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Analyzing the concept of disruptive behavior in healthcare work: an integrative review*

Análise do conceito comportamento destrutivo no trabalho em saúde: revisão integrativa

Análisis del concepto comportamiento destructivo en el trabajo sanitario: revisión integrativa

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ABSTRACT

Objective: To analyze the concept of disruptive behavior in healthcare work. **Method:** An integrative review carried out in the theoretical phase of a qualitative research substantiated by the theoretical framework of the Hybrid Model of Concept Development. The search for articles was conducted in the CINAHL, LILACS, PsycINFO, PubMed and SciVerse Scopus databases in 2013. **Results:** 70 scientific articles answered the guiding question and lead to attributes of disruptive behavior, being: incivility, psychological violence and physical/sexual violence; with their main antecedents (intrapersonal, interpersonal and organizational) being: personality characteristics, stress and work overload; and consequences of: workers' moral/mental distress, compromised patient safety, labor loss, and disruption of communication, collaboration and teamwork. **Conclusion:** Analysis of the disruptive behavior concept in healthcare work showed a construct in its theoretical stage that encompasses different disrespectful conduct adopted by health workers in the hospital context, which deserve the attention of leadership for better recognition and proper handling of cases and their consequences.

DESCRIPTORS

Health Personnel; Social Behavior; Interpersonal Relations; Concept Formation; Patient Safety; Review.

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INTRODUCTION

The health work process involves intense social interaction, incorporating complex range of needs that comprises health professionals, managers and patients. This interaction is undoubtedly determined by working conditions and human factors that can influence the results of the performed services and patient safety.

Currently, a weakness in the values, attitudes, skills and behaviors that determine the safety culture in healthcare organizations is evident. Moreover, many aspects of the work context greatly interfere in the establishment of safety culture, particularly mental and physical overload, insufficient education and professional training, poor teamwork, the variety of employment contracts, high turnover and bad practices/disruptive behaviors [1].

In this context, the study of labor conditions and subjective characteristics of the health worker have led to an assessment of safety culture in hospitals. One of the important aspects involved in this culture is the human factors involved in the occurrence of errors, incidents and adverse events.

A recent study found 58 categories of risks identified in all aspects of a hospital working system, highlighting the people (lack of professionalism); the tasks (high workload); the tools and technologies (misuse); the physical environment (disorganized workspace); and the organization (hierarchical culture and non-compliance with guidelines). The authors report that balancing the work system and encouraging active and adaptive roles of the workers are key principles to improve the quality of healthcare and patient safety[2].

However, what can be noticed is the constant presence of human factors that imply greater insecurity and lower quality of service. In addition to a lack of competence, professionalism and training in the area, there is an increasing amount of professionals in hospital organizations whose behavior is coated with intimidation and hostility, reflected in stress, frustration, loss of focus, poor communication and reduced information transfer between team members, thereby endangering patient safety[3].

At the core of these behaviors lies disruptive behavior, defined as conduct, whether verbal or physical, that affects or potentially could negatively affect patient care. Outbursts of anger, retaliation against a co-worker and comments that weaken the confidence of a health professional in providing patient care are examples of such behavior[4].

Given the above, we see that disruptive behavior is a concept that articulates human behavior, the work process in healthcare and patient safety. However, the existence of other parallel concepts leads to difficulties in this approach and in understanding the phenomenon in practice. For example, the concepts of bullying, lateral violence, harassment and institutional violence[5-10].

Our objective is to therefore analyze the disruptive behavior concept in healthcare work.

METHOD

This is an integrative literature review, developed in the theoretical phase of research on the analysis of the disruptive behavior concept in healthcare work, according to the Hybrid Model of Concept Development[11].

This theoretical and methodological framework interconnects theoretical analysis and empirical observation, focusing on key aspects of the definition and measurement of the phenomenon in question. It consists of three stages which may be operationalized gradually, stage by stage, or simultaneously: *The Theoretical phase* (concept selection, search and literature review, conceptual and operational definition of the concept – measuring instrument); *The Field phase* (integration of theoretical analysis with empirical observations concerning the phenomenon in the context in which it is manifested) which involves establishing the study setting, selecting case studies, collecting and analyzing data; and *The Final analytical phase*, comprising a comparison between the data resulting from the initial theoretical phase and empirical observations, and defining the concept of presenting the final product, as well as identifying conceptual gaps that drive the development of other research[11].

This article shows the results of the theoretical phase, which aims to obtain a comprehensive domain of literature by dealing with the concept and acquiring a thorough understanding of the scope and on how it has been used around the subjects and over time. Such understanding requires a systematic and interdisciplinary search, initially directed to understanding the concept of meaning and, secondarily, to the various forms that it has been or can be measured. It consists of the following steps: 1. Selection of concept; 2. Search in literature; 3. Approximation of meaning; and 4. Selection of the concept definition to be worked with[11].

In the first stage, the choice of concept for analysis was clarified, justifying that disruptive behavior is a complex construct, considered a broad term applied to a wide range of "bad behaviors" which are reported in healthcare literature. Therefore, we selected this concept to comprise the study object, due to its relevance in understanding how this behavior manifests itself (its attributes), being related to its origin (antecedents) and its impact on staff, patient and organization (consequences).

The second stage is the literature review, which was carried out by the integrative review method in its six steps: 1. Selection of hypotheses or questions for the review; 2. Sampling; 3. Representation of the primary search characteristics; 4. Analysis of the findings; 5. Interpretation of results; and 6. Presentation of the review[12].

Initially, the following guiding question for the search of documents in the databases was asked: *What are the attributes, antecedents and consequences of the disruptive behavior concept in healthcare work?*

For this review stage, texts from original research articles, review and theoretical reflection were considered. The search was conducted from August to December 2013, in the following electronic databases: CINAHL (Cumulative Index to Nursing and Allied Heath Literature); LILACS (*Literatura Latino-Americana e do Caribe em Ciências da Saúde*); PsycINFO (extensive database that includes more than three million literature

records reviewed by peers in behavioral sciences and mental health); PubMed Central (PMC) (*The U.S. National Library of Medicine and National Institutes of Health* services; and SciVerse Scopus (largest database of reviewed literature citations in the world, including abstracts and citations of articles for academic journals).

The following descriptors were adopted: Uncontrolled: *Disruptive Behavior*; and controlled (registered in the *Medical Subject Heading* – MeSH): *Nursing* (Enfermagem); *Social Behavior* (Comportamento Social); *Delivery of Health Care* (Assistência à Saúde); *Attitude of Health Personnel* (Atitude do Pessoal de Saúde); *Interpersonal Relations* (Relações Interpessoais); *Interdisciplinary Communication* (Comunicação Interdisciplinar); *Organizational Culture* (Cultura organizacional); *Burnout, Professional* (Burnout); *Bullying*; *Workload* (Carga de Trabalho); and *Patient Safety* (Segurança do Paciente).

These descriptors were combined with the help of the Boolean connector AND in its various possibilities of crisscrossing in the title fields, abstract and subject, always considering disruptive behavior as the key descriptor.

Inclusion criteria were defined as: manuscripts published in English, Portuguese or Spanish; which addressed the disruptive behavior concept by professionals in the context of healthcare work without defining publication period or type of study, and which answered the guiding question.

Once selected, the studies were submitted to a thorough and comprehensive reading. Then relevant information was extracted to form the analysis corpus of the concept. A spreadsheet was prepared in order to gather the following information from the articles: Title, Objective(s), Author(s), Type of publication and method, Reference, Descriptors (MESH) and Concentration area. In addition, the instrument contained a chart in which the concept of analysis variables (antecedents, attributes and consequences; related concepts/confounders) were collected from the articles and gathered in detail.

In the third stage, we analyzed the different meanings of the concept and, later, a definition of the concept to be worked with in the field phase (fourth stage) was chosen. These steps and the review findings are described in Results.

RESULTS

The results of the search in the databases are shown in Figure 1.

Seventy scientific papers published between 1999 and 2013 were included in this review, with a significant quantity from 2009 (46 articles). This result shows that studies on disruptive behavior grew considerably from 2000, which coincides with the same period in which studies on patient's safety started.

The emphasis of the studies was mostly directed at strategies to deal with disruptive behavior (90%), followed by the consequences of this behavior for workers, patients and organizations (84.3%). A fact that also drew attention is regarding the fact that only 44.3% of the studies presented some definition of disruptive behavior, which justifies the need for its analysis.

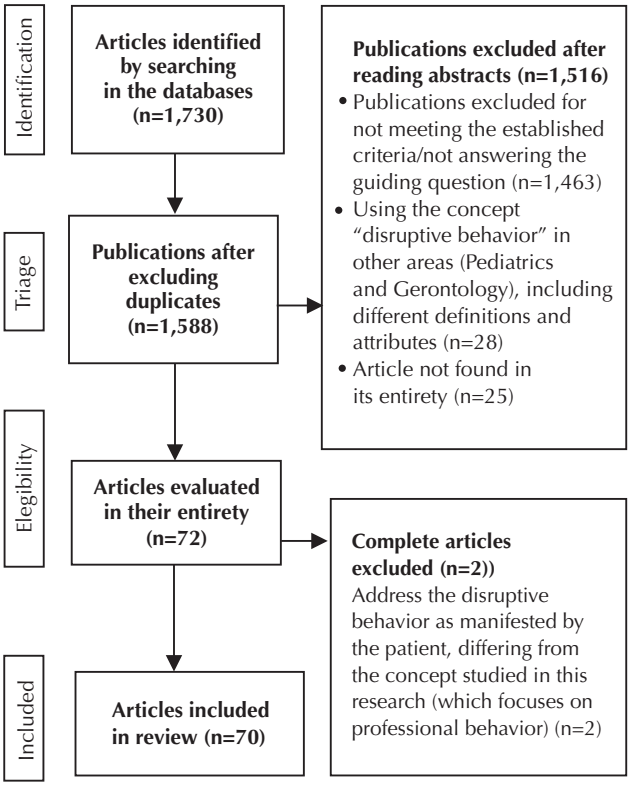

Figure 1 – Flowchart of the studies selected according to *Preferred Reporting Items for Systematic Reviews and Meta-Analyses* (PRISMA).

Regarding the type of study, there was a predominance of articles of theoretical reflection (24), and updates (21), followed by analytical and cross-sectional studies (14), qualitative studies (4), experience reports (3), research intervention/evaluation (2), systematic review (1) and a case study (1). This is more data that reveals the need for refining the concept. It is evident how important the study reviews and updates on the topic are, because they draw attention to a concept still little discussed in practice, however with significant prevalence and relevance regarding safety culture.

Regarding the professional category of the authors, studies by doctors and nurses published in medical journals (38) were predominant, followed by Nursing professionals (23) and others (9) (Health Management, Quality of Healthcare service, Hospital topics, Patient safety). The medical journals, in turn, were from the areas of Obstetrics and Gynecology, Academic medicine, Executive medicine, Management, Radiology and Neurology.

For the thematic focuses, we found that the main themes permeated the impact of disruptive behavior for patient safety, as well as discussion around this behavior among doctors, nursing staff and the relationship established between these professional categories. Studies which can be highlighted on the management of this behavior in practice were strategies adopted by leaders to deal with disruptive workers.

Concerning concept analysis, it was also essential to identify the concepts which were used in the literature as synonyms of disruptive behavior. Such concepts are characterized as differentiating elements, a term used by the hybrid model, meaning those concepts which are used as

synonyms or confounders of the analyzed concept. Studies using the concepts of Bullying, Intimidation, Horizontal/Lateral Violence and Abusive Behavior as synonyms of Disruptive Behavior were frequent, once again justifying the need for analysis of this concept.

Attributes of disruptive behavior in healthcare work

Attributes are words or phrases frequently used by the authors to describe the characteristics of the concept. For this study, disruptive behaviors reported in the articles were submitted to categorization and thorough analysis, which allowed for classifying the attributes of disruptive behavior into three patterns: Psychological Violence, Incivility and Physical/Sexual Violence. With this categorization, we can say that the concept of Disruptive Behavior in Healthcare Work is a theoretical construct, meaning a mental construction or synthesis made from the combination of several attributes that represent a spectrum of behaviors ranging from incivility to physical and/or sexual violence. Overall, 321 references of these behaviors were found in the 70 articles analyzed (Table 1).

Table 1 – Distribution of attributes and characteristic conduct of disruptive behavior in healthcare work according to the number of citations in the analyzed articles – Fortaleza, Ceará, Brazil, 2013.

Attributes and characteristic conduct of disruptive behavior	Number of citations
Psychological violence	
Publicly humiliating a co-worker.	47
Acting or speaking unkindly/Yelling.	31
Intimidating.	26
Using abusive language.	22
Throwing objects, instruments or medical records.	17
Creating gossip, bickering, sabotage, treason.	16
Making observations and showing discriminatory attitudes.	13
Withholding information to harm colleagues.	6
Making threats.	6
Others.	14
Total	**198**
Incivility	
Expressing outbursts of anger.	16
Disrespecting co-workers.	14
Making hypercritical or derogatory comments about the organization.	13
Being reluctant or refusing to answer questions and/or returning calls.	12
Disobeying norms, routines and organizational protocols.	12
Refusing to perform assigned tasks or displaying uncooperative attitudes during routine activities.	10
Acting unkindly, not listening, ignoring co-workers.	5
Others.	12
Total	**94**
Physical or sexual violence	
Sexual harassment.	15
Physical violence.	14
Total	**29**

In addition to the attributes and characteristic conduct of disruptive behavior, all adjectives and defining characteristics cited by the authors of studies to characterize disruptive individuals were identified. Such characteristics/adjectives are related to a lack of courtesy, rudeness and intimidation, and many are synonyms of one another. However, there was a preponderance of the adjectives intimidating, hostile, unkind/rude and abusive.

Antecedents of disruptive behavior in healthcare work

Antecedents of disruptive behavior in healthcare work, situations, events or phenomena which precede the concept of interest were studied, helping to understand the social context in which they were generally used. 191 citations of antecedents of disruptive behavior in healthcare work were found in the 70 articles analyzed, distributed into intrapersonal, interpersonal and organizational antecedents (Table 2).

Table 2 – Distribution of antecedents of disruptive behavior in healthcare work according to the number of citations in the analyzed articles – Fortaleza, Ceará, Brazil, 2013.

Antecedents	Number of citations
Intrapersonal	
Stress/critical situations, anxiety, fatigue and depression.	28
Personality characteristics/traits.	20
Lack of competence, autonomy and emotional intelligence at work.	14
Rooted beliefs and personal values.	10
Substance abuse.	4
Personal conflicts or family problems.	4
Psychiatric disorders.	4
Academic education.	3
Previous experience with disruptive behavior.	3
Total	**90**
Organizational	
Unresolved systemic problems.[a]	16
Work overload.	13
Dysfunctional organizational culture.	9
Highly stressful specializations/areas.	9
Inadequate staff placement/structure.	6
Lack of organizational support.	5
Demands of service users.	4
Conflict of roles or of power.	3
Others.	3
Total	**68**
Interpersonal	
Ineffective communication.	9
Divergence of opinions/thoughts.	8
Lack of teamwork/collaboration.	6
Authoritarianism.	5
Questioning medical orders.	5
Total	**33**

a. lack of equipment, supplies, diet items, schedules for procedures; unrealistic expectations; medications not delivered; lack of confidence in the support systems; hostile or poor working conditions; inadequate staff support; inefficient scales, among others.

Consequences are events or situations resulting from the use of the concept. In this analysis, it was possible to identify three orders of consequences: for the healthcare worker, the patient and the healthcare organization. The review identified 344 citations resulting from disruptive behavior in the 70 articles analyzed.

Table 3 – Distribution of consequences of disruptive behavior in healthcare work according to the number of citations in the analyzed articles – Fortaleza, Ceará, Brazil, 2013.

Consequences	Number of citations
For the worker/health team	
Moral and psychological suffering: from anxiety to Burnout.	48
Disruption of communication, collaboration and teamwork.	41
Labor losses: termination, turnover/change of unit and intention to leave the job.	40
Hostility in the workplace.	23
Dissatisfaction, decreased morale and engagement at work.	22
Fear, tension, loss of focus.	18
Removal or isolation.	15
Total	**207**
For the patient	
Compromised patient safety or quality of care.	73[a]
Dissatisfaction.	15
Total	**88**
For the health organization	
Costs of legal processes, recruiting new professionals and treatment of adverse events.	25
Impact on the dynamics and organizational culture.	14
Threat to the image of the institution/team.	10
Total	**49**

a. There could be more than one quote in the same article on the consequences of disruptive behavior for patient safety, such as medication errors, infection, a procedure in the wrong place, death, and others.

In knowing antecedents, attributes and consequences, an approach to define the meaning of disruptive behavior in healthcare work was conducted. It is known that although there is no universal definition of this concept among healthcare providers, several comparable definitions have been published. These usually included verbal abuse, sexual harassment, racial slurs, physical threats and blasphemy.

Chart 1 shows the definitions found in the analyzed articles, its authors and the emphasized variables.

Chart 1 – Distribution of disruptive behavior definitions found in the analyzed articles according to authorship and the emphasized variables – Fortaleza, Ceará, Brazil, in 2013.

Definition	Authorship	Variables
Any improper conduct, including sexual harassment and/or other forms of harassment or other forms of verbal or non-verbal conduct, which hinder or intimidate others so that the quality of care and patient safety may be compromised.	American Medical Association (AMA)[13-15]	Attributes and consequences
Any inappropriate behavior, confrontation or conflict – ranging from verbal abuse (abusive, intimidating, disrespectful, or threatening behavior) to physical or sexual harassment – which can negatively impact labor relations, effectiveness of communication, information transfer, and the care process and its outcomes.	Rosenstein[16-17] Rosenstein, O'Daniel[18-19] Rosenstein, Naylor[20] Rosenstein, Russel, Lauve[21]	Attributes and consequences
Disruptive behavior in the medical environment is defined as one that interferes with patient care or can reasonably be expected to interfere with the process of providing quality care.	Leape; Fromson Rosenstein[22]	Consequences
A disruptive physician is someone who undermines the practice of morality, increases turnover in practice or in the organization, takes the focus off of productive activities, increases the risk of ineffective or poor practice, intimidates or threatens to cause harm to others, and disproportionately causes stress for others in the workplace.	Pfifferling[23]	Consequences

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Definition	Authorship	Variables
Disruptive behavior was defined for including outbursts of anger, rudeness or verbal attacks; physical threats; bullying; failure to comply with existing policies; sexual harassment; idiosyncratic, inconsistent or passive-aggressive orders; demeaning comments about the organization; and destruction of the health team's regular function.	Veltman[24]	Attributes
Any behavior that creates a hostile work environment.	OR Manager[25]	Consequences
A form of medical impairment which has become a focus of attention in public health due to its disruptive impact on hospital staff, institutions and patient care.	Samenow, Swiggart, Spickard[26]	Consequences
It is the root cause of dysfunctional culture that permeates the healthcare, which hinders safety progress and is also a product of that culture.	Hickson, Pickert[27]	Consequences
Any kind of interpersonal interaction that can lead to inadequate patient care and negatively impact the organization's ability to operate in an orderly manner to fulfill its mission.	Piper[28]	Consequences
It can be defined in many ways. Disruptive behaviors are traditionally seen as: blasphemy; throwing objects; chronic delay or refusal to follow policies; passive-aggressive behavior, such as falling asleep in meetings or not participating in discussions.	Rawson et al.[29]	Attributes
It is a form of medical impairment that may increase the risk of medical errors, harming nursing retention programs, and that can sometimes ruin a hospital operation.	Gallup[30]	Consequences
It is an impregnated and intractable problem that undermines the safety culture for patients and physicians. These behaviors reduce teamwork and communication, harm patients, staff and the organization by destroying trust, mutual respect and colleagueship.	Walrath; Dang; Nyberg[3]	Consequences
Bullying, incivility and its associated disruptive behaviors are disruptive and insidious forces with negative consequences that require identification and intervention at an individual and organizational level.	Felblinger[31]	Attributes and consequences

Finally, one definition was chosen to be worked with. Considering the above-mentioned definitions, the definition considered the most clear and comprehensive was adopted by not only addressing the manifestation of disruptive behavior and its examples, but also the consequences for patients, staff and organization[16]. Thus, the operational definition of disruptive behavior adopted in the field phase was as follows: Any inappropriate behavior, confrontation or conflict – ranging from verbal abuse (abusive, intimidating, disrespectful, or threatening behavior) to physical or sexual harassment – which can negatively impact labor relations, effectiveness of communication, information transfer, and the care process and its outcomes.

This definition was used during interviews with nurses, doctors and nursing technicians in order to raise this issue in the work context of these professionals and select a model case described in the Field Phase, with results to be presented *a posteriori*.

DISCUSSION

This conceptual analysis identified that, in marked contrast to honest and respectful workers who are centered on the patient, there are healthcare workers who adopt disruptive behavior mainly concerned in asserting their own will. These individuals seek to benefit not by the logic of their arguments, but by their arrogant behavior[32]. Unfortunately, several studies analyzed have shown that the disruptive behavior is common in the hospital setting.

Regarding attributes, it was found that the most disruptive behavior conduct characteristics were concentrated in the categories of Violence and Psychological Incivility, which was also found in other studies[33-34].

In analyzing the experience of clinical nurses with disruptive behavior in the United States, researchers found the occurrence of this behavior among all contexts of practice and among a wide range of health professionals. A total of 168 different disruptive behaviors were identified and then synthesized into 21 categories. Within these categories, three themes or disruptive behavior patterns emerged: incivility, psychological aggression and violence[34]. Such patterns are the same as in this study.

For the authors, these concepts are described as follows: incivility in the workplace is a deviant low intensity behavior, which violates the workplace norms of mutual respect, may or may not have the intention of harming the target, it does not physically threaten the target, and it can transcend organizational hierarchy; psychological aggression relates to active or passive behavior that intentionally inflicts psychological damage to the target, such as gossip, intimidation and passive-aggressive behavior; and violence includes physical, active and direct forms of aggressive behavior[34].

In face of the considerations presented on the attributes of disruptive behavior, this initial analysis made it possible to

recognize how this behavior is presented in the healthcare work environment, and to include the most characteristic conducts within each highlighted attribute: incivility, psychological violence and physical/sexual violence.

It is essential to emphasize that the disruptive behavior patterns in this concept analysis may allow a better understanding of its manifestations in the three types, which must be addressed differently by the leaders of the health services, and associated with a number of essential elements and related factors; namely, their antecedents.

Regarding antecedents, a predominance of intrapersonal antecedents was found, being considered traits or conditions involving the individual such as personal characteristics, lack of competence, or fatigue. They involve controlling and aggressive personalities which inhibit effective communication[34].

Among the intrapersonal antecedents, there was a greater number of articles that addressed the growing stress and critical situations experienced in the healthcare environment, with anxiety, fatigue and depression as the main causes for the individual adopting disruptive behavior at work. In addition, characteristics or personality disorders of the disruptive individuals that predominated can range from defensive postures such as inability to face others or assuming negative intentions[8], to personality disorders, psychological problems and narcissism.

Organizational antecedents were also highlighted, referring to systems, processes, and culture atmosphere which inhibit interactions or work. The most frequently identified organizational threat has been high workload pressure, volume, and number of patients, in addition to unsolved systemic problems[3,34].

The problem is even greater in areas or specializations of high stress. Specialists in this subject affirm that disruptive events are more likely to occur in areas or specializations of high intensity, considered stressful care environments, such as operating and emergency rooms[19-20,35]; intensive care units; and specializations such as general surgery, cardiology, neurosurgery and orthopedics[36].

Finally, interpersonal antecedents were highlighted involving relationships between two people. The use of status to control others is an example[34], however ineffective communication and differences of opinions and thoughts that generate conflicts between co-workers stood out.

Poor communication can lead to personality conflicts, which result in disruptive behavior. That is, a general lack of effective communication skills can influence other antecedents of disruptive behavior, and it is therefore considered one of the most important associated factors[8].

Other interpersonal antecedents included constant criticism among health professionals, which makes the practice environment unproductive[37], in addition to conflicting social and cultural values[38] and diversity of the team[39]. It should be noted that intrapersonal anxiety increases interpersonal tension and leads to disruptive behavior within the organization[40].

Regarding consequences from disruptive behavior, consequences for workers and the healthcare team are emphasized. Regarding moral and psychological distress, a study with 1,500 healthcare workers and administrators of 50 hospitals in the United States found disruptive behavior as a contributing factor to increased stress at work and Burnout, as well as strongly influencing job satisfaction of nurses and their decisions to leave the profession[18].

A hostile work environment lowers morale, creates insecurity, and is one of the causes of Burnout. Also, it generates anxiety and depression, and leads individuals to focus internally, accentuating self-absorption and decreasing their empathy and willingness to cooperate. In addition to anger, humiliation, shame and frustration that anyone feels as a result of humiliating treatment, those who are still in the process of graduating/training may experience feelings of insecurity and loss of self-esteem[31,35].

It is worth emphasizing that any emotional challenge during a working life has a potentially negative impact on performance, actions, worker health, and consequently on patient safety[41].

Thus, the consequences can be considered the most relevant in analyzing the impact of disruptive behavior in healthcare work. It is considered that moral and psychological distress have a strong impact on other consequences, forming a vicious cycle of factors involved in the emergence and impact of disruptive behavior on the lives and work of healthcare professionals.

It can also be said that the impact generated on the moral and emotional state of workers is a determining factor for Burnout and for most of the adverse outcomes in healthcare services, for expressions of dissatisfaction and hostility, for the search for new jobs, and even for abandoning the profession.

However, in many cases nurses remain in the cycle of experiencing such problems often, but they do not often report or comment about them to their peers or managers. Profession abandonment cases are more common among US nurses, as evidenced in studies of this theoretical phase.

The consequences of disruptive behavior for patients were also prevalent in this review, mainly being mentioned in the analyzed studies and found in 88 citations. In this scope, the most reported compromise of patient safety was increased medical errors that contribute to lower patient satisfaction and other preventable adverse outcomes[42].

In a study, more than 20% of health professionals observed real harm to patients as a result of a disrespectful and abusive behavior among physicians and staff. Statistically, each year, 1 in every 20 hospital patients receive the wrong medication, 3.5 million will get an infection from someone who did not wash their hands or did not take other appropriate precautions, and thousands will die due to mistakes made while at the hospital[43].

From these neglectful, reckless workers or those that do not follow the policies and organizational protocols, we highlight doctors, nurses and other members of the healthcare team who adopt disruptive behavior. One author[23] points out the reasons why disruptive behavior increases the risk of ineffective or below standard care:

a) The necessary collaborative work is reduced, which affect patients, especially when dealing with complex cases which require respectful communication;

b) Errors increase due to anxiety around hypercritical comments;

c) Other health professionals refuse to work with patients of the disruptive doctor: their contribution is lost;

d) Cognitive disappearances (employees are physically there, but they are not present) increase due to a disruptive doctor.

Disruptive behavior is a threat to patient safety, as it can have both immediate and long-term negative effects on the victims. The latter experiences a mixture of intense feelings: fear, anger, shame, confusion, uncertainty, isolation, insecurity, frustration and depression. These feelings significantly affect a person's ability to think clearly and therefore they become more likely to make a mistake when making decisions or performing. In addition, bullying can encourage a person to commit an unsafe act[35].

The consequences have a rebound effect. Medical errors can result from disruptive behavior, which leads to miscommunication in the patient care team and may lead to new errors occurring[44].

The frequency and subtlety of insidious behavior results in continuous destruction of patient care and of staff interactions at all system levels[45].

Finally, with respect to the identified concept definitions (Chart 1), there was an observed emphasis on the consequences of disruptive behavior for patients, staff and the organization. However, the attributes that constitute essential characteristics of behavior have not been consistently addressed.

Thus, a broader definition and at the same time characteristic of disruptive behavior in healthcare work was initially selected so that over the empirical phase it was possible to approach the problem with the workers and try to gather relevant information favorable to refining this concept in the final stage.

CONCLUSION

This research analyzed the disruptive behavior concept in healthcare work through an integrative literature review which allowed for presenting it as a real problem experienced by healthcare workers in the hospital setting.

As the main attributes of this behavior in practice, we highlight incivility, psychological violence, and less frequently physical/sexual violence. Daily abrasiveness/rudeness, interpersonal and organizational disrespect, lack of collaboration among co-workers, humiliation and frequent intimidation configure the behaviors that represent the spectrum of disruptive behavior in healthcare work. Perpetrators are usually those who occupy the top of the hierarchy: doctors, nurses, unit managers and professionals who have been working in service longer with job stability and recognized clinical experience.

As antecedents of this behavior, intrapersonal antecedents can be highlighted (stress/critical situations, anxiety, fatigue and depression, characteristics/personality traits, lack of competence, autonomy and emotional intelligence at work, beliefs and entrenched personal values), followed by organizational antecedents (unresolved systemic problems and work overload).

Consequences aimed at the employee/staff and patients were predominant. We highlight moral and psychological distress; disruption of communication, collaboration and teamwork; labor losses; hostility in the workplace; dissatisfaction, decreased morale and engagement at work; the compromise of patient safety and quality of care; and the costs of legal processes, recruiting new professionals and treating adverse events.

Thus, there is an urgent need for a call to action by leaders, workers and users of healthcare services whose attention should be initially directed to raise awareness of professionals about disruptive behavior; to ensure open and effective interprofessional communication; and to lay the foundation for teamwork, collaboration and co-responsibility for safe care.

It is also necessary that hospitals develop ethical conduct policies which establish the difference between desirable and undesirable behaviors, and that all workers are able to talk about it without fear of retaliation or punishment. A culture of mutual respect leads to horizontal communication, establishing a bond and the appreciation of a healthy work environment.

RESUMO

Objetivo: Analisar o conceito comportamento destrutivo no trabalho em saúde. **Método:** Revisão integrativa realizada na fase teórica de pesquisa qualitativa fundamentada pelo referencial teórico-metodológico do Modelo Híbrido de Análise de Conceitos. A busca dos artigos foi realizada nas bases de dados CINAHL, LILACS, PsycINFO, PubMed e SciVerse Scopus, em 2013. **Resultados:** 70 artigos científicos responderam à questão norteadora e atenderam aos critérios de inclusão, permitindo evidenciar os atributos do comportamento destrutivo: incivilidade, violência psicológica e violência física/sexual; seus principais antecedentes (intrapessoais, interpessoais e organizacionais): características de personalidade, estresse e sobrecarga de trabalho; e consequentes: sofrimento moral/psíquico dos trabalhadores, comprometimento da segurança do paciente, prejuízos laborais, rompimento da comunicação, da colaboração e do trabalho em equipe. **Conclusão:** A análise do conceito comportamento destrutivo no trabalho em saúde evidenciou, em sua fase teórica, um constructo que abrange diferentes condutas desrespeitosas adotadas por trabalhadores de saúde no contexto hospitalar, merecendo atenção de lideranças da área para maior reconhecimento e manejo adequado dos casos e suas consequências.

DESCRITORES

Pessoal de Saúde; Comportamento Social; Relações Interpessoais; Formação de Conceito; Segurança do Paciente; Revisão.

RESUMEN

Objetivo: Analizar el concepto comportamiento destructivo en el trabajo sanitario. **Método:** Revisión integrativa realizada en la fase teórica de investigación cualitativa fundamentada por el marco de referencia teórico-metodológico del Modelo Híbrido de Análisis

de Conceptos. La búsqueda de artículos fue realizada en las bases de datos CINAHL, LILACS, PsycINFO, PubMed y SciVerse Scopus, en 2013. **Resultados:** 70 artículos científicos respondieron a la cuestión orientadora y atendieron los criterios de inclusión, permitiendo evidenciar los atributos del comportamiento destructivo: incivilidad, violencia psicológica y violencia física/sexual; sus principales antecedentes (intrapersonales, interpersonales y organizativos): características de personalidad, estrés y sobrecarga laboral; y consecuentes: sufrimiento moral/psíquico de los trabajadores, compromiso de la seguridad del paciente, perjuicios laborales, rompimiento de la comunicación, la colaboración y el trabajo en equipo. **Conclusión:** El análisis del concepto comportamiento destructivo en el trabajo en salud evidenció, en su fase teórica, un constructo que abarca diferentes conductas que presentan la falta de respeto adoptadas por trabajadores de salud en el marco hospitalario, mereciendo atención de liderazgos del área para mayor reconocimiento y manejo adecuado de los casos y sus consecuencias.

DESCRIPTORES

Personal de Salud; Conducta Social; Relaciones Interpersonales; Formación de Concepto; Seguridad del Paciente; Revisión.

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