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THE CONFLICT STYLES OF NURSE LEADERS AND THE INFLUENCE OF THESE STYLES ON DISRUPTIVE BEHAVIOR

M. Sc. Thesis

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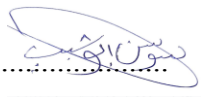
Dedication

I dedicate this valuable work to God Almighty that gave me the courage and power I needed to pursuit my goals. To my family for their love and endless support. To my parents who encouraged me to pursuit my dreams. To my supervisor Dr. Farid Ghrayeb. Farid Ghrayeb for their encouragement and support to finalize this work. Many thanks go to my friends for their support and continuous motivation to reach my goals and finalizing my thesis. To all my colleagues at Beit-Jala Governmental Hospital. I would like to express my sincere gratitude to all participants in the study.

Declaration

I certify that this thesis which is submitted to the Deanship of Graduate Studies to get the degree of master in on filed Nursing Management, this is my own research and my own work and it doesn't submit to any other universities or any institutions.

Signed: 

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Abstract

Introduction: Healthcare organizations have a wide range of departments, specializations, and service lines, as well as intricate relationships between them. Numerous factors might lead to conflict, which ultimately affects behavior. Leaders in the healthcare industry need to figure out how to handle disagreement while still fostering a cooperative, fun work environment. In the healthcare sector, intimidation and disruptive behavior can compromise patient care, lead to staff discontent, and result in professional attrition. These actions have been connected to problems with patient safety, nurse satisfaction, nurse retention, and poor teamwork and communication.

Study aim: The purpose of this study was to examine the perceptions of intimidation and disruptive behaviors in the health care setting and the nurse leader's conflict management style as well as explore the relationship between the perceptions of intimidation and disruptive behaviors in the health care setting and the nurse leader's conflict management style by demographic variables.

Methods: A quantitative cross-sectional study design with a convenience sample of nurses employed in five hospital settings in the northern area of Palestine was used for this study. Two studies were conducted: a smaller pilot research with 20 participants and a larger convenience survey with 311 participants. This satisfied the requirement of the power analysis for at least 98 members of the sample. A Type II error will be less likely with this sample size.

Results: The findings indicated that while an integrated conflict style predicted dangerous and incorrect disruptive activity by others (such as a pharmacist, nurse, or

supervisor), it also revealed a hazardous and improper disruptive behavior by doctors or prescribers. This study also contributed to the corpus of research on the relationship between disruptive conduct and job title, disruptive behavior and leader years of experience, and disruptive behavior and work unit and conflict style.

Conclusion: nurses have distinct perspectives on the world. Their emphasis for their patients is different, as is the way they were taught. But by accepting what each profession has to offer, nurses and doctors may learn a great deal from one another. The dynamics of the nursing profession will alter if physician-nurse cooperation becomes the norm. Instead of feeling subordinate, nurses will view themselves as change makers with important ideas to share. Collaboration between physicians and nurses to identify the most effective patient care strategy can benefit health care organizations.

In the future, patient safety and successful outcomes will take precedence over intimidation and disruptive actions in the healthcare environment.

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CHAPTER ONE

1.1 Introduction

In health care environments, disruptive and threatening actions can compromise patient treatment, lead to worker dissatisfaction, and result in professional attrition. In April 2008, Rosenfeld and O'Daniel reported that 77% of doctors and nurses acknowledged having seen these kinds of actions. According to Rosenstein and O'Daniel (2008), intimidating and disruptive behaviors have the potential to lead to medical errors, poor patient satisfaction, unfavorable outcomes, higher healthcare costs, and the resignation of qualified clinicians, administrators, and managers in search of more professional roles.

To be able to address intimidation and disruptive behaviors, they must be defined firstly. They have been defined by the Joint Commission "overt actions such as verbal outbursts and physical threats as well as passive activities such as refusing to perform assigned tasks or quietly exhibiting uncooperative attitudes during routine activities" (The Joint Commission, August 2009). Another definition of disruptive behavior that encompasses any inappropriate behavior, confrontation, or conflict, from verbal abuse (abusive, intimidating, disrespectful, or threatening behavior) to physical or sexual abuse, is considered disruptive behavior if it has the potential to have a negative impact on working relationships, the effectiveness of communication, the caregiving process, and its outcomes (Rosenstein, 2011). In the context of healthcare, it has been established that disruptive behavior has a negative consequence on the patient, nursing staff, and the organization. This will affect the therapeutic relationship, communication process, communication, teamwork, and information sharing by raising anxiety, affecting

concentration levels. adverse events, patient dissatisfaction, and compromised patient safety (Dois et al., 2018; Veltman et al., 2007; Rosenstein and Naylor, 2012). Examining the extent and effects of disruptive behaviors and intimidation in the healthcare context is crucial. The bulk of disruptive events involve professional doctors who, when under pressure, act inappropriately. But there are other people than doctors who can be intimidating or disturbing. These behaviors have also been observed in nurses, patients, families, and supervisors. Hospital managers foster a safe atmosphere for patients, families, healthcare professionals, doctors, and administrators by dealing with disruptive and frightening actions in the healthcare setting. Organizations must be committed to a culture of establishing a zero-tolerance policy and actively addressing disruptive behaviors by raising awareness of the potential that may happen. Because disruptive behaviors destroy employee morale, negatively affect service quality, and drive away talented employees, health care providers need to be educated on the effects of intimidating and disruptive behaviors. Policies also need to be developed to establish expected standards of behavior (Lauve, 2002; Rosenstein & O'Daniel, August 2008). Disruptive and threatening actions in the healthcare field may be due a variety of factors. It is required of doctors to manage potential lawsuits, control expenses, and fulfill productivity targets. In addition, they must contend with consumerism, managed care limitations, and government scrutiny. Physicians who experience these pressures get demoralized and develop a victim attitude. Disparities in responsibilities on the health care team, authority, autonomy, and empowerment might exacerbate pressures. Regarding nurses, the stresses that surround them in the healthcare environment also have an impact on them. Compared to doctors, nurses have higher time demands, irregular

schedules, changing jobs, and inadequate pay, according to Lauve (2002). It is especially challenging for caregivers to maintain trust and communication when shifts and rotations change (Lauve, 2002; The Joint Commission, July, 2008). It could be difficult to change contributing elements including personality, education, gender prejudices, past habits, and external influences. Other variables, nevertheless, are modifiable, including regulations, duties, responsibilities, leadership support, and tolerance for other cultures (Lauve, 2002). Usually, physician behavior was molded in school. Independent thought and accepting accountability for one's actions were emphasized to medical professionals. In contrast to encouraging teamwork and collaboration, this conduct fosters autonomy and a dominant behavioral tendency (Lauve, 2002).

The length of stay, negative occurrences, medical errors, patient safety, level of care provided, and patient satisfaction are all factors that might affect the patient environment. By creating standards and rules that combat disruptive conduct and offer education, the healthcare industry is working to address this (Porto & Lauve, 2006; Mantone, 2006; Rosenstein & O'Daniel, 2005). What causes disruptive behavior in the medical field? There are many reasons why this kind of behavior could take place, some of which include: the individuals exhibiting the behavior may be highly skilled and at the top of their field; they may excuse the behavior by claiming they were attempting to avoid patient complications or it was someone else's fault; physicians are peers and prefer to avoid confrontation of this kind; and the individual exhibiting the behavior may also generate income for the organization and other parties. (Bresloff, Joseph, and Hyman, 2009; Longo, 2010).

Over time, conflict has been seen from a variety of angles. As it relates to the government and upholding social order, as an unfortunate circumstance, and finally as a thought that can inspire creation. Conflict wasn't understood to have both productive and unproductive outcomes in an organization until the middle of the 20th century.

The literature is more recent when it comes to sources of conflict, conflict in organizations, and how to address various types of conflict. For handling conflict, models with three, four, and five styles have been devised. Conflict styles were distinguished by Rahim and Bonoma (2001) based on two fundamental dimensions: concern for oneself and concern for others. The five styles that were taken into account for this study as a result are integrating, obliging, dominating, avoiding, and compromising. (Rahim and Bonoma, 2001).

The American College of Physician Executives (ACPE) and the Institute for Safe Medication Practices (ISMP) are two organizations that have investigated the idea of disruptive behavior. In 2013 and 2003, the Institute for Safe Medication Practices conducted surveys on workplace intimidation. The question, which was pertinent to this study, was, "How frequently in the past year have you encountered potentially intimidating behaviors by physicians, by others?" It listed a number of behaviors.

The 2009 Doctor-Nurse Behavior Survey was done by the American College of Physician Executives. The relevant study-related inquiries included "how frequently do behavior problems between doctors and nurses at your healthcare organization arise?" and "what kinds of behavior problems have you experienced between doctors and nurses at your healthcare organization?".

1.2 Statement of the Problem

Intimidation and disruptive behaviors lead to patient safety concerns, nurse satisfaction, nurse retention, and inefficient communication and cooperation when occur in the healthcare setting (Fontaine & Gerardi, 2005; Institute for Safe Medication Practices (ISMP), 2004; Martin, 2008; Rosenstein & O‟‟Daniel, 2005). Previous studies revealed managers spend 20% to 90% of their time managing conflict at work (Vazirani, Hays, and Shapiro, 2014). Conflict at work has a negative impact on an organization's productivity, effectiveness, and morale. According to studies (Alshammari & Dayrit, 2017; Patton, 2014), conflict in the workplace contributes to employee stress, job satisfaction, absenteeism, grievances, a lack of teamwork, turnover rates, productivity, efficiency, and an increase in errors. (Alshammari & Dayrit, 2017; Patton, 2014).

Disruptive behavior: what is it? Verbal insults were documented by Ferns and Merabeau (2007), and Johnson (2009) talked about actions including refusing to answer the phone, becoming irritated when asked a question, verbal abuse, and even physical violence.

According to Maxfield et al., (2005), the behavior of some of the doctors was also verbally demeaning, including shouting and swearing. Disruptive doctors are highlighted by Gerardi and Forse (2009) to shout at coworkers and refuse to assist others when necessary. According to Rowe and Sherlock's (2005) research, verbal abuse directed at nurses most frequently takes the form of patronizing and demeaning language. Explosions of rage, criticizing the treatment of other doctors, and dishonorable behavior are added to the list of disruptive behaviors seen in healthcare by Leape and Fromson (2006). According to Gorgos (2004), the conduct included yelling and screaming,

throwing objects, insulting nurses and other medical staff, and making improper remarks. More significantly, healthcare executives claim that this kind of activity happens one to four times per month on average. Rosenstein and O'Daniel (2005) reported a comparable level of frequency, ranging from as frequently as once per day to as infrequently as 1 to 5 times per year.

Why does disruptive behavior continue? According to Bresloff, Joseph, and Hyman (2008), who speak for the hospitals, management wants to keep receiving referrals from doctors and doesn't want to lose money from those referrals. They are colleagues in the eyes of the doctor, and they are not willing to take on a different job.

According to Wiggins (2008), punishing doctors has significant financial repercussions. It is impossible to avoid the environment of non-reporting. Lynn (2010) makes reference to the idea of domination. In hospitals, doctors have held positions of authority. Disruptive medical professionals might be among the best in their field, if not the best. Tarkan (2008) discusses favoritism and a network that shields disruptive doctors from scrutiny. According to Sataloff (2008), our environment has changed, and the new environment is less accepting of social interaction and wit. He also implies that this new environment has various values that have significant legal repercussions. According to Roback et al., 2007 research, disruptive doctors justify their actions by saying they don't tolerate issues that could harm patients. They also found that certain medical professionals have a significant tendency to blame others when disruptive conduct occurs. What effects will this have on employee relations? According to Rowe and Sherlock (2005), the majority of nurses are capable of handling disruptive behavior but frequently experience feelings of rage and helplessness, which can affect morale and retention.

Disruptive behavior is cited by nurses as the "single most important contributing factor to job satisfaction and morale" (Porto and Lauve, 2006, p. 5). According to the authors, 31% of nurses were aware of someone whose employment had been terminated due to disruptive behavior. According to Samenow, Swiggant, and Spickard's (2008) research, disruptive behavior has a number of negative effects on an organization, including tension and low morale, employee turnover, ineffective team interactions, increased economic and legal threats, decreased employee confidence, a damaged reputation for the company, and a negative and damaging culture.

Collaboration and communication between nurses and doctors will always increase when disruptive and threatening behaviors are addressed. A multidisciplinary approach to patient treatment is made possible by this advancement, and this might result in better patient outcomes.

1.3 Purpose of the Study

This quantitative correlational study aims to examine the perceptions of intimidation and disruptive behaviors in the health care setting and the nurse leader's conflict management style as well as explore the relationship between the perceptions of intimidation and disruptive behaviors in the health care setting as perceived by nurses and the nurse leader's conflict management style by demographic variables.

1.4 Significance of the Study

This study will add to the body of knowledge in the field of leadership about the connection between allied health leaders' personality qualities and conflict management. 60% of the healthcare workforce is made up of allied health professionals including nurses, who are particularly vulnerable to workplace conflict caused by personality

indifference (Campbell et al., 2016); Kenney, Patton, and Walls (2014). Healthcare workers join groups and carry their values, beliefs, behaviors, and personality traits with them; these factors have an impact on organizational processes (Ayub et al., 2017). Disruptive behavior can affect beliefs, actions, motivation, and team norms (Ayub et al., 2017), which could have a negative effect on the choices made by leaders while resolving conflicts. Antonioni (1998) pointed out that disruptive behavior affects how people behave in conflict. According to the findings of various studies (Priyadarshini, 2017; Moberg, 2001), people's conflict-handling preferences are significantly correlated. Leaders need to be aware of their behaviors.

1.5 Research Objectives

1. To identify the perception of intimidation and disruptive behaviors frequency among nurses by demographic variables.
2. To determine how nurses perceived Conflict Style (Avoiding, Compromising, Dominating, Integrating, Obliging) and Improper Disruptive Behavior by Physicians.
3. To determine the nurse perceived Conflict Style (Avoiding, Compromising, Dominating, Integrating, Obliging) and Disruptive Behavior (Improper and Unsafe) by Physicians/Prescribers and/or others?
4. To compare the nurse perceived Conflict Style (Avoiding, Compromising, Dominating, Integrating, Obliging) and Disruptive Behavior (Improper and Unsafe) by Physicians/Prescribers and/or others by demographic variables?

1.6 Research Questions

1. What is the difference, if any, of the perception of intimidation and disruptive behaviors frequency among nurses by demographic variables?
2. What is the level of conflict management styles used by nurse managers from the nurses' perception in Palestinian hospitals?
3. Is there a relationship between the nurse perceived Conflict Style (Avoiding, Compromising, Dominating, Integrating, Obliging) and Disruptive Behavior (Improper and Unsafe) by Physicians and /or others?
4. Is there a relationship between the nurse perceived Conflict Style (Avoiding, Compromising, Dominating, Integrating, Obliging) and Improper Disruptive Behavior by Others by demographic variables?

1.7 Research Hypothesis

1. There is no statistically significant difference in the perception of intimidation and disruptive behaviors frequency among nurses by demographic variables.
2. There is no statistically significant difference in the nurse perceived Conflict Style (Avoiding, Compromising, Dominating, Integrating, Obliging) and Disruptive Behavior (Improper and Unsafe) by Physicians.
3. There is no statistically significant difference in nurse perceived Conflict Style (Avoiding, Compromising, Dominating, Integrating, Obliging) and Disruptive Behavior (Improper and Unsafe) by others

CHAPTER TWO:

LITERATURE REVIEW

2.1 Introduction

There are many different types of behavior that harms the working environment, including low attendance, negligent supervision, property damage, drug misuse, discrimination, being late for work, stealing, and many other types of behavior that affect coworkers, clients, and others. These actions can be grouped together under the concept of "counterproductive work behavior" (Ones and Dilchert, 2013).

While this construct may include one or more of the behaviors classified as disruptive behavior, the American College of Physician Executives and the Institute for Safe Medication Practices have identified a specific list of disruptive behaviors that a person may encounter in a healthcare setting.

This study is solely concerned with disruptive behavior, as described by the American College of Healthcare Executive and the Institute for Safe Medication Practices, as well as how the conflict management style of the leader may affect the degree of disruptive behavior in the work unit. Results from the evaluation of the literature on conflict style, disruptive conduct, and the association with one or more of the controlling factors were mixed, with and without statistical significance. Statistical significance was not mentioned in certain articles, and in other circumstances, no literature was discovered.

2.2 Conflict Style

Morrison (2008) examined Registered nurses' preferred conflict-handling philosophies and emotional intelligence. A total of 94 licensed nurses took part in the study. Morrison investigated conflict using the *Thomas-Kilmann* Conflict Mode Instrument (TKI). The five conflict management styles measured by *Thomas-Kilmann* are accommodating, avoiding, cooperating, competing, and compromising. The findings showed that conflict management and a collaborative conflict handling style had a substantial positive connection (r = 0.34). The Avoiding and Accommodating conflict styles were utilized by nurses more frequently than the other conflict styles, despite the fact that this study did not compare the effectiveness of each conflict style.

2.3 Gender and Conflict Style

Al-Hamdan, Shukri, and Anthony (2011) examined the conflict resolution methods employed by nurse managers in the Sultanate of Oman. There were 271 nurses total at 9 referral hospitals. The Rahim Organizational Conflict InventoryII (ROCI-II) and demographic information were the tools used. 219 female individuals and 52 male participants participated. Men scored higher on Compromising than women, which was the only gender-related difference that was shown to be significant.

Whitworth (2008) made an effort to ascertain the connection between several personality traits of female registered nurses and their approach to handling conflict.

The Thomas-Kilmann Conflict Mode Instrument and the Myers-Briggs Type Indicator were the tools employed. The participants were 97 female registered nurses from three healthcare facilities in south Mississippi. The findings showed that there was no statistically significant relationship between the personality traits of female registered nurses and their conflict resolution strategies in the major area of the study. They did discover the favored Conflict Styles listed below, though: In terms of avoidance and accommodation, 40.2% (n = 39) of the female nurses scored higher than average, while Collaborating (n = 54, 55.7%) and Competing (n = 51, 52.6%) scored lower.

Several studies (k = 29) using various tools, including CMS, MODE, and the Rahim Organizational Conflict Inventory-II, were examined by Holt and Devore in 2005.

The study involved 4,799 people, and the findings were incorporated into six styles that the researchers developed: Smoothing (similar to Obliging), Withdrawing (similar to Avoiding), Compromising, Problem Solving (similar to Integrating), and Forcing (similar to Dominating). Compromising had a substantial effect on female scores (d =.64), whereas Problem Solving (Integrating) had a minor effect (d =.21). In terms of Forcing (Dominating), men performed better and had a moderate effect (d = -.31). Males received a score of "0" while females received a code of "1".

Ivshin (2001) studied conflict resolution and its connection to both work and emotional intelligence. Participants in the National University programs as well as their friends and acquaintances who are currently employed or have been in the past five years were the subjects of the study. 166 people responded, and 53 were men (27.7%), whereas 113 women (59.2%) were present. The majority of respondents (35.6%) were between the

ages of 21 and 30 (n = 68), followed by those between the ages of 31 and 40 (n = 55, 28.8%), 41 to 50 (n = 32, 16.8%), 51 to 60 (n = 11, 5.8%), and 61 and over (n = 2).

The majority of respondents (36.1%) had bachelor's degrees, followed by associate's degrees (44.2%), master's degrees (27.1%), high school diplomas or equivalent (22.5%), and doctoral or professional degrees (5%). To gauge conflict styles, the Rahim Organizational Conflict Inventory (ROCI-II) was employed. Despite the fact that none of the male participants in this study displayed an Obliging conflict style, there were no statistically significant variations in conflict styles by gender.

Using the Thomas-Kilmann Conflict Mode Inventory (TKI), Reich, Wagner-Westbrook, and Kressel (2007) conducted a study of employees at a big metropolitan healthcare firm (N = 176). Participants also shared demographic data and information on job stress. In the study, 136 women and 41 males both took part. There were no gender disparities on any of the genders or conflict styles according to the study results.

2.4 Age and Conflict Style

Using tools from O.K. Consulting, Lorber and Savic (2011) conducted a study of nurses (N = 509) and interviewed 11 males and 496 women, with a leader median age of 43.5 years and an employee median age of 38 years. In 4 of 5 significant Slovenian hospitals, the study contrasted the perceptions of leadership style by nursing leaders and staff members. The results showed that leadership style and age had an impact on the method of conflict resolution used.

In the earlier-discussed research, Ivshin (2001) carried out investigations on conflict management and its connection to productivity and emotional intelligence. The majority

of respondents (35.6%) were between the ages of 21 and 30 (n = 68), followed by those between the ages of 31 and 40 (n = 55, 28.8%), 41 to 50 (n = 32, 16.8%), 51 to 60 (n = 11, 5.8%), and 61 and over (n = 2). Age and conflict styles did not differ statistically from one another.

Kiernan (1992) investigated the connection between organizational environment and conflict management among nurse managers and their personnel in medical-surgical units. The survey's nurse managers, whose ages ranged from 26 to 61, participated. The survey participants' ages ranged from 20 to 70, with an SD of 10.6 and an average age of 35.2. Each of the conflict styles—competing, collaborating, compromising, avoiding, and accommodating—was examined in relation to age. Age and conflict style only had one association, which was that a staff nurse's age is a good indicator of how they view openness on the unit (F = 11.63, p =.0007).

Age and the ROCI-I or any particular conflict style did not significantly differ, according to Kimball (2004) in the study (N = 739) previously cited.

Whitworth (2008) used The Thomas-Kilmann Conflict Mode Instrument in research of nurses (N = 97) ranging in age from 20 to 60, with 68% of the women being 41 years or older, and found no significant differences between conflict and age.

2.5 Job Title and Conflict Style

In a study of head nurses (N = 60), Hendel, Fish, and Galon (2005) investigated the conflict management strategies used by head nurses in general hospitals and looked at the association between leadership style and conflict management strategy choice. The

Thomas-Kilmann Conflict Mode Instrument was used to conduct a survey of sixty head nurses in five hospitals in Israel to assess conflict. One Conflict Management Style was found to be the only one used by about half of the respondents: 13% used only competing, 11% used only compromising, 11% used only accommodating, and 5.6% used only avoiding. The remaining players had a variety of personalities. The most popular mode was determined to be compromising (m = 7.30), while accommodating (m = 4.00) was the least popular.

The study discovered a substantial connection between conflict style and job title. The head nurse's usage of Compromising was shown to be significantly different from the other conflict approaches when compared to them. The Accommodating tactic was employed the least frequently. In the earlier-mentioned article, Kiernan (1992) investigated organizational environment and conflict resolution among nurse supervisors and their personnel in medical-surgical units. The 37 medical-surgical units that took part in the study had 37 head nurses (nurse supervisors) and 405 staff nurses. To assess conflict management style and organizational environment, the researcher employed the NOCDQ-B (modified by Duxbury et al., 1982) and the Thomas-Kilmann Conflict Mode Instrument (TKI, 1974). According to the findings, nurse managers favor a collaborative style of conflict resolution (X = 7.3, SD = 2.5, range = 2 to 12) over a compromising style (X = 7.8, SD = 1.9, range = 3 to 11). The least favoured method was Competing (X = 2.7, SD = 1.8, range = 0 to 6), followed by Avoiding (X = 6.2, SD = 2.5, range = 0 to 11) and Accommodating (X = 5.8, SD = 1.7, range = 3 to 10).

In a study by Whitworth (2008) involving 97 participants, it was discovered that employment level was adversely connected (r = -.21) with an accommodating conflict style. In other words, nurses in managerial roles tended to use Accommodating less.

2.6 Education and Conflict Style

In their study of nurses (N = 271), Al-Hamdan, Shukri, and Anthony (2011) examined 147 individuals with a general nursing diploma, 37 individuals with a bachelor's degree in nursing, 65 individuals with a general and specialized diploma, 11 individuals with a bachelor's in nursing and specialized diploma, and 11 individuals with a master's degree in nursing. According to the survey, nurse managers tended to adopt an Obliging approach less frequently the more educated they were.

Whitworth (2008) found that nurses with more years of education had significantly higher Accommodating scores (=.25, p =.02) when examining the relationship between various personality factors of female registered nurses (N = 97) and their method of handling conflict.

Thomas-Kilmann Conflict Mode Instrument was used by Reich, Wagner-Westbrook, and Kressel (2007) in their research of healthcare workers (N = 176). A bachelor's degree was the level of education most people had. According to the findings, nurses with more education exhibited a competing style (r =.16, p .05), while those with less education exhibited an accommodating style (r =.21, p.05).

Research on conflict resolution and its connections to emotional intelligence and the workplace was done by Ivshin in 2001. The majority of survey participants (n = 69, 36.1%) had bachelor's degrees, followed by associate's degrees (n = 44, 23%), master's degrees (n = 27, 14.1%), high school diplomas or equivalents (n = 22, 11.5%), and

doctorates or professional degrees (n = 5,2.6%). In terms of conflict styles, there were no statistically significant variations in schooling.

Using a sample size of 442, Kiernan (1992) investigated the link between organizational environment and conflict management among nurse managers and their staff in medical-surgical units. The most common nursing degree among staff nurses was an associate degree in nursing (54.9%), followed by a bachelor's degree in nursing (31.6%). Many of the nurse managers who took part in the study had a bachelor's degree in nursing (47.2%). There were no meaningful relationships between conflict resolution methods and the nature of nursing education.

2.7 Follower Years of Experience and Conflict Style

Years of experience were shown to be connected with an accommodating conflict style (r =.25) in Whitworth's (2008) study of the association between distinct personality variables of female registered nurses (N = 97) and their technique of handling conflict.

Al-Hamdan, Shukri, and Anthony (2011) conducted research on nurses in the Sultanate of Oman and gave out the Rahim Organizational Conflict Inventory II (ROCI-II) questionnaire to nurses working in 9 hospitals. In the study, which comprised 271 nurses, it was discovered that more senior and experienced nurses used integrating more frequently and avoided and obliged less.

2.8 Leader Years of Experience and Conflict Style

The Thomas-Kilmann Conflict Mode Instrument was used by Hendel, Fish, and Galon (2005) to measure conflict in their Israeli research (N = 60). Although demographics were not connected to the preferred conflict resolution method, tenure and teamwork were found to be significantly correlated. A chief nurse employed the collaborative form

of conflict management more frequently the longer she had been in that position. In medical-surgical units, nurse supervisors and their personnel were researched in connection to organizational environment and conflict management by Kiernan (1992).

The Thomas-Kilmann Conflict Mode Inventory (TKI) was the instrument. Participants in the study included 37 head nurses (nurse managers), with a mean age of 4.1 years (SD = 1.6, range 1 to 25), 2.2 years (SD = 1.4, range 1 to 15 years), and 9.4 years (SD = 7.1, range 0 to 27 years) of management experience. In addition, 405 staff nurses participated in the study, of whom 179 had one to five years of experience (44.3%), 82 had six to ten years (20.3%), and 61 had eleven to fifteen years (15.1%). The number of years spent as the head nurse and accommodating were found to be significantly correlated ($r = -.4614$, $p = .008$), as were the years spent in management ($r = -.4153$, $p = .018$).

In their study of nurses (N = 271) stated previously, Al-Hamdan, Shukri, and Anthony (2011) discovered that managers who had been in their management positions for a longer period of time utilized Integrating less.

2.9 Conflict Style and Disruptive Behavior

In medical-surgical units, nurse supervisors and their personnel were researched in connection to organizational environment and conflict management by Kiernan (1992). Participants in the study were Utah-based nurse managers and the registered nurses on their team. The study included 37 head nurses (also known as nurse managers). They were predominantly female (94.4%) and Anglo American (94.6%). They were 26 to 61 years old, with a mean age of 43.6 (SD: 9.6). The majority of these managers (47.2%) had a bachelor's degree in nursing. There were just two managers: one Asian American and one Hispanic American. The mean number of years spent as a nurse practitioner was

4.1 (SD = 1.6, range 1 to 25 years), the mean number of years spent as a nurse manager was 2.2 (SD = 1.4, range 1 to 15 years), and the mean number of years spent managing was 9.4 (SD = 7.1, range 0 to 27 years). There were also 405 staff nurses working in the 37 medical-surgical units. The majority of the nurses (95.6%) were female, and 90.6% were Anglo Americans. Their average age was 35.2 years (SD + 10.6, range 20 to 70).

A nursing associate degree (54.9%) was most common, followed by a nursing bachelor's degree (31.6%). 179 nurses had one to five years of experience (44.3%), 82 had six to ten years (20.3%), and 61 had eleven to fifteen years (15.1%). Additionally, there were 27 nurses with more than 25 years of experience, 36 nurses with 16 to 20 years of experience, and 19 nurses with 21 to 25 years of experience. The Thomas-Kilmann Conflict Mode Instrument (TKI, 1974) and the NOCDQ-B (modified by Duxbury et al., 1982) were employed by the researcher to assess organizational climate and conflict management style, respectively. According to the findings, nurse managers favor a collaborative approach of conflict resolution (M = 7.3), which is followed by a compromising style (M = 7.8). The following options were Avoiding (M = 6.2) and Accommodating (M = 5.8), with Competing (M = 2.7) being the least favored.

In a study of nurses (N = 515) working in cancer settings across Canada, Cummings, Olson, Hayduk, Bakker, Fitch, Green, Butler & Conlon (2008) used a subset of the Nursing Work Index-Revised (NWI-R) to evaluate work environment characteristics affecting oncology nurses' job satisfaction. The study revealed no connection between doctor-nurse interactions and support in resolving disagreement.

2.10 Disruptive Behavior

An investigation into doctors' disruptive behavior was conducted by the American College of Physician Executives (ACPE), according to Weber (2004). There were 1627 people that responded. Executive physicians made up all of the participants. The survey's creation was handled by ACPE. Within their organization, 276 (17%) of the respondents said that physician disruptive behavior happens once or twice a year, 392 (24.1%) said it happens three to five times a year, 309 (9%) said it happens more than five times a year, 294 (18.1%) said it happens monthly, 230 (14.1%) said it happens weekly, 56 (3.4%) said it happens daily, and only 70 or 4.3% of those surveyed said it never happens. There are several common issues that are reported, including: unwillingness to complete jobs or carry out obligations 51.7% (n = 803), physical abuse including throwing objects 9% (n = 140), insults 36.6% (n = 568), disrespect 82.6% (n = 1284), yelling 41% (n = 637) and other 13.5% (n = 210). 56.5% of the time, issues arise in a doctor's interactions with a nurse or physician assistant; 14.7% of the time, with another doctor; 14.5%, with staff members; and 14.2%, with a patient or patients.

The American College of Physician Executives' (ACPE) 2009 Doctor-Nurse Behavior Survey was covered by Johnson (2009). The ACPE created the survey tool. The poll received responses from 1428 nurse executives and 696 physicians executives. The majority of these people worked at hospitals (n = 1091, 68.9%); the remainder worked in university medical centers (9.3%), integrated health systems (7.3%), and group practices (5%), among other places.According to respondents, there are behavior issues between doctors and nurses on a daily basis to a maximum of 9.5%, weekly to a maximum of 30%, monthly to a maximum of 25.6%, several times to a maximum of 30.9%, once to a

maximum of 2.9%, and less than once a year to a maximum of 1.2%. When asked what kinds of behavioral issues were present, the following responses were given: making derogatory remarks and insults 84.5%, yelling 73.3%, cursing 49.4%, inappropriate jokes 45.5%, refusing to cooperate 38.4%, refusing to communicate 34.3%, trying to unfairly discipline someone 32.3%, throwing objects 18.9%, trying to unfairly fire someone 18.6%, spreading false rumors 17.1%, sexual harassment 13.4%, physical assault 2.8%, and other 10%.

2.11 Gender and Disruptive Behavior

Nurse-Physician Relationships: Impact on Nurse Satisfaction and Retention was the title of a survey done by VHA West Coast, which was reported on by Rosenstein & O'Daniel (2005). In total, 1,509 people took the poll. The question of whether or not gender affects the likelihood of disruptive behavior was put to the participants. 47% (n = 702) of the 1503 responses to this question agreed that gender does have some bearing on disruptive conduct. They were then quizzed to determine which gender was more likely to engage in disruptive behavior. The response (n = 950) was: doctors of either gender (n = 543, 57%), doctors of either gender (n = 17, 2%), and doctors of neither gender (n = 390, 41%). When this topic was posed to nurses, the responses were as follows: 53% gender makes no difference (n = 500), 7% male nurses (n = 63), and 40% female nurses (n = 372).

3.12 Age and Disruptive Behavior

Nurses working in Turkish healthcare facilities were mobbed at work by colleagues and managers, according to a study by Yildirim & Yildirim from 2006. The term "mobbing" refers to a wide range of improper actions that put pressure on others and undermine their support in the workplace. The researchers created the mobbing tool with input from subject-matter specialists. 180 nurses who worked in private hospitals and 325 nurses who worked in public hospitals were participants in the study (N = 505). Participants were all women. There were no statistically significant links between age and mobbing behaviors, according to the study.

In their investigation on physician abuse of nurses, Diaz and McMillin (1991) looked at 164 registered nurses (RNs) in California. With a mean age of 41.41 years, the nurses' ages ranged from 26 to 71. Different age groups and physician reports of abuse did not correlate statistically significantly.

3.13 Type of Nursing Unit and Disruptive Behavior

In 2009, Sjetne, Veenstra, Ellefsen, and Stavem conducted research in Norway on the relationships between nurse staffing models and nurses' perceptions of quality care and practice environment elements. There were 1137 nurses and 87 nursing units present. The dependent variables of Quality of Patient Care, Learning Climate, Individual Job Satisfaction, and Relationships with Physicians were studied using data from the Nurse Survey. The explanatory factors on the unit and its internal operations were provided via the Charge Nurse Survey. Additionally, the researchers examined data from the daily census, gathered demographics, and assessed the nurses' working environment using the

Ward Organizational Features Scales. The outcomes: In surgical units, relationships with doctors were weaker than in medical units (r = -6.145, p .05).

In 2008, Rosenstein & O'Daniel used the Nurse-Physician: Impact of Disruptive Behavior on Patient Care survey to perform a study of medical professionals and healthcare workers. Employees in hospitals along the United States' west coast were given the survey. 2,846 nurses, 944 doctors, 40 administrative executives, and 700 additional participants (N = 4,530) were present. The following specialties were found to have higher rates of disruptive behavior: general surgery (28%), neurosurgery (20%), cardiology (13%) orthopedic (10%) anesthesia (7%) and ob/gyn (6%). Medical units made up 35% of the clinical settings, followed by intensive care units (26%), operating rooms (23%), surgical units (20%), and emergency rooms (7%).

279 nurses and 146 nurse supervisors from 14 Magnet hospitals in the United States were interviewed by Kramer & Schmalenberg in 2003. There was no statistical analysis done because this was a tiny, non-randomized sample. The study did discover, however, that the standard of nurse/physician partnerships differed among services. Compared to those working in medical/surgical units, nurses in emergency and outpatient departments reported more positive collegial interactions.

2.14 Follower Years of Experience and Disruptive Behavior

In the earlier-mentioned study by Diaz & McMillin (1991), mistreatment of nurses by physicians was examined. 164 female registered nurses (RNs) from California were among the participants. The mean number of years of nursing experience was 17.19, with

a range of 2 to 55. One statistically significant association was the only one that years of nursing experience exhibited. The likelihood that a nurse would report an event when there was threatening behavior rose with more nursing experience (tauc =.15, p =.01).

2.15 Conflict Management in Healthcare

These results imply that productivity plays a role in at least some of the influence of personality on labor market outcomes. The authors also discovered evidence that this link is influenced by gender and university major. To determine whether the Big Five personality traits were associated with pro-environmental views or pro-environmental behaviors, Wuertz (2015) performed a study involving 100 participants. The Environmental Concern Scale (ECS), General Ecological Behavior Scale (GEB), and Self-Reported Pro-Environmental Behavior Scale were all used by the researchers. The findings showed a substantial relationship between openness and pro-environmental attitudes and activities. Additionally, there was a strong correlation between agreeableness and pro-environmental behaviors. Additionally, it was discovered that openness was a highly significant predictor of pro-environmental concern and activities.

Unresolved conflicts in healthcare settings, according to Greer et al. (2012), may compromise patient safety and lower the standard of service. To maintain the quality and safety of service and to offer a method for resolving conflict among people working in healthcare settings, the Joint Commission instructed healthcare facilities to adopt processes to handle conflict among leadership groups. As part of the accreditation process for hospitals, the Joint Commission's responsibility is to guarantee patient safety

and quality (Booth & Chute; 2017, Patton, 2017; Simpao, 2013). The healthcare setting is typically divided by a rank system, however conflicts can occur at any level within the institution. A problematic conflict management situation is also made possible by the fast-paced, multitasking nature of this type of work setting.

CHAPTER THREE:

MATERIALS AND METHOD

3.1 Introduction:

Conflict style, a leadership variable, is initially identified. This will be carried out as a result of discussions with a focus group of nurse managers and directors.

These people might have recognized the power, real leadership, or a variety of other leadership practices utilized by leaders to deal with disruptive conduct, which might have resulted in a different leadership philosophy. The focus group's descriptions of how to handle conflict inspired the researcher to use the leader's conflict style as an independent variable. The Rahim Organizational Conflict Inventory - II (ROCI-II) was chosen to be used.

The second variable found is the dependent variable, disruptive behavior, as it was described in surveys done by the American College of Healthcare Executives (ACPE) and the Institute for Safe Medication Practices (ISMP). The researcher combined the survey questions from both surveys and divided them into two constructs: inappropriate disruptive behavior and unsafe disruptive behavior. Based on the literature analysis, it was decided to evaluate disruptive conduct by doctors and prescribers separately from disruptive behavior by others (such as nurses, and supervisors).

The controlling factors came last. The following healthcare-specific variable was added in addition to the usual demographic variables (gender, age, education, experience, and job title): nursing unit type; sometimes known as a work unit.

This chapter describes the methodology used to examine the relationship between the nurse leader's conflict style and disruptive behavior after adjusting for followers' years of experience, leaders' years of supervisory experience, followers' gender, age, job title, and education level, and the type of nursing unit.

3.2 Sample

A self-administered questionnaire will be distributed to a convenience sample of 300 Healthcare workers who will be invited to participate the study. People will be encouraged to attend and to extend the invitation to another healthcare worker. Targeted participants ranged in age from 20 to 60+, and gender. Participation is completely voluntary and private. All information was combined.

3.3 Research Design

Correlations and multiple regressions will be utilized after descriptive statistics to determine the participant characteristics. The results of multiple regression employing blocked data included R, R2, R2, and for continuous variables. Every statistic has

a p value of.05. We will employ ANOVA w/Fischer LSD Post Hoc to assess for significance and differences for categorical variables that are significant in regression. SPSS version 27.0 will be used for all statistical analysis.

3.4 Instruments

3.4.1 Demographic Questionnaire

The demographic survey is created by the researcher. There are 13 questions that asked about gender, age, job title, education level, nursing unit type (work unit), years of experience as a follower, and years of experience as a leader in terms of supervision. One of the 13 questions asked about the region. Two dichotomous variables (follower gender and leader gender) and 10 categorical variables (follower age, follower job title, follower education, follower years of experience, follower type of nursing unit (work unit), leader age, leader job title, leader education, leader years of experience) are asked about in the survey.

3.4.2 Disruptive Behavior Survey

The Institute for Safe Medication Practices Survey on Workplace Intimidation and the American College of Physician Executives Doctor-Nurse Behavior Survey are combined to create the disruptive behavior survey. The survey will be administered twice: first for disruptive behavior on the part of doctors and prescribers and again for disruptive behavior on the part of others (such as a nurse, or supervisor).

This reliability of this surveys is lacked. A pilot study will be carried out between Jun 15 and July 20, 2023, using a convenience sample gathered from friends in other settings to avoid being included in the original study, in order to validate these constructs. The survey have 80 questions, including 13 questions about demographics, A 10-item questionnaire called the Improper Disruptive Behavior Survey, which will be used for

this dissertation, had 3 items from the ISMP Survey on Workplace Intimidation and 7 items from the ACPE Doctor-Nurse Behavior Survey. The ISMP Survey on Workplace Intimidation and the ACPE Doctor-Nurse Behavior Survey each contributed 5 items to the 9-item Unsafe Disruptive Behavior Survey that will be used for this study (one item from both surveys is combined). The survey is administered twice, once to inquire about the disruptive behavior of doctors and prescribers and again to inquire about the disruptive behavior of others (such as nurses, and supervisors). The questionnaires employ a 5-point Likert scale, with 1 denoting once a year or fewer frequently and 5 denoting daily. The components in each of the two constructs—improper disruptive behavior and unsafe disruptive behavior—have scores that are combined. An increased score denotes more disruptive activity.

3.4.3 Rahim Organizational Conflict -II (ROCI-II)

The Rahim Organizational Conflict Inventory - II will be used as the conflict survey.

The ROCI-II, often known as this instrument, asks participants to rate how well they get along with their boss and how they deal with conflict at work. It assesses five distinct aspects or modes of resolving interpersonal disputes: avoiding, compromising, dominating, integrating, and complying. A total of 28 items make up the questionnaire, including 6 for avoiding, 4 for compromising, 5 for dominating, 7 for integrating, and 6 for obliging. A 5-point Likert scale, with 1 denoting severe disagreement and 5 denoting strong agreement, is used in the survey. The results are combined for each conflict style. An increased score indicates more utilization of that conflict style. On the findings of this investigation, Cronbach's Alpha was performed.

3.5 Null Hypotheses

H01: According to the follower, after accounting for the leaders' and followers' genders, ages, jobs, levels of education, nursing unit type, followers' years of experience, and leaders' years of supervisory experience, there is no connection between the nurse leaders' perceived conflict style (avoidance, compromising, dominating, integrating, and obligation) and improper disruptive behavior by doctors or prescribers.

H02: According to the follower, after adjusting for the gender, age, job title, level of education, type of nursing unit, followers' years of experience, and leaders' years of supervisory experience, there is no connection between the nurse leaders' perceived conflict style (avoidance, compromising, dominating, integrating, and obedience) and unsafe disruptive behavior by doctors or prescribers.

H03: According to the follower, after adjusting for the gender, age, job title, level of education, type of nursing unit, followers' years of experience, and leaders' years of supervisory experience, there is no connection between the nurse leaders' perceived conflict style (avoidance, compromising, dominating, integrating, and obligation) and inappropriate disruptive behavior by others.

H04: According to the follower, after adjusting for the gender, age, job title, level of education, type of nursing unit, followers' years of experience, and leaders' years of supervisory experience, there is no connection between the nurse leaders' perceived conflict style (avoidance, compromising, dominating, integrating, and obligation) and unsafe disruptive behavior by others.

3.6 Ethical Considerations

The questionnaire was anonymous, risk-free, and optional. The cost of participation was waived. There were no dangers that were foreseen for participants. An informed consent was signed by each participant. The internal review board at Al-Quds University gave its approval to the survey.

CHAPTER FOUR:

Results

4.1 Demographic characteristics of the Respondents

Three hundred twenty questionnaires were distributed to the nursing staff at government and private hospitals in Palestine. Three hundred seventy-three (97.2%) respondents returned completed questionnaires and were included in the statistical analysis**.** The study sought to determine the demographic characteristics of the respondents. The characteristics measured in the study were; gender, age, level of education, Years of experience, and type of shift.

To verify the validity of the tool of study, it was presented to a group of reviewers who are specialized in this field. All their notes were taken into consideration. In addition, to check the reliability of the tool it was applied of a sample of nurses, which included 20 male and female nurses from government and private hospitals other than those in the sample. Reliability is defined as the extent to which an instrument consistently measures a concept. The Reliability scale (Alpha Cronbach) computed on a pilot study was 0.881.

The results in Table 4.1 shows that (53.1%) of the respondents were males while the rest (46.1%) were female suggesting that there was gender parity in the department of healthcare services in Palestine. The results also showed that more than half (55.9%) of the respondents were aged between 30-39 years, followed by (36.7%) were aged between

20-29% years. Regarding the level of education, more than half (54.0%) of participants were bachelor holder, (3.7%) diploma holder, and (10.3%) were mater degree holders. The types of job titles were categorized as staff nurse, charge nurse, Head Nurse, and continuous education. The majority of nurses was staff nurses (196, or 63.0%). Regarding nurse's experience, 41 (13.2%) had less than 1 years of experience, 133 (42.8%) had 1-5 years of experience, 61 (19.6%) had 10 years of r experience, and only 39 (10.6%) had 16 and more years of experience. Finally, for the type of shift, 136(40.5%) reported evening shift, 78 (25.1%) reported morning shift, 45(14.5%) reported night shift, and 62(19.9%) reported others (evening and night which they called BC).

Table (4.1): The distribution of follower demographic characteristics of the Respondents

Characteristic	**Numbers**	**Percentages (%)**
Gender		
Male	165	53.1%
Female	146	46.9%
Age-group		
20-29 years	114	36.7%
30-39 years	174	55.9%
40-49 years	23	7.4%
Qualification		
Diploma	104	33.4%
Bachelor	168	54.0%
Master	32	10.3%
Others	7	2.3%
Job title		
Staff nurse	196	63.0%
Head nurse	74	23.8%
Head nurse	12	3.9%
Continuous education	29	9.3
Department		
Medical/surgical	193	62.1%
Pediatric	49	15.8%
ICU	49	15.8%
Maternity	20	6.4%
Years of experience		
Less than 1 year	41	13.2%

Characteristic	Numbers	Percentages (%)
Gender		
Male	165	53.1%
Female	146	46.9%
1-5 years	133	42.8%
6-10 years	43	13.8%
11-15 years	61	19.6%
16 years and more	39	10.6%
Usual shift that you work		
Day	78	25.1%
Evening	126	40.5%
Night	45	14.5%
Others	62	19.9%

4.2 Disruptive Behavior Questionnaire Ratings

Table 4.2 shows the distribution of scores on improper behavior by others (e.g. pharmacist, nurse, supervisor). The survey for disruptive behavior by others used the same scale as the survey for disruptive behavior by physicians/prescribers. Very few participants reported experiencing a high frequency of unsafe disruptive behavior by physician from nurses' perspectives.

Table 4.2: The distribution of scores on improper behavior by physicians from nurses' perspectives

Characteristics		Frequency	%
Reluctance or refusal to answer your questions, return phone call	**often**	146	46.9
	Sometimes	65	20.9
	Rarely	27	8.7
	Never	73	23.5
Condescending language or tone of voice	**often**	40	12.9
	Sometimes	143	46.0
	Rarely	67	21.5
	Never	61	19.6
Impatient with questions	**often**	66	21.2
	Sometimes	118	37.9
	Rarely	127	40.8
	Never	-	
Strong verbal abuse	**often**	98	31.5
	Sometimes	77	24.8

	Rarely	103	33.1
	Never	33	10.6
Negative or threatening body language	**often**	54	17.4
	Sometimes	123	39.5
	Rarely	89	28.6
	Never	45	14.5
Reporting you to your manager (actual or threat)	**often**	83	26.7
	Sometimes	94	30.2
	Rarely	124	39.9
	Never	10	3.2
Just give what the attending ordered	**often**	62	19.9
	Sometimes	69	22.2
	Rarely	100	32.2
	Never	80	25.7
Physical abuse	**often**	54	17.4
	Sometimes	144	46.3
	Rarely	22	7.1
	Never	91	29.3

Table 4.3 shows the distribution of scores on improper behavior by others (e.g. pharmacist, nurse, supervisor). The survey for disruptive behavior by others used the same scale as the survey for disruptive behavior by physicians/prescribers. Very few participants reported experiencing a high frequency of unsafe disruptive behavior by others from nurses' perspectives.

Table 4.3: The distribution of scores on improper behavior by others from nurses' perspectives

Items		Frequency	%
Reluctance or refusal to answer your questions, return phone call	often	120	38.6
	Sometimes	104	33.4
	Rarely	36	11.6
	Never	51	16.4
Condescending language or tone of voice	often	98	31.5
	Sometimes	124	39.9
	Rarely	80	25.7
	Never	9	2.9
Impatient with questions	often	69	22.2
	Sometimes	128	41.2
	Rarely	105	33.8
	Never	9	2.9
Strong verbal abuse	often	86	27.7
	Sometimes	129	41.5
	Rarely	76	24.4
	Never	20	6.4
Negative or threatening body language	often	61	19.6
	Sometimes	143	46.0
	Rarely	65	20.9
	Never	42	13.5
Reporting you to your manager (actual or threat)	often	93	29.9
	Sometimes	109	35.0
	Rarely	99	31.8
	Never	10	3.2
Just give what the attending ordered	often	79	25.4
	Sometimes	140	45.0
	Rarely	41	13.2
	Never	51	16.4
Physical abuse	often	87	28.0
	Sometimes	91	29.3
	Rarely	74	23.8
	Never	59	19.0

Table 4.4 shows that very few participants reported experiencing a high frequency of unsafe disruptive behavior by physician from nurses' perspective

Table 4.4: The distribution of scores on unsafe behavior by physician from nurses' perspectives

Items		Frequency	%
Yelling	**Once a year/or less**	265	85.2
	Several Times a Year	37	11.9
	Monthly	9	2.9
Cursing	**Once a year/or less**	148	47.6
	Several Times a Year	163	52.4
Degrading comments and insults	**Once a year/or less**	139	44.7
	Several Times a Year	150	48.2
	Monthly	13	4.2
	Weekly	9	2.9
Refusing to work together	**Once a year/or less**	74	23.8
	Several Times a Year	172	55.3
	Monthly	65	20.9
Refusing to speak to each other	**Once a year/or less**	98	31.5
	Several Times a Year	193	62.1
	Monthly	12	3.9
	Weekly	8	2.6
Spreading malicious rumors	**Once a year/or less**	97	31.2
	Several Times a Year	194	62.4
	Monthly	20	6.4
Inappropriate joking	**Once a year/or less**	113	36.3
	Several Times a Year	132	42.4
	Monthly	33	10.6
	Weekly	33	10.6
Trying to get someone disciplined unjustly	**Once a year/or less**	112	36.0
	Several Times a Year	134	43.1
	Monthly	65	20.9
Trying to get someone fired unjustly	**Once a year/or less**	117	37.6
	Several Times a Year	110	35.4
	Monthly	38	12.2
	Weekly	46	14.8
Throwing objects	**Once a year/or less**	104	33.4
	Several Times a Year	170	54.7
	Monthly	37	11.9
Sexual harassment	**Once a year/or less**	157	50.5
	Several Times a Year	134	43.1
	Monthly	20	6.4
Physical assault	**Once a year/or less**	144	46.3
	Several Times a Year	120	38.6
	Monthly	27	8.7
	Weekly	20	6.4

Table 4.5 presents the results of using One-way ANOVA, and shows that there are statistically significant differences between intimidating behaviors by physicians/ prescribers and five demographic variables, namely “age-group”, years of experience”, “department” “position”, and “type of shift”. The other character “level of education” was not significantly different regarding disruptive behavior by physicians/prescribers.

Table 4.5 The ANOVA for intimidating behaviors by physicians/ prescribers and demographic variables

	Characteristics	Mean (SD)	F-statistics(df)	P-value
Age-group	20-29 year (n=114)	2.06(.9)	16.34(2)	<.001
	30-39 year (174)	2.54(.6)		
	40-49 year (23)	2.20(.4)		
Level of education	Diploma (104)	2.27(.9)	1.62(3)	.185
	Bachelor (168)	2.39(.7)		
	Master (32)	2.38(.9)		
	Others (7)	1.88(.5)		
Years of experience	Less than 1 year (41)	1.72(.4)	23.30(4)	<.001
	1-5 years (133)	2.24(.8)		
	6-10 years (43)	2.37(.4)		
	11-15 year (61)	2.93(.7)		
	16 year and above (33)	2.56(.3)		
Department	Medical/surgical (193)	2.19(.8)	13.41(3)	<.001
	Pediatric (49)	2.34(.6)		
	ICU (49)	2.89(.5)		
	Maternity (20)	2.38(.9)		
Position	Staff nurse (196)	2.43(.8)	9.59(3)	<.001
	Charge nurse (74)	2.00(.5)		
	Head nurse (12)	2.59(.5)		
	Continuous education (29)	2.56(.3)		
Type of shift	Day (78)	2.09(.6)	16.03(3)	<.001
	Evening (126)	2.62(.7)		
	Night (45)	1.94(.9)		
	Others (62)	2.37(.4)		

Table 4.6 presents the results of using One-way ANOVA, and shows that there are statistically significant differences between intimidating behaviors by others (e.g., pharmacist, nurse, supervisor) and five demographic variables, namely "age-group", years of experience", "department" "position", and "type of shift". The other character "level of education" was not significantly different regarding intimidating behaviors by others (e.g., pharmacist, nurse, supervisor).

Table 4.6 The ANOVA for intimidating behaviors by others (e.g., pharmacist, nurse, supervisor) and demographic variables

	Characteristics	Mean (SD)	F-statistics(df)	P-value
Age-group	20-29 year (n=114)	1.91(.8)	13.69(2)	<.001
	30-39 year (174)	2.33(.6)		
	40-49 year (23)	2.01(.4)		
Level of education	Diploma (104)	2.17(.9)	.82(3)	.482
	Bachelor (168)	2.18(.6)		
	Master (32)	1.97(.4)		
	Others (7)	2.14(.3)		
Years of experience	Less than 1 year (41)	1.68(.5)	37.00(4)	<.001
	1-5 years (133)	1.97(.7)		
	6-10 years (43)	2.03(.2)		
	11-15 year (61)	2.93(.7)		
	16 year and above (33)	2.20(.3)		
Department	Medical/surgical (193)	1.99(.7)	22.50(3)	<.001
	Pediatric (49)	2.18(.4)		
	ICU (49)	2.83(.5)		
	Maternity (20)	2.00(.9)		
Position	Staff nurse (196)	2.26(.8)	12.17(3)	<.001
	Charge nurse (74)	1.75(.4)		
	Head nurse (12)	2.48(.5)		
	Continuous education (29)	2.35(.5)		
Type of shift	Day (78)	199(.7)	6.22(3)	<.001
	Evening (126)	2.35(.8)		
	Night (45)	1.96(.9)		
	Others (62)	2.10(.3)		

Table (4.7) shows frequencies and percentages of behaviors by Physicians that nurses experienced in the past year several times a year. The results showed that refusing to work together (62.1%), followed by Refusing to work together (55.3%), and Throwing objects (54.7%) were the most prevailing behavior by physicians against nurses. Whereas, the least prevailing behavior was trying to get someone fired unjustly (35.4%) and yelling (11.9%).

Table 4.7: The percentages and frequencies of Improper Disruptive Behavior by Physicians that nurses experienced in the past year

Please indicate how frequently in the past year you've experienced these behaviors by Physicians	% Of Once a Year or Less	% Of Several Times a Year	% of Monthly	% of Weekly	% of Daily
Yelling	265(85.2)	37(11.9)	9(2.9)	-	-
Cursing	148(47.6)	163(52.4)	--	-	-
Degrading comments and insults	139(44.7)	150(48.2)	13(4.2)	9(2.9)	-
Refusing to work together	74(23.8)	172(55.3)	65(20.9)	-	-
Refusing to speak to each other	98(31.5)	193(62.1)	12(3.9)	-	8(2.6)
Spreading malicious rumors	112(36.0)	134(43.1)	65(20.9)	-	-
Trying to get someone fired unjustly	117(37.6)	110(35.4)	38(12.2)	46(14.8)	-
Throwing objects	104(33.4)	170(54.7)	37(11.9)	-	-
Sexual harassment	157(50.5)	134(43.1)	20(6.4)	-	-
Physical assault	144(46.3)	120(38.6)	27(8.7)	20(6.4)	-

Table (4.8) shows frequencies and percentages of unsafe Disruptive Behavior that nurses experienced in the past year several times a year. The results showed that just give what I/the attending ordered (55.9%), followed by return phone calls or page (50.8%), and throwing objects (46.3%) were the most prevailing unsafe Disruptive Behavior by others against nurses. Whereas, the least prevailing unsafe Disruptive

Behavior was Refusing to work together (35.4%) and negative or threatening body language (30.9%).

Table 4.8: The percentages and frequencies of Unsafe Disruptive Behavior by Others that nurses experienced in the past year

Please indicate how frequently in the past year you've experienced these behaviors by Physicians	% Of Once a Year or Less	% Of Several Times a Year	% of Monthly	% of Weekly	% of Daily
Impatience with questions	128(41.2)	122(39.2)	13(4.2)	23(7.4)	25(8.0)
Reluctance to answer your questions	74(23.8)	142(45.7)	76(24.4)	19(6.1)	-
Return phone calls or page	91(29.3)	158(50.8)	12(3.9)	23(7.4)	27(8.7)
Just give what I/the attending ordered	81(26.0)	174(55.9)	48(15.4)	8(2.6)	-
Refusing to speak to each other	92(29.6)	116(37.3)	68(21.9)	35(11.3)	-
Refusing to work together	90(28.9)	110(35.4)	103(33.1)	8(2.6)	-
Negative or threatening body language	92(29.6)	96(30.9)	78(25.1)	45(14.5)	-
Throwing objects	88(28.3)	144(46.3)	71(22.8)	8(2.6)	-
Sexual harassment	138(44.4)	131(42.1)	25(8.0)	17(5.5)	-
Physical abuse and/or physical assault(	125(40.2)	122(39.2)	47(15.1)	17(5.5)	

Table 4.9 presents the correlations matrix between intimidating behaviors by others disruptive behavior (both improper and unsafe). The results showed that there were no statistically significant relationships found between disruptive behavior (both improper and unsafe) exhibited by others and intimidating behaviors. This lack of significant correlation suggests that these types of disruptive behaviors do not appear to be strongly associated with particular intimidating behaviors. This type of analysis can be important

in understanding workplace dynamics and how different behaviors and approaches relate to one another.

Table 4.9 The Correlations Matrix Between the Two Continuous Variables (Intimidating behaviors by others and disruptive behavior (both improper and unsafe).

		Intimidating behaviors by others
Intimidating behaviors by others	Pearson Correlation	1
	Sig. (2-tailed)	
	N	311
Improper	Pearson Correlation	-.039
	Sig. (2-tailed)	.496
	N	311
Unsafe	Pearson Correlation	-.012
	Sig. (2-tailed)	.835
	N	311

Table 4.10 presents the correlations matrix between intimidating behaviors by physician/or other prescriber and disruptive behavior (both improper and unsafe). The results showed that there were no statistically significant relationships found between disruptive behavior (both improper and unsafe) exhibited by others and intimidating behaviors. This lack of significant correlation suggests that these types of disruptive behaviors do not appear to be strongly associated with particular intimidating behaviors. This type of analysis can be important in understanding workplace dynamics and how different behaviors and approaches relate to one another.

Table 4.10 The Correlations Matrix Between the Two Continuous Variables (Intimidating behaviors by physician and disruptive behavior (both improper and unsafe).

		Intimidating behaviors by physician
Intimidating behaviors by physician	Pearson Correlation	1
	Sig. (2-tailed)	
	N	311
Improper	Pearson Correlation	.035
	Sig. (2-tailed)	.539
	N	311
Unsafe	Pearson Correlation	.058
	Sig. (2-tailed)	.311
	N	311

Table 4.11 presents the mean scores of all conflict management survey items and its dimensions. The results showed that the highest mean score of conflict management styles' dimensions was compromising style with a mean score of 2.44, SD =0.8, followed by obligating style with a mean score of 2.36, SD=0.8, and Dominating Style with a mean score of 2.31, SD = 0.7.

However, the lowest mean score domains were Avoiding Style dimension and Integrating Style dimension with a mean score of 2.29, SD = .515 and 2.21, SD = 0.7, respectively.

Regarding the integrating style items, the highest integrating item was "My nurse leader collaborates with his/her subordinates to come up with decisions acceptable to his/her" with a mean score 2.36, SD =1.1, followed by "My nurse leader tries to investigate an issue with his/her subordinates to find a solution acceptable to him/her" with a mean score 2.30, SD = 1.2. whereas, the least integrating item was "My nurse leader integrates his/her ideas with those of his/her subordinates to come up with a decision jointly", "My nurse leader tries to work with his/her subordinates to find solution to a problem that satisfies his/her expectations" and "My nurse leader exchanges accurate information with

his/her subordinates to solve a problem together" with a mean score 2.14, SD =0.8, 2.11, SD – 0.8, and 2.11, SD = 1.0, respectively.

Regarding the avoiding style, the highest avoiding item was "My nurse leader tries to avoid unpleasant exchanges with his/her subordinates" with a mean of 2.61, SD = 1.1, followed by "My nurse leader attempts to avoid being "put on the spot" and try to keep his/her conflict with his/her subordinates to him/herself" with a mean score 2.61, SD =1.1. However, the least avoiding item was "My nurse leader avoids an encounter with his/her subordinates" with a mean score of 2.21, SD = 1.2, followed by "My nurse leader attempts to avoid being "put on the spot" and try to keep his/her conflict with his/her subordinates to him/herself" with a mean score of 1.66, SD = 0.8.

Relating to Dominating Style, the highest Dominating Style item was "My nurse leader sometimes uses his/her power to win a competitive situation" with a mean score of 2.54, Sd = 1.2, followed by "My nurse leader uses his/her expertise to make a decision in his/her favor with a mean score 2.39, SD = 0.8. On the other hand, the least Dominating Style item was "My nurse leader uses his/her expertise to make a decision in his/her favor" with a mean score of 2.25, SD = 1.0, followed by "My nurse leader generally firms in pursuing his/her side of the issue" with a mean score 2.02, SD = 0.8.

For Obligating Style dimension, the highest Obligating Style item was "My nurse leader generally tries to satisfy the needs of his/her subordinates" with a mean score 2.63, SD = 1.0, followed by "My nurse leader usually accommodates the wishes of his/her subordinate" with a mean score 2.61, SD = 1.4. whereas, the least obligating style item was "My nurse leader gives in to the wishes of his/her subordinate" with a mean score of

2.18, SD = 1.2, followed by "My nurse leader tries to satisfy the expectations of his/her subordinates" with a mean score of 2.10, SD = 1.0.

Finally for the Compromising Style dimension, the highest Compromising Style item was "My nurse leader tries to find a middle course to resolve an impasse" with a mean score 2.62, SD = 10, followed by "My nurse leader negotiates with his/her subordinates so that a compromise can be reached" with a mean score of 2.50, SD = 1.3.

Table 4.11 Mean scores for each Conflict management styles' items and its domains (n= 311)

Item	Mean	SD
Integrating Style		
1. My nurse leader tries to investigate an issue with his/her subordinates to find a solution acceptable to him/her	2.30	1.2
2. My nurse leader integrates his/her ideas with those of his/her subordinates to come up with a decision jointly	2.14	.8
3. My nurse leader tries to work with his/her subordinates to find solution to a problem that satisfies his/her expectations	2.11	.8
4. My nurse leader exchanges accurate information with his/her subordinates to solve a problem together	2.11	1.0
5. My nurse leader tries to bring all his/her concerns out in the open so that the issues can be resolved in the best possible way	2.23	.9
6. My nurse leader collaborates with his/her subordinates to come up with decisions acceptable to his/her.	2.36	1.0
7. My nurse leader tries to work with his/her subordinates for a proper understanding of a problem	2.27	1.2
Overall Mean Score (7 items)	**2.21**	**.7**
Avoiding Style		
1. My nurse leader attempts to avoid being "put on the spot" and try to keep his/her conflict with his/her subordinates to him/herself	1.66	0.8
2. My nurse leader usually avoids open discussion of his/her differences with my supervisor.	2.29	1.1
3. My nurse leader tries to stay away from disagreement with his/her subordinates	2.49	1.0
4. My nurse leader avoids an encounter with his/her subordinates	2.21	1.2
5. My nurse leader tries to keep his/her disagreement with his/her subordinates to him/herself in order to avoid hard	2.50	1.1

feelings		
6. My nurse leader tries to avoid unpleasant exchanges with his/her subordinates	2.61	1.1
Overall Mean Score (6 items)	**2.29**	**0.7**
Dominating Style		
1. My nurse leader uses his influence to get his ideas accepted	2.34	1.1
2. My nurse leader uses his authority to make a decision in his favor	2.39	.9
3. My nurse leader uses his/her expertise to make a decision in his/her favor	2.25	1.0
4. My nurse leader generally firms in pursuing his/her side of the issue	2.02	.8
5. My nurse leader sometimes uses his/her power to win a competitive situation	2.54	1.2
Overall Mean Score (5 items)	**2.31**	**.7**
Obligating Style		
1. My nurse leader generally tries to satisfy the needs of his/her subordinates	2.63	1.0
2. My nurse leader usually accommodates the wishes of his/her subordinate	2.61	1.4
3. My nurse leader gives in to the wishes of his/her subordinate	2.18	1.2
4. My nurse leader usually allows concessions to his/her subordinates	2.42	1.3
5. My nurse leader often goes along with the suggestions of his/her subordinates	2.24	.9
6. My nurse leader tries to satisfy the expectations of his/her subordinates.	2.10	1.0
Overall Mean Score (6 items)	**2.36**	**.8**
Compromising Style		
1. My nurse leader tries to find a middle course to resolve an impasse	2.62	1.0
2. My nurse leader usually proposes a middle ground for breaking deadlocks	2.35	1.0
3. My nurse leader negotiates with his/her subordinates so that a compromise can be reached	2.50	1.3
4. My nurse leader uses "give and take" so that a compromise can be made	2.28	1.1
Overall Mean Score (4 items)	**2.44**	**.8**

Table 4.12 presents the results of using One-way ANOVA, and shows that there are statistically significant differences between all conflict styles dimensions (Avoiding, Compromising, Dominating, Integrating, Obliging) and age-group variables.

Table 4.12: Differences between age-group in terms of total scores of Conflict management styles (n= 311)

Dimensions	Age-group		Mean (SD)	F-statistics(df)	P-value
Avoiding	20-29	N=114	1.87(.7)	54.31(2)	<.001
	30-39	N=174	2.46(.5)		
	40-49	N=23	3.07(.1)		
Compromising	20-29	N=114	1.83(.7)	77.11(2)	<.001
	30-39	N=174	2.72(.7)		
	40-49	N=23	3.32(.5)		
Dominating	20-29	N=114	1.88(.6)	43.50(2)	<.001
	30-39	N=174	2.51(.6)		
	40-49	N=23	2.92(.6)		
Integrating	20-29	N=114	1.99(.8)	9.48(2)	<.001
	30-39	N=174	2.32(.6)		
	40-49	N=23	2.51(.1)		
Obliging	20-29	N=114	1.81(.8)	71.94(2)	<.001
	30-39	N=174	2.58(.6)		
	40-49	N=23	3.45(.3)		

Table 4.13 presents the results of using One-way ANOVA, and shows that there are statistically significant differences between all conflict styles dimensions (Avoiding, Compromising, Dominating, Integrating, Obliging) and level of education variables.

Table 4.13: Differences between level of education in terms of total scores of Conflict management styles (n= 311)

Dimension	Education	N	Mean (SD)	F-statistics(df)	P-value
Avoiding	diploma	N=104	1.95(.5)	24.64(3)	<0.001
	bachelor	N=168	2.57(.7)		
	Master	N=32	2.08(.4)		
	PhD	N=7	1.67(.9)		
Compromising	diploma	N=104	2.01(.6)	20.22(3)	<0.001
	bachelor	N=168	2.71(.9)		
	Master	N=32	2.56(.5)		
	PhD	N=7	1.64(.1)		
Dominating	diploma	N=104	2.03(.7)	21.09(3)	<0.001
	bachelor	N=168	2.58(.6)		
	Master	N=32	1.85(.4)		
	PhD	N=7	1.89(.1		
Integrating	diploma	N=104	2.19(.8)	11.11(3)	<0.001
	bachelor	N=168	2.36(.6)		
	Master	N=32	1.64(.6)		
	PhD	N=7	1.73(.2)		
Obliging	diploma	N=104	2.08(.8)	21.20(3)	<0.001
	bachelor	N=168	2.68(.8)		
	Master	N=32	1.79(.8)		
	PhD	N=7	1.67(.9)		

Table 4.14 presents the results of using One-way ANOVA, and shows that there are statistically significant differences between all conflict styles dimensions (Avoiding, Compromising, Dominating, Integrating, Obliging) and years of experience variables.

Table 4.14: Differences between years of experience in terms of total scores of Conflict management styles (n= 311)

Dimension	Experience	N	Mean (SD)	F-statistics (df)	P-value
Avoiding	less than 1 year	N=41	1.83(.5)	61.25(4)	<0.001
	1-5	N=133	1.94(.7)		
	6-10	N=43	2.43(.1)		
	11-15	N=61	2.82(.4)		
	16 and more	N=33	3.13(.5)		
Compromising	less than 1 year	N=41	1.81(.5)	66.48(4)	<0.001
	1-5	N=133	2.01(.7)		
	6-10	N=43	2.79(.2)		
	11-15	N=61	2.95(.7)		
	16 and more	N=33	3.55(.9)		
Dominating	less than 1 year	N=41	1.83(.6)	93.13(4)	<0.001
	1-5	N=133	1.92(.6)		
	6-10	N=43	2.63(.2)		
	11-15	N=61	2.57(.3)		
Integrating	16 and more	N=33	3.58(.5)	45.13(4)	<0.001
	less than 1 year	N=41	1.84(.7)		
	1-5	N=133	1.88(.7)		
	6-10	N=43	2.20(.1)		
	11-15	N=61	2.93(.3)		
Obliging	16 and more	N=33	2.69(.4)	72.53(4)	<0.001
	less than 1 year	N=41	1.85(.7)		
	1-5	N=133	1.85(.8)		
	6-10	N=43	2.81(.2)		
	11-15	N=61	3.05(.3)		

Table 4.15 presents the results of using One-way ANOVA, and shows that there are statistically significant differences between all conflict styles dimensions (Avoiding, Compromising, Dominating, Integrating, Obliging) and department variables.

Table 4.15: Differences between department in terms of total scores of Conflict management styles (n= 311)

Dimensions	Department	N	Mean	F-statistics (df)	P-value
Avoiding	medical/surgical	193	2.03(.6)	67.55(3)	<0.001
	Pediatric	49	2.20(.3)		
	ICU	49	2.99(.4)		
	maternity	20	3.33(.9)		
Compromising	medical/surgical	193	2.21(.7)	67.07(3)	<0.001
	Pediatric	49	2.20(.5)		
	ICU	49	2.85(.5)		
	maternity	20	4.25(.9)		
Dominating	medical/surgical	193	2.03(.6)	73.16(3)	<0.001
	Pediatric	49	2.33(.3)		
	ICU	49	2.77(.6)		
	maternity	20	3.80(.9)		
Integrating	medical/surgical	193	1.97(.7)	37.94(3)	<0.001
	Pediatric	49	2.21(.6)		
	ICU	49	2.85(.5)		
	maternity	20	3.00(.9)		
Obliging	medical/surgical	193	2.05(.8)	41.46(3)	<0.001
	Pediatric	49	2.51(.6)		
	ICU	49	2.98(.4)		
	maternity	20	3.50(.9)		

Table 4.16 presents the results of using One-way ANOVA, and shows that there are statistically significant differences between all conflict styles dimensions (Avoiding, Compromising, Dominating, Integrating, Obliging) and position variables.

Table 4.16: Differences between position in terms of total scores of Conflict management styles (n= 311)

Dimensions	Position	N	Mean (SD)	F-statistics (df)	P-value
Avoiding	staff nurse	196	2.17(.6)	51.71(3)	<0.001
	charge nurse	74	2.06(.6)		
	head nurse	12	2.96(.5)		
	continuous education	29	3.44(.2)		
Compromising	staff nurse	196	2.29(.6)	23.64(3)	<0.001
	charge nurse	74	2.38(.9)		
	head nurse	12	2.65(.4)		
	continuous education	29	3.55(1.1)		
Dominating	staff nurse	196	2.23(.6)	39.45(3)	<0.001
	charge nurse	74	1.20(.5)		
	head nurse	12	3.33(.7)		
	continuous education	29	3.24(.8)		
Integrating	staff nurse	196	2.22(.7)	30.24(3)	<0.001
	charge nurse	74	1.81(.7)		
	head nurse	12	2.38(.4)		
	continuous education	29	3.13(.2)		
Obliging	staff nurse	196	2.31(.7)	20.60(3)	<0.001
	charge nurse	74	2.05(1.1)		
	head nurse	12	2.97(.6)		
	continuous education	29	3.29(.3)		

Table 4.17 presents the results of using One-way ANOVA, and shows that there are statistically significant differences between all conflict styles dimensions (Avoiding, Compromising, Dominating, Integrating, Obliging) and type of shift variables.

Table 4.17: Differences between type of shift in terms of total scores of Conflict management styles (n= 311)

Dimension	Type of shift	N	Mean (SD)	F statistics (df)	P-value
Avoiding	day	78	2.15(.8)	29.71(3)	<0.001
	evening	126	2.32(.5)		
	night	45	1.73(.7)		
	others	62	2.83(.5)		
Compromising	day	78	1.86(.6)	83.59(3)	<0.001
	evening	126	2.52(.5)		
	night	45	1.89(.8)		
	others	62	3.41(.8)		
	Day	78	1.99(.8)	21.78(3)	<0.001
	evening	126	2.32(.6)		
	night	45	2.08(.6)		
	others	62	2.86(.7)		
Integrating	day	78	2.08(.8)	9.18(3)	<0.001
	evening	126	2.20(.7)		
	night	45	1.97(.9)		
	others	62	2.60(.4)		
Obliging	day	78	2.11(.8)	45.11(3)	<0.001
	evening	126	2.27(.6)		
	night	45	1.84(1.1)		
	others	62	3.26(.4)		

In order to explain the results presented in table 4.17, Likert scale traditional analysis and key is used as presented in the following table.

Table 4.3: Likert scale key

Mean	**Scale**
1 – 2.33	Low
2.34 – 3.66	Intermediate
3.67 - 5	High

Table 4.18 presents the total mean score for each of conflict style dimensions from nurses' perception. Nurses reported low level in three dimensions, namely: integrating,

dominating, and obligating dimensions. On the other hand, they reported moderate level in two conflict management style dimensions, namely: avoiding and compromising.

Table 4.18 Total mean score for each domain of conflict management style (n=311)

Conflict domains	N	Mean	Std. Deviation	Conflict rating
Integrating	311	2.2915	.69564	Low
Avoiding	311	2.4397	.84205	Intermediate
Dominating	311	2.3087	.73310	Low
Obligating	311	2.2145	.71978	Low
Compromising	311	2.3644	.84842	Intermediate

4.3 The Correlations Matrix Between disruptive behavior and conflict styles.

The correlation matrix between disruptive behavior and conflict styles, two continuous variables, is displayed in Table 4.19. Conflict style and inappropriate disruptive conduct by doctors or prescribers were significantly correlate. Conflict style and risky disruptive conduct by doctors or prescribers were significantly correlate.

Conflict style and inappropriate disruptive conduct by others were significantly correlated. Other people's inappropriate disruptive behavior had a moderately positive correlation (r =.352) with the integrating style of conflict management, a strong positive correlation (r =.630) with the obliging style, and a strong positive correlation (r =.770) with the compromising style.

Conflict style and other people's dangerously disruptive behavior were significantly correlated. The three conflict management styles that showed the strongest positive correlations were the compromising style (r =.815), the obliging style (r =.761), and the

integrating style (r =.753). These behaviors were classified as unsafe disruptive behavior by others.

The disruptive behavior components and the conflict styles showed strong correlation with each another.

Physicians' and prescribers' inappropriate disruptive behavior was found to be weakly positively correlated with their unsafe disruptive behavior (r =.035) and a highly positively correlated with other people's improper disruptive behavior (r =.908) and with unsafe disruptive behavior (r =.703).

The study found a strong positive correlation between the unsafe disruptive conduct shown by physicians/prescribers and the incorrect and unsafe disruptive behavior exhibited by others (r =.908) and by others (r =.703).

There was a strong positive correlation (r =.637) between hazardous disruptive activity and improper disruptive behavior by others.

An integrating conflict style and an obliging conflict style (r =.823), an integrating conflict style and a dominating conflict style (r =.757), an integrating conflict style and an avoiding conflict style (r =.850), and an integrating conflict style and a compromising conflict style (r =.635) all showed significant correlations.

An obliging conflict style and an avoiding conflict style (r =.871) as well as an obliging conflict style and a compromising conflict style (r =.847) showed significant relationships. A dominant conflict style and an avoiding conflict style showed a strong association (r =.822). A compromising conflict style and an avoiding conflict style showed a strong link (r =.811).

Table 4.19 The Correlations Matrix Between the Two Continuous Variables *(disruptive behavior and conflict styles).*

Correlations										
		1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**
Disruptive behavior physician	r	1	.908**	.035	.703**	.625**	.439**	.523**	.740**	.542**
	P-value		.000	.539	.000	.000	.000	.000	.000	.000
disruptive behavior by nurse	r	.908**	1	-.039	.686**	.557**	.348**	.508**	.763**	.530**
	P-value	.000		.496	.000	.000	.000	.000	.000	.000
Improper	r	.035	-.039	1	.637**	.554**	**.770****	.608**	**.352****	**.630****
	P-value	.539	.496		.000	.000	.000	.000	.000	.000
Unsafe	r	.703**	.686**	.637**	1	.796**	.816**	.750**	**.753****	**.761****
	P-value	.000	.000	.000		.000	.000	.000	.000	.000
Avoiding	r	.625**	.557**	.554**	.796**	1	.811**	.822**	.850**	.871**
	P-value	.000	.000	.000	.000		.000	.000	.000	.000
Compromising	r	.439**	.348**	.770**	.816**	.811**	1	.832**	.635**	.847**
	P-value	.000	.000	.000	.000	.000		.000	.000	.000
Dominating	r	.523**	.508**	.608**	.750**	.822**	.832**	1	.757**	.849**
	P-value	.000	.000	.000	.000	.000	.000		.000	.000
Integrating	r	.740**	.763**	.352**	.753**	.850**	.635**	.757**	1	.823**
	P-value	.000	.000	.000	.000	.000	.000	.000		.000
Obliging	r	.542**	.530**	.630**	.761**	.871**	.847**	.849**	.823**	1
	P-value	.000	.000	.000	.000	.000	.000	.000	.000	
**. Correlation is significant at the 0.01 level (2-tailed).										

CHAPTER FIVE

Discussion and Conclusion

This chapter presents the summary of the study results, discussion of the results, conclusion, recommendations, and limitation of the study.

5.1 Summary of the Study

This study investigates the perception of nurses regarding the intimidation disruptive behaviors in different healthcare settings. The relationship between different demographic variables included in this study and the frequency of how often nurses perceived they experienced intimidating and disruptive behaviors. This study targeted four governmental hospitals and two private hospitals in the northern region of Palestine, 320 questionnaires were distributed, and 311 were returned with a response rate of 97.2%.

5.2 Discussion

The first research question was, "Is there any differences in the perception of intimidation and disruptive behaviors frequency among nurses by demographic variables?" The results showed that there is a significant difference in the frequencies of experiencing intimidation disruptive behaviors between the nurses by different demographic variables, namely: gender, age-group, years of experience, type of shift, and department. The results also showed that there are no significant differences in the frequencies of experiencing intimidation disruptive behaviors between the nurses by level of education. These results are different from the results of a previous study done by

Smetzer and Cohen (2005). The possible explanation for this finding may be that less experienced nurses may be not sheltered by more experienced nurses. On the other hand, the study results are consistent with other previous similar study conducted by

The relationship between total years of work experience and the in the frequencies of experiencing intimidation disruptive behaviors between the nurses by Anderson (2002), which showed that more than half of the nurses surveyed experienced disruptive behavior during their first six years of employment.

It's interesting to note the correlation between job roles within the nursing profession and the likelihood of experiencing disruptive behavior from physicians or prescribers. The fact that Registered Nurses (RNs) and Nursing Supervisors/Managers encounter more of this behavior, likely due to their closer interactions with physicians, highlights an area where targeted training and intervention could be beneficial.

Developing training programs that focus on conflict management styles and effective communication with physicians and prescribers could indeed help improve the overall work environment and reduce instances of disruptive behavior. This finding underscores the importance of addressing these dynamics within healthcare settings, especially given the limited existing data on how job titles relate to experiences of disruptive behavior in this context.

Implementing such training initiatives could not only enhance workplace relationships and collaboration but also contribute to a more positive and supportive environment for nursing professionals.

The variation in disruptive behavior experienced across different work units within healthcare settings suggests that organizational culture and the nature of care delivered

may play significant roles. Work units that handle higher severity care, trauma cases, or have rapidly changing environments might experience different dynamics in their interactions with physicians and prescribers compared to units with different characteristics or skill sets.

Conducting an analysis of each unit's culture and how employees navigate communication with physicians and prescribers within that context could be highly beneficial. This analysis could help identify strengths and challenges within each unit's culture and provide insights into how to effectively manage and mitigate disruptive behavior. This finding aligns with existing literature, which also highlights the impact of work unit dynamics on experiences of disruptive behavior (Rosenstein, 2002; Rosenstein & O‟Daniel, 2005; Rosenstein & O‟Daniel, 2008; Smetzter& Cohen, 2005; Solfield & Salmond, 2003).

By understanding these nuances, healthcare organizations can tailor interventions and support mechanisms to foster better collaboration and communication, ultimately enhancing the overall work environment and patient care outcomes.

The key finding that an Integrating Conflict Style was the sole predictor for both Improper Disruptive Behavior and Unsafe Disruptive Behavior by others, but not specifically by Physicians/Prescribers, suggests an interesting dynamic in how conflict management approaches relate to disruptive behavior in healthcare settings.

This finding implies that having an integrating conflict style—characterized by a collaborative and problem-solving approach—can be effective in mitigating disruptive behavior from various sources within the healthcare environment, not just physicians or

prescribers specifically. It underscores the importance of fostering a culture of respectful and constructive conflict resolution across all levels of healthcare teams.

While conflict style may not directly predict disruptive behavior by physicians or prescribers, the broader application of integrating conflict strategies could still contribute to a more positive and supportive workplace climate, reducing instances of disruptive behavior overall.

These insights highlight the potential value of training and supporting healthcare professionals in adopting effective conflict management styles that promote teamwork, communication, and ultimately, a safer and more respectful working environment.

5.3 Limitation of the Study

Based on the acknowledged limitations of the study, here's a summary of the identified constraints:

Sample of Convenience

- The study utilized a sample of convenience, which means that participants were selected based on their accessibility or availability rather than through random sampling.
- This limitation suggests that the findings may not be generalizable to the entire population of nurses or healthcare settings, as the sample may not accurately represent the broader demographic or geographic diversity.

Lack of Specific Questions

- The study did not include questions related to the size of the hospital or the nursing unit.

- This omission is important because the size of the healthcare institution and specific nursing units could potentially impact the frequency and perception of intimidating behaviors.

Focus on Leader Characteristics

- All responses in the study were provided by followers (presumably nurses) regarding various leader characteristics.
- While this approach provides valuable insights into nurses' perceptions of their leaders, it may overlook other important factors or perspectives within the healthcare environment.

Variables Not Considered

- The study did not explicitly inquire about certain leader characteristics, such as leader gender, ethnicity, age, job title, education, or years of supervisory experience.

This limitation suggests that certain nuances or variations in leadership characteristics that could influence perceptions of intimidation may not have been fully explored.

Acknowledging these limitations is crucial for understanding the scope and applicability of the study's findings. Future research in this area could aim to address these constraints by employing more diverse sampling methods, including a broader range of variables, and considering additional contextual factors within healthcare settings.

5.4 Recommendations for Future Research

The exploration of conflict management styles and their impact on disruptive behavior in healthcare settings presents several intriguing avenues for future research. Here are some potential perspectives and questions that could be investigated:

1. **Impact of Chief Medical Officer (CMO) and Suite Executives' Conflict Management Styles:**
    - Investigate whether the conflict management style of the CMO or other suite executives influences the level of disruptive behavior exhibited by physicians and prescribers.
    - Explore how different conflict management approaches at the executive level can contribute to a positive or negative organizational culture regarding conflict resolution.
2. **Integrative Conflict Management and Counterproductive Behaviors:**
    - Investigate whether utilizing an integrating conflict management style by unit leaders correlates with decreased counterproductive behaviors among physicians and prescribers.
    - Explore the effectiveness of integrative conflict resolution techniques in promoting a collaborative and respectful work environment.
3. **Training in Integrative Conflict Management for Unit Leaders:**
    - Assess the potential benefits of training unit leaders in handling conflict using an integrating approach.

- Measure outcomes such as reduced turnover rates, increased job satisfaction, improved employee engagement, enhanced communication, and higher quality of patient care resulting from conflict management training.

4. **Long-Term Organizational Impact:**
    - Examine the long-term organizational impact of promoting effective conflict resolution strategies among healthcare leaders.
    - Investigate how a culture of constructive conflict management can contribute to overall organizational resilience, staff retention, and patient outcomes.

These future research opportunities hold promise for advancing knowledge in healthcare management and improving the quality of healthcare delivery. By exploring these dimensions, researchers can provide valuable insights into the complex dynamics of conflict resolution within healthcare organizations and inform evidence-based practices for promoting a positive and productive work environment.

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Appendices

الجزء الأول: المعلومات الشخصية

يرجى اختيار ما ينطبق عليك من إجابة.

الجنس:

1. أنثى.
2. ذكر.

العمر:

1. من 20–29 سنة
2. من 30–39 سنة
3. من 40–49 سنة
4. من 50– 59 سنة
5. 60 سنة فأكثر

المؤهل العلمي:

1. دبلوم
2. بكالوريوس
3. ماجستير

المسمى الوظيفي:

1. مدير قسم التمريض
2. اداري (ليس ممرض)
3. مشرف نهاري
4. مشرف مسائي/ليلي
5. رئيس قسم
6. ممرض قانوني

القسم الثاني:

من فضلك أخبرنا عن عدد المرات التي واجهت فيها سلوكًا مخيفًا في العام الماضي.

الخيارات: غالبًا = أكثر من 10 مرات هذا العام

أحيانًا = 3-10 مرات هذا العام

نادرًا = 1-2 مرات هذا العام.

أبدا = لم اتعرض

يرجى الإشارة إلى عدد المرات التي واجهت فيها هذه السلوكيات مخيفة في العام الماضي باستخدام المقياس المبين اعلاه، ووضع إشارة (X) في المربع أمام كل منها:	**من قبل الممرض/المشرف/ مدير التمريض**			
سلوك تخويف محتمل	غالبا	احيانا	نادرا	ابدا
التردد أو الرفض للإجابة على أسئلتك، الرد على المكالمة الهاتفية				
لغة متعالية أو نبرة صوت				
غير صبور مع الأسئلة				
الإساءة اللفظية القوية				
لغة الجسد السلبية أو التهديدية				
إبلاغ مديرك عنك (فعليًا أو تهديدًا)				
فقط أعط ما أمر به الحضور				
الاعتداء الجسدي				

يرجى الإشارة إلى عدد المرات التي واجهت فيها هذه السلوكيات من قبل الأطباء في العام الماضي، وضع إشارة (X) في المربع أمام كل منها:	مرة واحدة او اقل سنويا	عدة مرات سنويا	اتعرض شهريا	اسبوعيا	يوميا
الصراخ					
اللعن					
التعليقات المهينة والشتائم					
رفض التحدث مع بعضهم البعض					
نشر الشائعات الخبيثة					
مزاح غير لائق					
محاولة تأديب شخص ما بشكل غير عادل					
محاولة طرد شخص ما ظلما					
رمي الأشياء					

التحرش الجنسي					
الاعتداء الجسدي					

يرجى تحديد المربع المناسب بعد كل عبارة، للإشارة إلى كيفية تعاملك مع خلافك أو صراعك مع مشرفك. حاول أن تتذكر أكبر عدد ممكن من حالات الصراع الأخيرة عند ترتيب هذه العبارات.

1. غير موافق بشدة 2. غير موافق 3. محايد 4 موافق 5. موافق بشدة

الفقرة	غير موافق بشدة	غير موافق	محايد	موافق	موافق بشدة
يحاول قائد التمريض الخاص بي التحقيق في مشكلة بالتشاور مع موظفيه لإيجاد حل مقبول له					
يحاول قائد التمريض عمومًا تلبية احتياجات موظفيه					
يحاول قائد التمريض الخاص بي تجنب "المواجهة" ويحاول الاحتفاظ بصراعه مع التمريض لنفسه.					
يقوم قائد التمريض بدمج أفكاره مع أفكار التمريض للتوصل إلى قرار مشترك					
يحاول قائد التمريض العمل مع موظفيه لإيجاد حل لمشكلة ترضي توقعاته					
عادةً ما يتجنب قائد التمريض الخاص بي المناقشة المفتوحة حول خلافاته مع مشرفي.					
يحاول قائد التمريض إيجاد حل وسط لحل المأزق					
يستخدم قائد التمريض نفوذه لفرض أفكاره					
يستخدم قائد التمريض سلطته لاتخاذ قرار لصالحه					

ISMP Survey on Workplace Intimidation

Please take a few minutes to tell us about your experiences with intimidation in the workplace. The purpose of this questions is to elicit information about how frequently healthcare practitioner encounter intimation, the form is takes, and its overall effect on medication safety. For the purpose of this questions “intimation” is defined as: any overt or covert interaction between healthcare professionals that results in either an intended or unintended reluctance to speak up about concerns, question patient care, or share an opinion on a subject.

Please tell us how frequently in the past year you have encountered potentially intimidating behaviour.

Key: Often=more than 10 times this year, Sometimes=3-10 times this year, Rarely=1-2 times this year.

potentially intimidating behaviour	By physicians			
	often	**Sometimes**	**Rarely**	**Never**
Reluctance or refusal to answer your questions, return phone call				
Condescending laguage or tone of voice				
Impatient with questions				
Strong verbal abuse				
Negative or threatening body language				
Reporting you to your manager (actual or threat)				
Just give what the attending ordered				
Physical abuse				

potentially intimidating behaviour	By nurse or supervisor			
	often	**Sometimes**	**Rarely**	**Never**
Reluctance or refusal to answer your questions, return phone call				
Condescending laguage or tone of voice				
Impatient with questions				
Strong verbal abuse				
Negative or threatening body language				
Reporting you to your manager (actual or threat)				
Just give what the attending ordered				
Physical abuse				

ACPE Doctor-Nurse Behavior Survey utilized for study

Please indicate how frequently in the past year you've experienced these behaviors by Physicians	**Once a Year or Less than Once a Year**	**Several Times a Year**	**Monthly**	**Weekly**	**Daily**
Yelling					
Cursing					
Degrading comments and insults					
Refusing to work together					
Refusing to speak to each other					
Spreading malicious rumors					
Inappropriate joking					
Trying to get someone disciplined unjustly					
Trying to get someone fired unjustly					
Throwing objects					
Sexual harassment					
Physical assault					

Please check the appropriate box after each statement, to indicate *how you handle your disagreement or conflict with your supervisor*. Try to recall as many recent conflict situations as possible in ranking these statements.

1=Stongly disagree, 2 =disagree, 3= neutral, 4 = agree, 5 = strongly agree

Items	SD	D	N	A	SA
My nurse leader tries to investigate an issue with his/her subordinates to find a solution acceptable to him/her					
My nurse leader generally tries to satisfy the needs of his/her subordinates					
My nurse leader attempts to avoid being "put on the spot" and try to keep his/her conflict with his/her subordinates to him/herself					

My nurse leader integrates his/her ideas with those of his/her subordinates to come up with a decision jointly					
My nurse leader tries to work with his/her subordinates to find solution to a problem that satisfies his/her expectations					
My nurse leader usually avoids open discussion of his/her differences with my supervisor.					
My nurse leader tries to find a middle course to resolve an impasse					
My nurse leader uses his influence to get his ideas accepted					
My nurse leader use his authority to make a decision in his favor					
My nurse leader usually accommodates the wishes of his/her subordinate					
My nurse leader gives in to the wishes of his/her subordinate					
My nurse leader exchanges accurate information with his/her subordinates to solve a problem together					
My nurse leader usually allow concessions to his/her subordinates					
My nurse leader usually proposes a middle ground for breaking deadlocks					
My nurse leader negotiates with his/her subordinates so that a compromise can be reached					
My nurse leader tries to stay away from disagreement with his/her subordinates					
My nurse leader avoid an encounter with his/her subordinates					
My nurse leader uses his/her expertise to make a decision in his/her favor					
My nurse leader often goes along with the suggestions of his/her subordinates					
My nurse leader uses "give and take" so that a compromise can be made					
My nurse leader generally firms in pursuing his/her side of the issue					
My nurse leader tries to bring all his/her concerns out in the open so that the issues can be resolved in the best possible way					
My nurse leader collaborates with his/her subordinates to come up with decisions acceptable to his/her.					
My nurse leader tries to satisfy the expectations of his/her subordinates					

My nurse leader sometimes uses his/her power to win a competitive situation					
My nurse leader tries to keep his/her disagreement with his/her subordinates to him/herself in order to avoid hard feelings					
My nurse leader tries to avoid unpleasant exchanges with his/her subordinates					
My nurse leader tries to work with his/her subordinates for a proper understanding of a problem					

أنماط الصراع بين قادة التمريض وتأثير هذه الأساليب على السلوك التخريبي

اعداد الطالبة: سوسن كمال محمود أبو شنب

اشراف الدكتور: فريد اغريب

ملخص

المقدمة: تضم مؤسسات الرعاية الصحية مجموعة واسعة من الأقسام والتخصصات ومجالات الخدمة، فضلاً عن العلاقات المعقدة بينها. قد تؤدي عوامل عديدة إلى الصراع، مما يؤثر في النهاية على السلوك. يحتاج القادة في قطاع الرعاية الصحية إلى معرفة كيفية التعامل مع الخلاف مع الاستمرار في تعزيز بيئة عمل تعاونية وممتعة. في قطاع الرعاية الصحية، يمكن أن يؤدي الترهيب والسلوك التخريبي إلى تعريض رعاية المرضى للخطر، ويؤدي إلى استياء الموظفين، ويؤدي إلى الاستنزاف المهني. تم ربط هذه الإجراءات بمشاكل تتعلق بسلامة المرضى، ورضا الممرضات، والاحتفاظ بالممرضات، وضعف العمل الجماعي والتواصل.

هدف الدراسة: هدفت هذه الدراسة الى دراسة تصورات التخويف والسلوكيات التخريبية في بيئة الرعاية الصحية وأسلوب إدارة الصراع لدى قادة التمريض وكذلك استكشاف العلاقة بين تصورات التخويف والسلوكيات التخريبية في بيئة الرعاية الصحية وقائد التمريض.

ألمنهجية: دراسة مقطعية كمية مع عينة مناسبة من الممرضات والإداريين العاملين في خمسة مستشفيات في المنطقة الشمالية من فلسطين لهذه الدراسة. تم إجراء دراستين: بحث تجريبي أصغر شارك فيه 20 مشاركًا ودراسة استقصائية أكبر للملاءمة شملت 311 مشاركًا. وهذا يلبي متطلبات تحليل القوة لما لا يقل عن 98 عضوا من العينة. سيكون الخطأ من النوع الثاني أقل احتمالاً مع حجم العينة الحالي.

النتائج: أشارت النتائج إلى أنه في حين توقع أسلوب الصراع المتكامل نشاطًا تخريبيًا خطيرًا وغير صحيح من قبل الآخرين (مثل الصيدلي أو الممرضة أو المشرف)، كما اظهرت الدراسة وجود سلوك تخريبي خطير وغير لائق من قبل الأطباء أو مقدمي الوصفات الطبية. ساهمت هذه الدراسة أيضًا في قاعدو بيانات مفيدة للأبحاث المستقبلية حول

العلاقة بين السلوك التخريبي والمسمى الوظيفي، والسلوك التخريبي وسنوات خبرة القائد، والسلوك التخريبي ووحدة العمل وأسلوب الصراع.

الخلاصة: الأطباء والممرضون لديهم وجهات نظر متميزة حول العالم. ويختلف تركيزهم على مرضاهم، كما هو الحال بالنسبة للطريقة التي تم تعليمهم بها. ولكن من خلال قبول ما تقدمه كل مهنة، قد يتعلم الممرضون الكثير من بعضهم البعض. سوف تتغير ديناميكيات مهنة التمريض إذا أصبح التعاون بين الطبيب والممرض هو القاعدة. بدلاً من الشعور بالتبعية، سوف ينظر الممرضون إلى أنفسهم على أنهم صناع تغيير لديهم أفكار مهمة للمشاركة. يمكن أن يفيد التعاون بين الأطباء والممرضات لتحديد استراتيجية رعاية المرضى الأكثر فعالية لمنظمات الرعاية الصحية في المستقبل، ستكون لسلامة المرضى والنتائج الناجحة الأولوية على التخويف والإجراءات التخريبية في بيئة الرعاية الصحية.