Workplace Bullying and Emotional Exhaustion among Registered Nurses and Non-nursing, Unit-based Staff

A Senior Honors Thesis Presented in Partial Fulfillment of the Requirements for the Degree of Bachelor of Science in Nursing with Distinction

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Chapter 1

Introduction

Workplace bullying is a significant problem for nurses in the hospital. In a recent sentinel event alert, the Joint Commission (JC) recognized the severity of workplace bullying, publicizing several negative consequences that can stem from bullying behavior. The hostility that stems from workplace bullying among nurses can contribute to medical errors, poor patient satisfaction, and increased healthcare costs. Studies have shown that there is also a correlation between nursing retention rates and workplace bullying on a hospital unit (JC, 2008). There are many negative actions that are considered to be bullying behavior. Verbal abuse, threats, humiliation, intimidation, and behaviors that interfere with job performance are all considered workplace bullying (Einarsen & Hoel, 2001). Bullying includes accusations of incompetence despite a history of excellence in the area of practice, gossiping about co-workers, withholding information pertinent to patient care, constant feelings of stress and fear of additional bullying events, being told by a supervisor to "get tougher skin" or "work out your differences" when approached about bullying, and screaming or yelling at a fellow worker in front of others to make him/her look bad (Murray, 2009). These behaviors, among other negative actions in the workplace, can all lead to demoralization and victimization in the individual suffering from bullying behavior (Longo & Sherman, 2007).

While many research studies have shown that workplace bullying exists, there is very little information about what precipitates this hostility among nurses. Some researchers hypothesize that nurses are an "oppressed group" in the hospital setting, and they predict that

horizontal hostility is a result of oppressed group behavior (Hutchinson, Wilkes, Vickers, & Jackson, 2008). However, while the oppressed group model is a good theory for the origins of workplace bullying, very few studies have been done to support this hypothesis. Workplace bullying could also be attributed to organizational features and job stress (Hutchinson et al., 2008).

This study examined the incidence of workplace bullying at two Midwestern academic healthcare institutions and to determine if there is a relationship between emotional exhaustion among nurses and other hospital staff and the incidence of workplace bullying on a designated hospital unit. The goal of this study was to further describe negative behaviors among healthcare professionals that contribute to workplace bullying and hostility among healthcare workers.

Specific Aims

1.) Describe the incidence of workplace bullying on 7 inpatient nursing units at 2 large Midwestern academic medical centers.
2.) Determine if there are differing experiences of workplace bullying by sex, race, hospital, years of experience in the profession, years of experience on the current unit, clinical specialty, and job title.
3.) Determine if there is a relationship between prevalence of emotional exhaustion among staff and the incidence of workplace bullying on an inpatient unit.

Chapter II

Literature Review

Workplace bullying in the healthcare profession has been recognized as a problem for healthcare organizations since the 1980's (Quine, 2002). There is a growing body of research done internationally on workplace bullying in countries including Australia, New Zealand, the United Kingdom, Ireland, Japan, Turkey and the United States of America (Farrell, 1997; Johnson, 2009; Quine, 2002). Because the concept of being bullied is subjective in nature and is based on how one perceives the situation, there have been some discrepancies in the definition of workplace bullying. In many studies, the term workplace bullying has been used synonymously with the term horizontal hostility. Horizontal hostility is defined as bullying behavior among peers or co-workers on the same status within an organization (Johnson & Rea, 2009) while workplace bullying encompasses all forms of negative actions among co-workers, regardless of hierarchal structure (Johnson & Rea, 2009). Therefore, the term workplace bullying is inclusive to all members of a healthcare team. The Joint Commission recognizes workplace bullying as a sentinel event and defines some common bullying behaviors among nurses as verbal outbursts, physical threats, reluctance or refusal to answer another nurse's question, uncooperative attitudes among a healthcare team, and condescending language or voice intonation (JC, 2008). Aggression towards nurses in the workplace can come from several sources including patients, doctors, administrators, nurse managers, or other nurses.

In an Australian study on workplace aggression among nurses, nurses found intra-staff aggression, and aggression towards nurses from nurses, to be the most distressing. (Farrell 1997) Nurses questioned about bullying recognized both negative physical and verbal actions as

components of bullying whether executed in an active or passive manner by the bully (Farrell, 1997). Johnson (2009) concludes that while it can be difficult to discern workplace bullying from simple conflicts in the workplace environment, workplace bullying is more severe because the conflict is perpetual and never resolved. A victim of workplace bullying experiences at least two negative acts a week for a minimum of six months (Johnson & Rea, 2009).

Workplace Bullying: A Problem for Nurses and Other Non-Nursing Unit-Based Staff

A high prevalence of workplace bullying in various healthcare organizations has been demonstrated in several studies. In a study including nurses from Massachusetts, 31% of the respondents reported incidents of bullying (Simons, 2008). In a survey completed by members of the Washington State Emergency Nurses Association, 27% of the respondents had experienced acts of bullying in the past 6 months (Johnson, 2009). Another study analyzing the prevalence of disruptive behavior among healthcare professionals in 50 Veterans Hospitals Associations found that 86% of nurses witnessed disruptive behavior from physicians, and 72% had witnessed disruptive behavior among nurses (Rosenstein & O'Daniel, 2005). While the prevalence of workplace bullying varies across studies, it is a definite problem experienced by all types of employees working in a healthcare organization.

Workplace bullying can result in negative outcomes for nurses on a personal level, and impact negatively on patients and the healthcare system. Nurses who have been bullied have reported symptoms including weight loss or gain, hypertension, cardiac palpitations, gastrointestinal disorders, headache, insomnia, and chronic fatigue (Bigony, Lipke, Lundberg, McGraw, Pagac, & Rogers, 2009). Those who experience workplace bullying report negative psychological effects as well including higher stress levels, low self-esteem, anxiety, depression,

and suicidal ideation (Johnson & Rea, 2009; Quine, 2002). In a British study, 25 percent of nurses indicated that they felt workplace bullying affected their physical health (Quine, 2001).

Studies have shown that nurses are less likely to perform at their best skill level in stressful situations perpetuated by workplace bullying (Farrell, 1997). In effect, workplace bullying can lead to medication errors, unsafe patient care and adverse patient outcomes (JC, 2008). In a study by The Institute for Safe Medication Practices (ISMP), survey respondents indicated a widespread impact of negative workplace behaviors on medication errors. Nearly half of the participants claimed that intimidating behaviors impacted the way they administered medications in an unsafe manner. Even more striking is that approximately 7 percent of participants indicated they had committed a medication error due to circumstances surrounding bullying actions (ISMP, 2004). Another study found that 54% of nurses believed that workplace bullying affected patient safety; 25% of nurses in the same sample perceived bullying to affect patient mortality (Rosenstein & O'Daniel, 2005).

Workplace bullying can produce decreased job satisfaction, increased job stress, and increased absenteeism among nurses, having negative effects on nurse retention rates and a nurse's intention to leave an organization. (JC, 2008; Johnson, 2009; Kivimakil, Elovainio, & Vahtera, 2000; Quine, 2002). This is a large problem in light of the nursing shortage.

Potential Causes of Workplace Bullying

While it is clear that workplace bullying is prevalent among nurses, and serious implications can result from this problem. A popular theory of workplace bullying is the oppressed group theory which attributes workplace hostility and aggression as a defense mechanism among a group of social equals that are also part of an oppressed group (Johnson,

2009; Simons, 2008). In this model, colleagues on the same level of an organization experience aggression from members higher in the organizational hierarchy, and as a result of low self esteem and poor group identity they direct abusive behavior towards one another (Hutchinson et al., 2008). In support of this theory, a study that found a high prevalence of workplace bullying among junior doctors determined that junior doctors belonging to minority ethnic groups and women experienced high incidences of workplace bullying compared to white men (Quine, 2002). Other researchers claim that workplace bullying is caused by organizational factors such as tolerance of bullying behavior, misuse of authority, and the lack of organizational policies and procedures for addressing workplace bullying (Hutchinson, Vickers, Jackson, & Wilkes, 2006; Johnson, 2009). It is important to determine the cause(s) of workplace bullying so that appropriate interventions can be made to eliminate the problem.

Workplace Bullying Solutions

Because little research has been done on workplace bullying, an exact solution for the problem has yet to be determined (Johnson, 2009). The first step in solving the problem is awareness; by educating healthcare professionals about workplace bullying and its negative outcomes, healthcare workers can prepare themselves to decrease this behavior (Bigony et al., 2009; JC, 2008; Johnson, 2009; Johnson & Rea, 2009; Rosenstein & O'Daniel, 2005). In one study, Stevens (2002) organized an in-depth focus group about workplace bullying for healthcare workers followed by an educational workshop for nursing managers and supervisors. After the intervention, job retention rates increased by 6 percent within the healthcare institution. Healthcare organizations should also conduct an assessment of their employees to determine the prevalence of the problem on different nursing units (Rosenstein & O'Daniel, 2005). Currently, JC requires healthcare organizations to define acceptable and disruptive behaviors in their codes

of conduct and to create and implement a process to manage inappropriate behaviors (JC, 2008). More specific solutions for workplace bullying can be found by determining the special cause(s) of the problem.

Burnout

Burnout is, "a syndrome of emotional exhaustion and cynicism that occurs frequently among individuals who do 'people work' of some kind" (Maslach & Jackson, 1981). Nurses invest physical, psychological, and social energy in caring for their patients, predisposing them to experiencing burnout. The prevalence of burnout is associated with decreased quality of patient care, absenteeism on a unit, low morale, and increased job turnover (Maslach et al., 1981). Because burnout can result in increased job stress and dissatisfaction for a nurse, it is possible that burnout may be associated with workplace bullying on a hospital unit.

Chapter III

Methods

The primary purpose of this study was to examine the incidence of workplace bullying in two large academic medical centers and determine if a relationship exists between workplace bullying and emotional exhaustion. The research questions were:

1.) What is the incidence of workplace bullying on 7 inpatient units among 2 Midwestern academic medical centers?
2.) Does the incidence of workplace bullying vary by hospital, sex, race, years of experience in the profession, years of experience on the current unit, clinical specialty, and/or job title?
3.) Is there a relationship between the prevalence of emotional exhaustion among staff and the incidence of workplace bullying on an inpatient unit?

Study Design

This was a cross-sectional correlational research design using a 54-item survey.

Sample and Settings

This was a convenience sample which included volunteer registered nurses (RNs), licensed practical nurses (LPNs), health unit coordinators/unit clerks, patient care assistants, surgical technicians and service technicians that work on the respective nursing units. A total of seven units were selected at two academic medical center. The units at both medical centers were selected based upon recommendations from the Clinical Directors of each Institute at medical

center B and the Chief Nursing Officer at medical center A. Job titles were selected on the basis that all of the above professions report to the nurse managers on the respective inpatient units. The sample for this study in hospital A included RNs (n=71), unit clerks (n=3), patient care assistants (n=13), and surgical/perioperative technologists (n=30). In hospital B, participants included RNs (n=91), LPNs (n=1), health unit coordinators (n=9), patient care nursing assistants (n=12), and surgical equipment technicians (n=63). A total of 6 people chose not to share their job title. Thus, the total sample included 299 individuals: 119 from Hospital A and 180 from Hospital B.

At medical center A, nurses and unit-based non-RN staff were surveyed in the main hospital operating room (n=48), the cardiac hospital operating room (n=25), and the cardiac intensive care unit (n=46). Nurses and unit-based non-RN staff were surveyed in operating room (n=60), 2 medical units (n=64), and one surgical unit (n=55) at medical center B.

Instruments

The survey used to assess the frequency and intensity of workplace bullying and burnout among the participants on the 7 chosen inpatient units was a 54-item survey that incorporated the Negative Acts Questionnaire (NAQ), the Emotional Exhaustion subscale of the Maslach Burnout Inventory (MBI), and some additional questions. The Negative Acts Questionnaire is a standardized tool consisting of 22 questions that was originally created to measure perceived exposure to workplace bullying and harassment in any work setting (Einarsen & Hoel, 2001). In the NAQ, the respondent is asked how often they have experienced 22 behaviorally defined negative acts within the last 6 months; within the NAQ, the terms “workplace bullying” or “harassment” are never used. Frequency of experiencing these negative acts is rated by the

participant as never, occasionally, monthly, weekly, or daily. The reliability and validity of the NAQ have been well established with Cronbach alpha scores ranging from .81-.92 in various research studies (Lutgen-Sandvik, Tracy, & Alberts, 2007; Mikkelsen & Einarsen, 2001; Salin, 2001).

The Maslach Burnout Inventory (MBI) is a 25-item survey that has been used since 1981 to assess job burnout among employees in any work setting. It examines three areas contributing to burnout: emotional exhaustion, personal accomplishment, and depersonalization. In each area, participants are asked to evaluate both the intensity and frequency of their feelings pertaining to characteristics of burnout on a Likert scale ranging from 0 to 6. The survey has good reliability with a Cronbach alpha of 0.83 (frequency) and 0.84 (intensity). For this study, only the emotional exhaustion subscale of the MBI was used. This subscale contains 9 items relating to the intensity and frequency of feelings of emotional exhaustion. The emotional exhaustion subscale has been determined to be very reliable with Cronbach coefficient alpha scores of 0.89 (frequency) and 0.86 (intensity).

An additional 23 questions were included. Of these questions, 8 were related to demographic information about the participant. Another question explicitly asked the participant:

> "Have you been bullied at work? We define bullying as a situation where one or several individuals persistently over a period of time perceive themselves to be on the receiving end of negative actions from one or several persons, in a situation where the target of bullying has difficulty in defending him or herself against these actions. We DO NOT refer to bullying as a one-time incident,"

to measure the individual's perception of whether or not he/she had been bullied. This question was later compared to how participants responded to the NAQ. Six questions related to the

individual's experience of witnessing bullying behaviors on the hospital unit, 2 questions related to the individual's job satisfaction, and 3 questions related to perceived job stress. The remaining 4 questions pertained to patient care and workplace safety.

Procedure

Information about the study was disseminated at staff meetings. Following IRB approval at institutions A and B, the research team met with nurse managers on the inpatient units selected to participate in the study. Information about the survey was disseminated to the participants by nurse managers and the research team at staff meetings. Participants were given approximately 1 month to complete the survey at both medical centers. At hospital A, participants returned the surveys in a sealed envelope in a locked box on their respective inpatient units. Participants at hospital B completed their surveys, placed them in a preaddressed envelope, and returned them to the research team via interoffice mail.

Chapter IV

Data Analysis

After the surveys were collected, data were entered into a password protected computer and analyzed used SPSS version 17.0. Responses to the survey were analyzed using descriptive statistics and multivariate statistics.

Aim 1

The frequency, intensity, and target scores of workplace bullying were calculated using responses to the Negative Acts Questionnaire. The frequency score of bullying was calculated by adding the number of negative acts a participant experienced weekly and/or daily. Intensity of workplace bullying was calculated by adding the number of negative acts that subjects experienced more often than never. A participant was considered a "target" for workplace bullying if he/she had a frequency of 2 or greater (e.g. the subject experienced at least 2 different negative acts daily or weekly) (Lutgen-Sandvik et al., 2007).

Aim 2

The experience of workplace bullying on different demographic factors was analyzed by comparing the average frequency and intensity scores among 7 different demographic variables: race, sex, hospital, job title, years of experience in the profession, years of experience on the current unit, and clinical specialty. Average intensity scores among the 7 groups were analyzed using a one-way ANOVA with 7 factors. The average frequency scores among the different demographic groups were not normally distributed; therefore, non-parametric statistics were used to compare average frequencies among the 7 groups. For demographic groups with only 2

variables (e.g. race: black/white, sex: male/female, etc.), a Mann-Whitney test was used. A Kruskal-Wallis test was used for demographic factors with more than two variables (e.g. job title: RN/PCA/Other, years of experience: <2 years/ 2-10 years/ >10 years, etc.). Variance of bullying intensity and frequency was deemed significant for demographic factors with p scores of .050 or less.

Aim 3

The Emotional Exhaustion Subscale of the Maslach Burnout Inventory consisted of 9 questions about behaviors that characterize feelings of emotional exhaustion. Participants were asked to rate how often they experienced the job-related feelings from 0-6 (0= never, 6= daily). The numerical ratings of the 9 job-related feelings were summed together to determine an individual's score on the Emotional Exhaustion Subscale. An overall score of 0-16 is considered low, 17-26 is considered moderate, and 27 or greater is considered high emotional exhaustion (Maslach & Jackson, 1981). The relationship between participants' experience of workplace bullying and emotional exhaustion were tested by using a Pearson's product moment correlation coefficient.

Chapter V

Results

A total of 299 surveys were completed. The overall response rate for both medical centers was 33%. The response rates for each medical center and the units surveyed can be seen in Table 1. Respondents included RNs, LPNs, PCAs, unit clerks, and surgical/equipment technicians.

Aim 1

Table 2 shows the percentage of participants who claimed they experienced the 22 bullying acts defined in the NAQ daily, weekly, or monthly. The top eight bullying behaviors participants experienced were withholding of information (22.5%), being ignored (22.3%), having one's competence questioned (22%), gossiping (21.3%), humiliation (20.9%), shouting (19.2%), being excluded (19%), and having key areas of responsibility removed or replaced with trivial and/or unpleasant tasks (16.7%). The three bullying acts that nurses and unit-based non-RN staff experienced the least were physical abuse (2.4%), hinting from others that one should quit his/her job (4.7%), and being asked to meet impossible deadlines (6.8%).

Bullying experience of participants was measured by calculating their intensity and frequency scores and determining the percent of participants that were deemed targets of workplace bullying. The average number of acts that participants experienced more often than never (intensity) was 8.75. An average of 1.74 acts was experienced weekly or daily (frequency). 13.7% of participants were characterized as targets of workplace bullying, i.e., they had a frequency score of at least 2 (those who experienced at least 2 bullying acts weekly or daily).

29.8% of participants claimed they witnessed co-workers being bullied when asked, "Have you witnessed bullying of others on your hospital unit/work area during the past 6 months?" However, when asked explicitly, "Have you been bullied at work?" only 4.4% of participants indicated they had been bullied weekly or daily.

Participants who indicated they had been bullied (4.4%) were asked who they had been bullied by. Physicians and RNs working on their respective units were the most frequent culprits of negative acts. 20.4% indicated they were bullied by physicians and 19.5% answered that they had been bullied by RNs on their unit. 11.4% were bullied by "other" employees on the unit, 7.4% indicated being bullied by the nurse manager, 7.4% were bullied by patient care assistants, and 7.7% were bullied by RNs on other units. Participants who experienced workplace bullying were bullied the least by employees in other departments (2.7%), unit clerks (4.7%), and the charge nurse (5%).

Participants were asked if their experiences of workplace bullying contributed to near and/or actual errors in their patient care. 5.8% of participants had committed near or actual errors as a result of bullying behavior. When participants were asked if patient safety was compromised during the work week as a result of negative behaviors they experienced, 4.8% of respondents answered "yes."

Aim 2:

No significant differences in bullying frequency or intensity were found based on race, sex, job title, and years of experience in the profession. However, as shown in Table 3, bullying intensity varied among years of experience on a current unit ($p=.021$) and clinical specialty ($p=.050$). Nurses and other non-nursing, unit-based staff with 0-2 years of experience and 2.1-5

years of experience on their current units had lower average intensity scores, 7.62 and 9.04 respectively. Staff with 5.1-10 years and greater than 10 years of experience had higher bullying intensity scores, 11.35 and 9.46 respectively. These scores suggest that bullying experience increased for nurses and other non-nursing, unit-based staff as they spent more years working on their unit. While years of experience in the profession were not found to cause a significant variance in bullying intensity, bullying intensity did increase with experience, similar to how it increased as unit staff spent more years working on their respective units. Nurses and other non-nursing, unit-based staff with less than two years of experience had an average bullying intensity of 7.19, staff with 2-10 years of experience had an average bullying intensity of 8.88, and staff with more than 10 years of experience had the highest average bullying score of 9.67. There was a significant difference in bullying intensity by clinical specialty (OR, ICU, Medical Unit, or Surgical Unit). Staff working on the surgical unit had the highest average bullying intensity (10.40) followed closely by OR nurses and other non-nursing, unit-based staff with an average intensity score of 9.67. Staff working in the ICU and on the medical units reported the lowest average intensity scores, 8.26 and 6.26 respectively.

As seen in Table 3, bullying frequency was significant only between the two hospitals ($p= .020$). Medical Center A had an average bullying frequency of 1.97 and Medical Center B's average bullying frequency was 1.58.

Aim 3

46.8% of participants had a low emotional exhaustion score, 28.1% had a moderate score, and 22.1% had a high score on the emotional exhaustion subscale of the MBI. These results are shown in Table 4. There was a significant moderate positive correlation of $r=.55$ between

emotional exhaustion and bullying intensity score (p= .00). There was also a significant moderate positive correlation of r=.52 between emotional exhaustion and bullying frequency. This indicates a significant positive relation between the experience of workplace bullying and perceived emotional exhaustion. As emotional exhaustion increases, the experience of bullying acts increase.

Chapter VI

Discussion

The sample used in this study included both nurses and non-nursing, unit-based staff working in an inpatient, nursing unit setting. By including all personnel who work on a nursing unit and not just nurses, bullying behavior was examined from the perspective of multiple professions in healthcare. The sample included males and females, white and non-white races, and individuals with varying years of experience in their careers. It would have been beneficial if more staff with greater than 10 years of experience participated in the study so that the results could have been more comparable based on varying degrees of experience. While the sample was inclusive of all nurses and non-nursing, unit-based staff, the voluntary nature of the study impacted how representative the study was of each individual profession. The sample good numbers of registered nurses and surgical/perioperative technologists; however, the response rate from unit clerks, PCAs, and LPNs was small. The results of this study can only be applied to those specific units that were sampled; bullying behavior varies depending on the nursing unit, so it is not possible to generalize the results of this study to all nurses and other non-nursing, unit-based staff in healthcare.

The results of this study show that workplace bullying is a problem for nurses and other non-nursing, unit-based staff at the 2 academic medical centers that participated in the study. On average, participants experienced 1.74 bullying acts weekly or daily. 13.7% of participants were considered targets for workplace bullying; however, when nurses and other non-nursing, unit-based staff were asked explicitly whether or not they had been bullied in the past 6 months, only 4.4% claimed they had been bullied weekly or daily. When comparing the results to this question

with the percentage of staff who were considered targets for workplace bullying based on the scores of the Negative Acts Questionnaire, it seems that there is normalization of bullying behavior among healthcare staff. While nurses and other non-nursing, unit-based staff have identified that they experience some of the 22 negative behavioral acts defined by the NAQ, they do not necessarily equate these actions with workplace bullying shown by the 9.3% discrepancy between those considered targets for workplace bullying and those who identify with being bullying on a daily or weekly basis. These results show that nurses and other non-nursing, unit-based staff may not be familiar with what defines workplace bullying. This discrepancy between the 13.7% who were considered targets for workplace bullying based on responses to the NAQ and those who self-identified as being bullied/witnessed others being bullied might be explained by normalization of bullying acts in the workplace. This finding is similar to what has been reported in general among U.S. workers: there is a discrepancy between bullying as scored in the negative acts questionnaire and responses to direct inquires about perceptions of having experience bullying (Lutgen-Sandivk et al., 2007)

Workplace bullying varied significantly by only 3 demographic factors: hospital, years of experience on the current unit, and clinical specialty. While previous research studies have focused on workplace bullying in younger nurses (McKenna, Smith, Poole & Coverdale, 2003; Vessey, Demarco, Gaffney & Budin, 2009), this study found that bullying experience was less for nurses and other non-nursing, unit-based staff with less experience on the current unit and less experience in the profession when compared with the bullying of staff with more experience on the current unit and more experience in the profession. These results are supported by more recent research studies on workplace bullying (Johnson & Rea, 2009). Similar to the current study which found that nurses who had been working for 2-10 years and greater than 10 years

had the highest average bullying intensity and frequency, Vessey, et al. (2009) found that nurses who reported bullying had been working for an average of 6.32 years. In another recent study, emergency room nurses did not find that there were significant differences by age or years of experience. The work of Johnson (2009), Vessey et al (2009), and the current study may suggest that the old adage of "nurses eat their young" may be changing. One possible explanation for this is that the newer generation of nurses, the Millenials, is being taught zero tolerance towards bullying and to stop the negative behavior from the beginning. It is also possible that newer nurses are being made aware of the workplace bullying problem and taught that it is not to be tolerated. This teaches them to better recognize negative actions and deal with the conflict more effectively.

The highest levels of bullying were reported on the surgical unit and in the hospital room while the lowest levels of bullying were found on the ICU and medical units. These findings differ from those of Vessey, et al. (2009) who found that among a sample of 303 nurses, the highest levels of bullying were reported on medical-surgical units (23%) and critical care (18%) while lower levels were found in the operating room/post anesthesia care unit (9%). These varying findings indicate that workplace bullying may be affected more by factors including organizational structures within an institution and on a unit rather and perceived job stress than simply one's clinical specialty. In the same study, perpetrators of bullying included seniors nurses (24%), charge nurses (17%), nurse managers (14%), and physicians (8%) (Vessey et al., 2009). Their findings also differ from those of the current study which found bullying behaviors to be committed most frequently by physicians (20.4%), RNs on the unit (19.1%), nurse managers (7.4%), and charge nurses (5%). This once again indicates that bullying behavior is impacted by the organizational culture of a hopsital.

Extensive research has been done to indicate that burnout is a problem for healthcare workers, specifically nurses. Similar to workplace bullying, many studies have linked nurse retention rates, job stress, and patient satisfaction to levels of burnout among nursing staff (Greco, Laschinger, & Wong, 2006; Leiter, Harvie & Frizzell, 1998). In this study, a positive correlation was found between the prevalence of workplace bullying and emotional exhaustion, a component of burnout. While about 47 percent of nurses were at low risk for emotional exhaustion, over 53 percent of nurses were at moderate or high risk for emotional exhaustion. Considering that emotional exhaustion/burnout and workplace bullying have been shown to impact nurse retention rates and patient care outcomes, the high emotional exhaustion scores of those surveyed indicates a large problem. This study suggests that an intervention targeting workplace bullying should also consider addressing coping with emotional exhaustion and burnout.

Limitations of this study include the voluntary nature of participation, which limited the representation of all demographic groups involved. The results are limited to the units and medical centers that participated; the results cannot be generalized to other medical institutions. The surveys were distributed at both medical centers at different times, providing a potential confounding variable that could have impacted the different average bullying scores at both institutions. Finally, it is impossible to distinguish whether or not those who participated in this study had a greater or lesser experience with workplace bullying compared to those who chose not to participate.

Chapter VII

Conclusion

Workplace bullying continues to be a pervasive problem as evidenced by the bullying scores at the two medical centers that participated in this study. Bullying is a problem for all staff working on a nursing unit. Physicians and RNs are the largest culprits of bullying behavior. An individual's perception of whether or not he/she is being bullied may differ from the NAQ's definition of what constitutes bullying behavior. In this study, the experience of workplace bullying differed among nurses and other non-nursing, unit-based staff by years of experience on the current unit, clinical specialty, and medical center. There is a moderate positive relationship between workplace bullying and emotional exhaustion.

Since workplace bullying has been established as a major problem in healthcare, further research needs to be done on an intervention to address the problem. The literature suggests that the first step to solving the workplace bullying problem is an educational intervention (Bigony, et. al, 2009; JC, 2008; Johnson, 2009; Johnson & Rea, 2009; Rosenstein & O'Daniel, 2005). By raising awareness about the problem of workplace bullying, healthcare staff may become less tolerant of this negative behavior. The Joint Commission now requires healthcare organizations to have accessible policies and procedures to handle workplace bullying (JC, 2008). Keeping this in mind, an appropriate intervention for bullying actions might include educating healthcare managers and administrators about disciplinary actions to handle bullying behaviors similar to the intervention tested by Stevens (2002). Workplace bullying persists as a problem not only for nurses, but also for other non-nursing, unit-based staff. It is imperative that any intervention designed to reduce bullying behavior address all healthcare staff.

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Table 1

Response Rate

Medical Center	*Inpatient Unit*	*Response Rate*
Medical Center A	Operating Room (Main Hospital)	41% (48/118)
	Operating Room (Cardiac Hospital)	39% (25/64)
	Cardiac Intensive Care Unit	34% (46/134)
Medical Center B	Medical Units (2 total)	39% (66/170)
	Surgical Unit	56% (20/36)
	Operating Room	24% (94/400)

Table 2

Percent of Participants Reporting Negative Acts

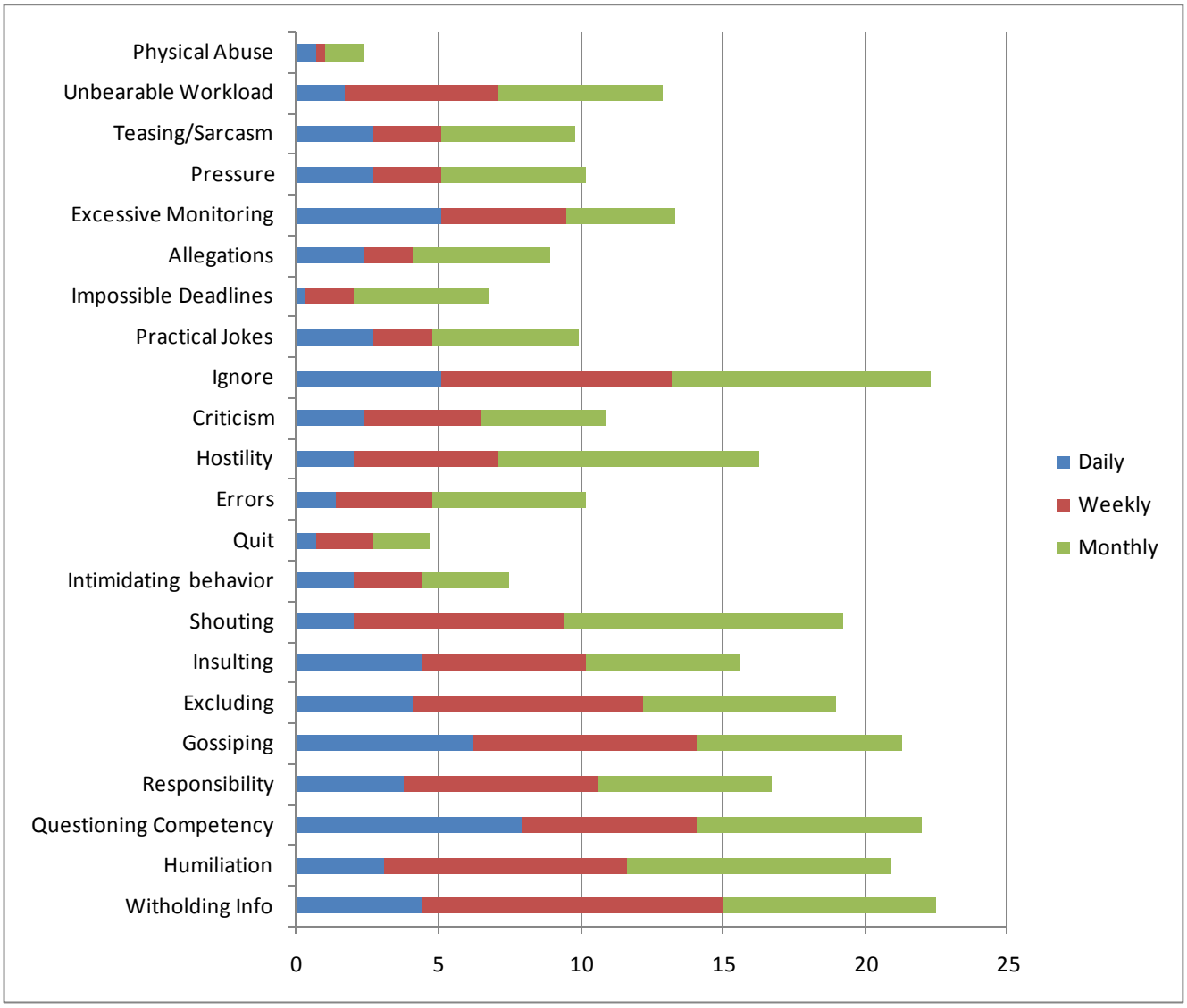

Table 3

Bullying Variance by Demographic Factors

Demographic	Intensity	Significance (p)	Frequency	Significance (p)
Race				
White (n=206)	9.16	.300	1.67	. 470
Non-white (n=86)	7.79		1.79	
Sex				
Female (n=227)	8.77	.717	1.68	.992
Male (n-66)	8.67		1.85	
Hospital				
Medial Center A	9.66	.247	1.97	.020
Medical Center B	8.15		1.58	
Job Title				
RN (n= 162)	8.77		1.54	
PCA (n=25)	6.72	.501	.88	.630
Other (n=106)	9.04		2.23	
Years of Experience				
<2 years (n= 75)	7.19		1.39	
2-10 years (n= 119)	8.88	.745	1.71	.120
>10 years (n= 99)	9.67		2.04	
Experience on Current Unit				
0-2 years (n= 132)	7.62		1.72	
2.1-5 years (n=79)	9.04	.021	1.27	.290
5.1-10 years (n=49)	11.35		2.84	
>10 years (n=26)	9.46		1.38	
Clinical Specialty				
OR (n= 167)	9.67		2.09	
ICU (n= 46)	8.26	.050	1.35	.221
Medical unit (n= 66)	6.26		1.03	
Surgical unit (n= 20)	10.40		2.05	

Table 4

MBI Emotional Exhaustion Scores

MBI Score	Percent of Nursing Staff
Low (0-16)	46.8%
Moderate (17-26)	28.1%
High (>27)	22.1%