the health center complex and 16. 5% in the hospital, 22. 1% in Lebanon, 10. 5% in Australia and 15. 2% in Brazil. Furthermore, sexual harassment impacted 64% in India, 90% in Israel and 56% in Japan, 69% for the UK, 48% in Ireland and 76% in the US.

The Institute of Safe Medication Practice (ISMP) surveyed over 2000 healthcare providers in 2004 including nurses (1565), pharmacists (354), and others (176) and reported that 88% of the surveyed staff suffered bullying by other workers in the form of haughty language or voice intonation. 87% felt impatience when questioned and 79% were unwilling or refuse to respond to questions or telephone calls.

The Nursing journal website (2006) asked guests " in the last 6 months have you observed any nurse dealing inappropriately with others?" 55% of all visitors claimed yes. This was demonstrated by a survey administered in 2007 to 663 nurses; 46% informed that LV was " very serious" or " somewhat serious" issue in their healthcare area and 65% reported witnessing DB repeatedly (Stanley 2007).

Ulrich (2006) surveyed 4000 nurses; 18% reported verbal abuse from another nurse, while 25% of all participants rated the quality of teamwork and communication with other nurses as fair or poor.

A minor study in Boston (2001) involving 26 new graduate nurses reported that 96% of respondents had seen LV during their first year of work, 46% stated that the act was against them. Acts of LV included being set them up to fail with an " unreasonable assignment", sabotage, undermining, or not being available (Griffin 2004).

According to a survey written by the Workplace Bullying Institute in 2010 and commissioned by Zogby International survey (2010), an estimated 35% of the U. S. workforce has been bullied at workplace; 62% of bullies are men; 58% of targets are women, 68%of bullying is same-gender harassment; an additional 15% witness it. Half of all Americans have directly experienced it. Simultaneously, 50% of targets and witnesses never report the incident (silent epidemic).

Leymann's (1993, cited in Einarsen1999) asserts that four elements are noticeable in prompting bullying at workplace: (1) lacks of work design, (2) deficits in leadership performance, (3) a socially visible status of the victim, and (4) reduced ethical standards in the working department. Einarsen et al. (2003) designed a workplace bullying framework; which gives an overview of how factors on different levels may interact at different stages in the multifaceted bullying process. This framework calls the attention not only to individual factors (in victims and perpetrators) but also to contextual, organizational and social factors. Salin (2003b) adapted this framework (Fig.

2), which builds and argues a planned adjustment of the framework by constructing on organizational factors of intimidation and its tolerance/intolerance by using terms such as ' enabling/disabling' factors (Fig. 3).

The Problem

A survey conducted by TJC (2008) involving 4350 healthcare providers revealed that 77% witnessed DP by doctors and 65% by nurses. These behaviors are frequently demonstrated by professionals in positions of power and include unwillingness or rejection to answer questions; return telephone calls or pagers; patronizing language or voice intonation, and impatience with questions.

In response to these events, TJC (2008) issued a patient safety alert affirming that the existence of threatening and unapproachable behaviors weakens the effectiveness of teamwork, erodes professional behaviors, and creates an unhealthy work environment". This sort of toxic environment can lead to malpractice risk (Rosenstein and O'Daniel 2005, Morrissey 2003, ISMP 2008), patient dissatisfaction and to preventable adverse outcomes, (Rosenstein and O'Daniel 2005, Gerardi 2008, Ransom and Neff et al 2000), increase cost of care, (Gerardi 2008, Ransom and Neff et al 2000) and causes competent clinicians, administrators and managers to look for new workplaces in more professional settings. Lutgen-Sandvik (2009) stated that nurses employed in a toxic, threatening environment often dread going to work and many face the day with feelings of " impending doom". Recurrent exposure to bullying headed some nurses to retreat into silence, which led to

disruption in communication and teamwork. Furthermore, continuous bullying may alter nurses' self-confidence, initiativity and innovation resulting in psychological and occupational impairment (WBI 2003). All of these factors combine their effects to disrupt the stability of employees, the organization, and the patient's safety.

Unfortunately, there is no research study in the United Arab Emirates (UAE) handling the issues of LV except for a minor one conducted in Saqr Hospital in Ras Al Khaimah. The executive director stated that DB by physicians, including Sexual harassment and verbal abuse is a major cause of nurses' stress and dissatisfaction at the hospital. Such abuse pushes the nurses to turnover (Zain 2010). Moreover, unhealthy nurses-physicians rapport and authority abuse by the doctors have contributed to nurse turnover in the UAE (khaleej, T 2009). The absence of studies involving the whole emirates does not mean that the problem does not exist. Based on my observation as part of the healthcare system, many nurses especially Asians suffer from different kinds of hostility from physicians, superiors, peers, patients and their families in their work. This hostility take the form of shouting, oral degrading expressions, oral ironic remarks, raised eyebrow, unflattering face gestures, apparent detesting, and sexual harassment.

Literature Review

History

The notion of LV is not a new phenomenon. Horty (1985, cited by Piper 2003) defined the disruptive doctor as " as a very clinically competent to the extent of considering himself as the most experienced in the healthcare

organization. The troublesome physician is naturally very tough to contact and hence argumentative and antagonistic. In the 1990s, DBs by doctors began to be labeled in the literature as a form of physician impairment (Piper 2003). Gawande (2000) revealed in his article " When Good Doctors Go Bad" how the medical community was not set to suitably address physician's DB. Rosenstein et al. (2002) found out that lack of physician awareness, appreciation, value, and respect for nurses were serving to fuel the countrywide nursing shortage, profoundly impacting job satisfaction and morale for nurses. So what motivates TJC to ask the medical community to act against violence after two decades? Researchers agree that two milestone matters brought the dispute of LV to the front (Lutgen-Sandivk 2007, Rocker 2008, Rosenstein & O'Daniel 2008, Seidel, 2006).

The Institute of Medicine (IOM) published in 1999, To Err is Human. The report determined that medical errors cause between 44, 000-98000 deaths yearly- more than result from vehicle accidents, breast cancer or AIDS (Baker 2009). The report emphasized the necessity to consider organizational resources and human factors that harmfully influenced patient care (Rosenstein & O'Daniel 2008).

The risk of a nursing shortage. Aiken et al. (2001) found in his global study in a sample of 43, 329 nurses that job dissatisfaction was highest in the USA (41%) followed by Scotland (38%), England (36%), Canada (33%) and Germany (17%). More striking, however, was that 27-54% of nurses less than 30 years of age intended to quit within 12 months of data collection in all countries.

The U. S. A had a shortage of 150, 000 nurses and that number is expected to reach 800, 000 by the year 2020 (Childers 2005). Consequently, the nurses will be incapable to meet the forthcoming patients' needs if this continues. One reason of turnover is the frustration caused by DBs.

Rosenstein et al. (2002) noted that nurse-physician relationship is the key element for retaining nurses. Rosenstein surveyed 2562 from 142 hospitals from 11 Voluntary Hospital Association regions. The sample included 389 physicians, 1615 nurses and 104 senior level executives. More than 90% informed witnessing DB by physician and over 33% of nurses tend to turnover. Using a scale of 1-10 to identify the level of nurse's satisfaction and moral; LV ranks pretty high (8. 01)

Figure 4

Theoretical Framework

Rowell (2010) suggested five theories about LV. (See Appendix I).

Causes of LV

Physicians related

Several researchers stated that the physician's training at the hospitals make them vulnerable to DB (Kuhn 2006, Rosenstein & O'Daniel, 2008). During their training; doctors learned to think individualistically and to become accountable for their activities. This mentality promotes self-reliance, self-sufficiency and an " autocratic", bullying conduct which is the antithesis of teamwork (Rosenstein et al. 2002). According to Kuhn (2006),

the absence of quality control starting in university and it is nearly difficult to be fired from internship. This leads the physicians to see themselves as the so-called " captain of the ship" but possibly do not have the necessary skills to keep it right. This also produces a hierarchal model of healthcare which builds passive roles for nurses and other subordinates (Rosenstein &O'Daniel 2008)

Piper (2003) found that DB is usually demonstrated by excellent clinicians who are accepted by their patients and the society. As they habitually have a notable record of accomplishments; victims may be unwilling to intervene considering the behavior as an exceptional one. Moreover, Piper stated that hospital managers who are supposed to implement the policies are confronted with the challenge of whether to ignore the behavior, or take a difficult decision of firing a great physician who shows too much enthusiasm.

According to Rosenstein & O'Daniel (2008) some hospital directors are disinclined from averting the aggressive attitudes of the physicians because they are not hospital employees and willingly admit their patients to the hospital and thus considered a source of organizational income.

Growing external forces such as governmental supervision, pressures for more productivity, managed care restrictions, lower payment, and increasing liability risk cause disruptive physician behavior (Rosenstein et al. 2002). Practicing physicians are overwhelmed with paperwork. As a result, demoralization, and anger will develop leading to oppressive conducts. Another likely cause is the stress inherent in today's medical environment

such as mental exhaustion and environmental stressors experienced by physicians lead them to commit medical errors (Kuhn 2006).

Staff related

The oppression theory will be applied to understand the nurse-to-nurse aggression. Healthcare institutions are controlled by the administrators and physicians who use their authority to rule subordinates. It is obvious that when any oppressed group recognizes that it is not possible to direct its power upward, the group then places their powerlessness and frustration on one another. These peer-to-peer hostilities, which reduce self-esteem, are called LV (Sheriden-Leos2008, Griffin 2004, Leiper 2005). Dunn (2003) confirmed in a study involving 500 nurses in the operating theater that the great numbers of nurses were verbally attacked by the surgeons. This sort of offensive abuse led the oppressed group to develop personal characteristic such as disunity and inability to oppose the physicians because of their positions, authority and ability to revenge from the nurses. Rowell (2005) estimated that 81% of oppressors are bosses, 14% peers, and 5% lower rank staff. Referring to Griffin (2004) this form of oppression causes the nurses to feel helpless, disrespected and self-loathing. Stanley and Martin (2007) have suggested an applied model of oppressed group behavior to demonstrate how LV seems to manifest itself in the workstation (Fig. 4). It also useful in predicting nurses' retention and satisfaction.

Gender is another factor. Many studies revealed that females are more susceptible to LV than males. Dunn (2003) rationalized that women tend to suppress their feelings of bitterness. In addition, women are habitually

considered inferior to men within society in general and healthcare organization in specific. Accordingly, it is not astonishing to see recurrent acts of sabotage in the nursing as 90% of nurses are females. Leiper (2005) has a parallel opinion and said that females generally underestimate their efforts and have lesser self-esteem than males so they can be irritated more easily and have a predisposition to yell at others. Dellasega (2009) concluded that males express their anger more frequent with bodily violence and this is usually accepted and women exhibited it through character insult, mortification, disloyalty and rejection.

ISMP (2004) surveyed 2095 nurses (86% female and 14 % male) and found that DB was nearly equal. Thomas (2003) agrees with this finding.

Not all Researchers support the oppression theory as the mechanism for DBs. Ratner (2006) view the oppression theory as condescending to nurses, making them appear as the powerless victim. Another standpoint suggests that organizational cultures, sustained struggles for authority, inconsistent work standards and management styles results in LV (Hallberg 2007). Further organizational causes include shortage, work overload, lack of administrative support, relations among groups, and organizational reform (Rocker 2008).

Patient/Family related

Patient or family members with a history of DB should be considered at high risk for becoming violent. Violence results from those who are frustrated, rampant, mentally ill, and substance abuser.

Finally, LV is not frequently reported by victims and therefore run unaddressed. Fear of revenge, the stigma related to " blowing the whistle" on a peer, a wide-ranging averseness to oppose an oppressor (TJC 2008), the status quo, lack of confidentiality, lack of administrative support, and lack of awareness or reluctance among doctors to change inhibit the reporting (Rosenstein et al. 2002). Similar to other kinds of mistreatment, staff violence is repeatedly viewed as an isolated matter and individuals are occasionally unwilling to talk about it (Gammons 2006). On several occasions, LV is not informed because it isn't identified. Some practitioners doubt that bullying has happened except when somebody shouts or uses attacking language (Beyea 2004).

Forms and Manifestations OF LV: (see Appendix II)

Effects of LV on: Nursing workforce, Organization and Patient

The Nursing workforce

Defamation of professional dignity, stress, anxiety, frustration, and anger (Rosenstein & O'Daniel 2008), sleeping disorders, reduced self-esteem, low morale, disconnectedness from their colleagues, depression, apathy, and excessive sick leave (Alspach 2007, Longo & Sherman 2007), Suicide attempt (Griffin, 2004). According to the WBI, 45% of respondents had stress-related health problems which include debilitating anxiety, panic attacks, clinical depression (39%), and even post-traumatic stress.

Not astonishingly, the adverse effects of LV are not only restricted to the targets. Co-workers witnessing LV report stress and job dissatisfaction.

Witnesses who never report are confused how to stop assailant. Unluckily, their silence often leads them to despair and turnover (Lutgen-Sandvik 2007).

Healthcare Organization

Manifestations include: increased patient illnesses, increased healthcare costs, unplanned absences, law suits (Rowell 2005), malpractice risks (TJC 2008) and turnover (Rosenstein & Q'Daniel 2008, Griffin 2004). Rocker (2008) states that between one third and one half of all work related absences and illnesses are a result of office bullying. According Yamada (2009) some victims pursue compensation or disability benefits as they are no more able to endure work stress and intimidation.

Along with Stanley (2010) the overall increase in nurses' turnover induced by LV from 2002 to 2007 is 32%. Turnover costs the organization per RN for 2007 $82, 000 – 88, 000. Additional costs are decreased productivity and loss of experienced and knowledgeable nurses.

Malpractice of physicians and other healthcare providers, which is estimated at 4-6%, has a vast impact on organizational costs. Patients and families detect aggressive work environments (TJC 2008) and are ready to sue when they are faced with arrogant or insensitive behavior from healthcare workers (Aleccia 2008 as cited by TJC 2008).

The Patient

Rosenstein (2008) surveyed 4530 participants from 102 USA organizations from 2004-2007. The survey questions were intended to assess the

respondent's perception of the link between DB and patient care. The links were as follow: 66% adverse events, 71% medical errors, 53% compromises in safety, 72% detrimental impacts on quality of care, 25% patient mortality, 18% were aware of a specific adverse event, 75% of them believe that the adverse event could have been prevented. According to Dunn (2003) some nurses may control patients by putting off their response to the patient's needs- pain medicines, etc. Displeased nurses can also keep patient's family uninformed about the patient's health status or not support them when needed. Stanley (2010) reported that 1. 5 million patients are harmed by medication errors yearly.

DISCUSSION

In today's sophisticated healthcare setting, each system brings particular skills to patient's care. Whether the clinician is a nurse, or any other healthcare workers; each has a unique set of expertise and acquaintance that enable them to view the patient from a particular standpoint. Each field is taking care of the patient at distinctive times and intervals of the day. The doctor visits the patient one or two times a day for 15-20 minutes whereas the nurse employs several successive hours bedside his patient. Therefore, the nurse is the first one who detects and attends the alteration in patient's status, not the physician. The patient and the efficacy of the healthcare team are dependent on each other to thoroughly and assertively communicate the changes in the health status of the patient. Unhappily; DB hinders this communication process which affects patient's outcomes.

It is of merit to mention that the international picture of LV is no difference from UAE. I have been working in the clinical setting for 16 years in different hospitals as a nurse and in a health institution as a teacher and clinical instructor. I have been exposed to and witnessed many episodes of Dbs. For example, I remember a situation when the head nurse asked the Surgeon whether he wants to start the patient on diet or continue keeping him nothing by mouth. The doctor replied in an offensive manner; give him " Shoes". The head nurse asked him to write this in the " order sheet". Sadly but true, the doctor did it without giving consideration to anything. The nurses felt that they were disrespected and were frustrated because of the recurrent response from the administration when DB is reported as " status quo". That instance happened before 9 years but this troublesome situation impacted my psychological status that I recall it as if it occurred yesterday. Another incident, Though I do not like to recall it, but its profound effect keeps it all the time in my imagination when the nurse came to the nursing counter crying once an aged patient got the money from his pocket and asked her to satiate his sexual desire.

Furthermore, nurse on nurse aggression is also clear and take different forms ranging from verbal and non-verbal attack such as intentional rolling of eyes, folding arms, gazing into space when communication is being attempted, backbiting, withholding information...etc. to physical assault such as pushing each other. These DB extended also to the patient particularly the dependent and the unconscious patients who were insulted either by bad words or inappropriate care. The negative effect of these DBs was manifested by medical errors, reduced patient safety and care, decreased

performance and productivity, frustration, dissatisfaction, turnover, and poor hospital reputation.

Although these are merely anecdotal notes, there are comparable events recognized in the research. Rosenstein & O'Daniel (2006) presented selected comments acquired from a survey of 4530 healthcare providers. They include terms such as " RN did not call doctor about change in patient's health status because the doctor had a history of abusive behavior" and " particular surgeons give the impression that they have the right to be impolite and verbally offensive. It is hard to maintain a high level of performance when repetitively scared of being yelled at" (Rosenstein & O'Daniel2006).

Unhappily, DB is not solely restricted to doctors. Rosenstein's survey data supports the issue that DB spread to other non-physicians employees. Remarks include; " DB from nurses is much more upsetting. I expect it from the surgeons but not from my peers" and " please realize that most stress is from RN managers, not MD's". According to Rosenstein & O'Daniel (2008), the most common situation that triggered DP by doctors, as conveyed by nurses, was calling physicians to report a decline in the patient's condition. This shows a failure in communication that ought to bring dreadful results on the patient. For instance, if the physician's order is inaccurate or not clear. The nurse many not carry out the order until clarified by doctor. If the nurse is anxious about making a telephone to the doctor due to fear of an annoyed eruption, she might postpone the call or make another work around by evading the doctor entirely and including another party. If there is inaccurate order of medicine, this situation can be revealed in various ways, all with

awful outcomes for the patient. Primarily, the issue will not be verbalized as the practitioner did not desire to confront the stellar reputation of the doctor or because they were demoralized by previous behavior (ISMP 2008). Consequently, the incorrect medicine will be given. If the nurse calls the doctor and feels that the physician is irritated, the incorrect medicine can still be given and secondary repercussions such as being unable to correct the order in the future can result. Unfortunately, several nursing staff has to live with the guilt of a serious error because they did not follow up on a questioned situation (ISMP 2008). The negative outcomes of such an error can result in stress and frustration for all involved and thus can bring about DB.

Limitations

Workplace LV is a complicated issue. A diversity of expressions is used to reveal similar behaviors . Although they possess distinctive meanings, the terms are frequently used interchangeably in the nursing literature. There are also a many workplace abuse that might be categorized as DB.

First, the paper has focus merely on psychological and/or verbal abuse and not physical or sexual harassment. Second, the majority of literature focuses on LV in nursing profession in particular and to a certain degree