3-2022

The Impact of Disruptive Physician Behavior on Support Staff and Patients: A Quantitative Secondary Analysis

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This dissertation, directed and approved by the candidate's committee, has been accepted by the College of Graduate and Professional Studies of Abilene Christian University in partial fulfillment of the requirements for the degree

Doctor of Education in Organizational Leadership

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Date

03 / 07 / 2022

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by

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March 2022

Dedication

This study is dedicated posthumously to my mother Dorothy Marino, who was my biggest source of encouragement throughout her lifetime. She taught me to believe in myself and to work hard to attain and achieve my goals. She would be very proud of this accomplishment. Second, I wish to dedicate this study to my sisters Sherri Smith and Vicki Ryon, who have been alongside me this entire journey, filling the gaps with encouragement and support. You helped me make the original decision to apply and gave me the confidence to believe that I could do it. For the many phone calls and prayers, I thank you. Mother would be proud of how you filled in.

Acknowledgments

I would like to acknowledge my chair Dr. Cecilia Hegamin-Younger, who provided valuable feedback, encouragement, and knowledge throughout the entire exhaustive dissertation process. I thank you for your wisdom, your grace, and most of all, your patience. You are a shining example of educational leadership that I hope to emulate in the future. To my committee members, Dr. Lawrence Santiago, I appreciate you for challenging me to go deeper into the writing process. To Dr. Scott Self, I'm thankful for your guidance and encouragement throughout this entire process. As an educator, you were a difference-maker for me. I'm grateful you agreed to be on my committee.

I would like to acknowledge some very special people in my life that have supported me and held me up in prayer throughout this entire process. Scott Smith, you were patient and kind when many times I was confined to the "computer cave," grumpy and tired. My Monday Night Men - Brothers in Christ, thank you for your support and prayers.

Carla Hanson, Elizabeth Spurlock, Vanessa Torres, and Justin Whisenant, thank you for helping me get what I needed to make this possible. I'm grateful to be surrounded by people like you every day.

To my fellow Group of Four that helped me through this journey: Rusty Hohlt, Sherry Latten, and Jan Oldham, I could not have made it without you. I'm thankful to have gone along this ride with you and am glad we can all celebrate our milestones together.

And finally, to all my instructors, advisors, and assistants at A.C.U., thank you for the faith-filled journey. I was pleasantly surprised by not just the educational growth, but the spiritual enrichment that came throughout this incredible journey. ***Soli Deo gloria!***

Abstract

In this quantitative secondary analysis, the purpose was to examine the nature of disruptive physician behavior (DPB) from the support staff and patient perspectives. Healthcare staffing shortages existed prior to the global pandemic and have increased, creating importance for employee retention and recruitment. I wanted to understand the impact of physician behavior on staff turnover rates in a private oncology practice, its effect on patient satisfaction rates, and to compare these rates of physicians that display DPB with physicians that do not display this behavior in a private hematology oncology community outpatient setting in the Southwest United States. To answer these questions, the researchers analyzed staff satisfaction scores (n = 5,529), staff turnover rates, patient satisfaction scores, and their relationships to physicians' behaviors (n = 476) in 81 clinical locations (n = 18,000) using five clinical and nonclinical instruments: an employee opinion survey, a patient satisfaction survey, an employee turnover rate report, a physician disruption report, and the site characteristic report. A statistical analysis was performed, and results confirmed that DPB had a statistically significant impact on staff satisfaction when rating physician communication and behavior. The mean average for communication was 85.13 for clinics with no DBP and 65.17 at severe DPB clinics, representing a 19.96 margin in rating. The results showed that staff felt similarly about the behavior of the physician when compared to the organizational values. Results were statistically significant for staff turnover of locations with no DPB that had an average staff turnover of more than 2.3% (SD = 1.4%). The average turnover percentage in the moderate category of clinical locations was 5.1% (SD = 2.0%). Results for the impact of DPB on patient satisfaction scores were not statistically significant. This study supports the need for continued research on DPB and its impact on the clinical environment.

Keywords: disruptive behavior, toxic leadership, toxic triangle theory, staff turnover rate, staff satisfaction, patient satisfaction

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Chapter 1: Introduction

In the outpatient oncology setting, the relationship between physician provider, staff, and patient creates a dynamic that changes lives. Most people walk into their oncologist's office scared and unsure of their future (Hansen et al., 2019). The clinical environment sets the mood for the patient experience. Most patients reported their first experience at their oncologist office was frightening, some even using the term chaotic (Hansen et al., 2019; Turner & Turner, 1985). The relationships within the clinical care team play a vital role in the continuity of care (Jeyathevan et al., 2017). The physician provider and office staff work in concert to offset the fear and provide a positive experience for the patient. This helps a patient take control of their disease process.

In 2020, the COVID-19 pandemic saw a new hero emerge—the physician. These frontline workers have put their own lives on the line to take care of others. On occasion, as stressors mount, the physician provider may fall into a pattern of malcontent behavior (Buerhaus, 2021). When this occurs, the clinical environment can become unfavorable, making it more difficult to mask the discontent. Abusive behavior demonstrated by physicians creates an environment of instability for the clinical staff and translates into patient care. Coined as *disruptive physician behavior* (DPB) by Alan H. Rosenstein (2002), abusive behavior characterizes any action exhibited by a physician that creates a substandard level of treatment and impedes the organization's ability to meet their mission of patient care (Piper, 2003). This behavior not only impacts the interprofessional relationships between the physicians and clinical staff (Bowels et al., 2016; Cullen et al., 2017; Katz et al., 2020), it also has a profound impact on patient safety and quality of care (Danielsson et al., 2018; Katz et al., 2020). As the clinical staff react to DPB, their focus shifts from the patient to the frustration and fear of retaliatory

consequences. This anxiety inhibits decision-making abilities and often leads to burnout (Hu et al, 2020). Burnout adversely affects employee turnover rates and patient care, creating an environment that lacks continuity of care. One subspecialty that suffers when there is a lack of continuity of care that impedes the ability to establish rapport and credibility is outpatient community oncology.

From the moment a patient hears the word cancer, a patient must meticulously navigate a world of firsts and unknowns. The oncology care team plays a pivotal role in the patient's journey. Jeyathevan et al. (2017) interviewed patients with lung cancer to assess the importance of continuity of care. Characteristics of continuity of care that registered as critical included coherence, connection, and consistency to the oncology care team. The care team becomes the anchor when the environment is in a perpetual state of change, underscoring the critical nature of civility in the clinic as continuity and constants are challenged daily.

A healthcare team must possess the ability to remain agile to navigate the constant state of change. Embracing change must be at the forefront of the healthcare organization and physician provider to adjust to the continual demands of the private and public sector. The processes and structures supporting the healthcare infrastructure change daily (Jacobson & Parmet, 2018). An environment of chaos fosters a climate of stress and negatively influences organizational culture (Galdikeine et al., 2019; Rosenstein et al., 2016). Stressors introduced into the organization erupt into workplace conflict. Physicians have a choice in their reaction and leadership as these stressors arise. Does the clinical environment change in way that it changes the patient experience? Can the collective staff and patient experience predict the clinical environment, more specifically, the physician-provider's behavior? The present healthcare environment not only deals with the stress of the nature of the disease process but fundamental

structural changes in the healthcare system. The physician's ability to provide positive leadership becomes more important as the stressors of healthcare and a pandemic continue to create new challenges every day.

Conflict Initiators in Healthcare

The Cost of Healthcare

One of the structural changes facing physicians in today's healthcare environment that contribute to workplace stress is the need to create a cost-effective healthcare system that will sustain the growing needs of an aging population. To combat this need, healthcare payers apply new payment models. The physicians must fully understand the new requirements and payment structure models to survive. This level of change adds to the stressful environment in the clinical setting. New payment models contribute to the stressful work environment.

A growing trend steers payers away from fee-for-service, a system that thrives on quantity, to a value-based contract environment. In this new environment, value is seen as more important than quantity. Physicians are being reimbursed not on the quantity of patients but the value in how they treat their patients. The Centers for Medicare and Medicaid Services (CMS) have implemented the oncology care model (OCM), a payment model developed to test improvements in the delivery system that incentivizes physicians to provide efficient care while improving quality of care at a lower cost (Kline et al., 2015).

As a researcher and healthcare financial manager, MacStravic (2007) saw a broader application of implementing value-based operations across the entire healthcare industry. Prescription drug coverage, insurers, and healthcare organizations are impacted in a value-based world. Healthcare entities would need a paradigm shift in how they viewed their operations, processes, and industry (MacStravic, 2007). Leadership is a major factor in success of process

change and must be thoroughly planned and intentional. For many years, the focus of this paradigm shift in healthcare systems has been cost containment that results in improved outcomes. This shift has taken on a global perspective as systems across the globe have begun to implement value-based design.

The value-based model of Porter and Lee put patient value at the center of daily operations. Perceived value equates to satisfaction and perceived clinical environment. There is a trade-off between outcomes and costs. In this new system, putting the patient first becomes the most important aspect of care (Koomans & Hilders, 2016). Koomans and Hilders (2016) maintain that "healthcare should be organized, measured, and reimbursed to create patient value" (p. 45). Koomans and Hilders (2016) contended that for the change to be sustainable and successful, it must be design driven. Using design as a change tool, the focus needs to be on the capabilities to adapt to the patient's needs and the empowerment and transparency of ideas and methods (Koomans & Hilders, 2016). Traditionally, healthcare professionals focus on clinical performance, while change efforts are focused on improving and striving for excellence according to their defined guidelines. With a new perspective, physicians will need to focus on strategy, process, style, performance, and most importantly, the customer (Koomans & Hilders, 2016). These new models of payment change the paradigm in which physicians are used to practicing. A physician that has historically had the autonomy to examine and treat a patient in the way they are comfortable may have to apply a template and make sure boxes are checked to qualify for payment. For the physician, this represents a new way of practicing medicine and in some cases adds time and stress to their day. These value-based measures put the physician provider on alert with staff and patients observing their behavior, ready to share their opinion. For the physician, the new measures equate to more work and less time to spend with their

patient. The unsuspecting physician, feeling frustrated, may shut down, causing their staff to wonder if something is wrong. Unintentionally, the physician provider is disrupting the clinic flow.

The United States spends more of its gross domestic product on healthcare than other countries around the world, yet improved outcomes continue to fall behind those of other developed countries worldwide, resulting in more significant healthcare risks for the average U.S. citizen (Stone, 2017). To combat this imbalance, the Institute of Healthcare Improvement (IHI) created the triple aim framework that sought to balance healthcare costs, improve the patient experience, and provide equitable access for all patients (Ryan et al., 2016; Stone, 2017).

The cost of healthcare for the average patient continues to rise as innovation and development increases (Owaid, 2017; Takura et al., 2021). In private practice, physicians find it more challenging to remain fiscally stable and place a more considerable burden on patient satisfaction to maintain revenue (Owaid, 2017). The rise of value-based programs has altered the environment of healthcare by introducing a value-based reimbursement model opposed to the traditional fee-for-service payment model. Programs, such as the oncology care model (OCM) and alternative payment model (APM) formulated by the CMS attempt to create financial and performance accountability by offering higher quality patient care while containing costs (Centers for Medicare & Medicaid, 2016). This represented a paradigm shift and a major change in how private practices provide clinical healthcare. Healthcare has had to contend with constant change, adding to the stressors of a volatile environment.

Toxic Leadership

Through the past century, the definition of leadership has evolved to fit a wide scope of behaviors and styles. From the early twentieth century, domination described the enviable

characteristic of a leader, focusing on enforcing the will over a group of followers (Northouse, 2016). The definition of leadership progressed through the mid-20th century to a style of influence and coercion over dominance (Northouse, 2016). Society and individual rights evolved, and the perception of a good leader followed. In the 21st century, leaders combine influence, traits, and transformation to address leadership in more inclusive styles, such as authentic, spiritual, servant, and adaptive leadership styles (Northouse, 2016). Some leaders will display positive attributes, while others display negative attributes. It is the negative attributes that lead to toxic leadership and create challenges in the clinical environment.

Whicker (1996) researched leaders that demonstrated those negative attributes and used the term toxic leadership, which added a new dimension to discovering the effects of leadership on follower behavior and reaction. Padilla et al. (2007) posited that interactions between the leader, subordinates, and the conducive environments formed a toxic triangle and later created the toxic triangle theoretical model (Thoroughgood et al., 2012). Padilla et al. (2007) based their definition of toxic leadership on the five features of destructive leadership:

1. Destructive leadership is seldom absolutely or entirely destructive: there are both good and bad results in most leadership situations.
2. The process of destructive leadership involves dominance, coercion, and manipulation rather than influence, persuasion, and commitment.
3. The process of destructive leadership has a selfish orientation; it is focused more on the leader's needs than the needs of the larger social group.
4. The effects of destructive leadership outcomes that compromise the quality of life for constituents and detract from the organization's main purposes.

5. Destructive organizational outcomes are not exclusively the result of destructive leaders but are also products of susceptible followers and conducive environments.

DPB suggests that some physician leaders have returned to the early form of leadership—dominance.

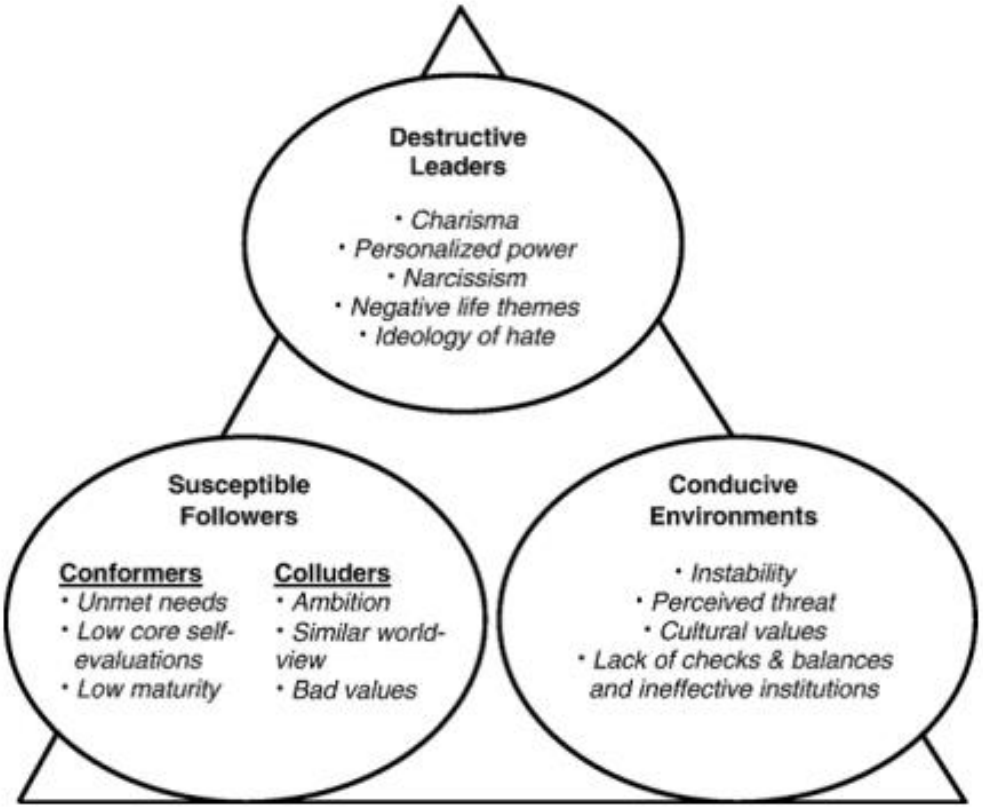
The Toxic Triangle

Healthcare requires continuity of care and cooperation from its leaders, staff, and the workplace culture to establish trust and confidence among the care team. The World Health Organization (WHO; 2010) defined a healthy work environment as one where physicians and the entire care team "collaborate to use a continual improvement process to protect and promote the health, safety, and well-being of all workers and the sustainability of the workplace" (p. 6). A healthy workplace combined with healthy leadership result in the pursuit of quality care and patient satisfaction (Lorber, 2018). Inversely, does lower patient satisfaction and team cohesiveness suggest a detrimental environment influenced by leadership? At the intersection of destructive leadership, susceptible followers, and an environment or culture that fosters negativity is the toxic triangle. These three elements describe what attributes interact when leadership becomes unethical and difficult within an environment that would normally feed on trust and respect. Padilla et al. (2007) pursued the root cause and effect of a destructive leader on their environment. For far too long, empirical research failed to attribute any aspects of the follower and the culture in a toxic environment. Termed the toxic triangle, groups displayed negative outcomes when a combination of three factors were present: destructive leaders, susceptible followers, and a conducive environment (Padilla et al., 2007). Each side of the triad possessed characteristics that defined the factors as shown in Figure 1. These three factors exist in congruency to form a dysfunctional group often incapable of creating desired outcomes.

Healthcare requires continuity of care and cooperation from all three factors to establish trust and confidence in the physician.

Figure 1

The Toxic Triangle



Note. Figure 1 illustrates the toxic triangle made of destructive leaders, susceptible followers, and a conducive environment. Reprinted from "The toxic triangle: Destructive leaders, susceptible followers, and conducive environments," by A. Padilla, R. Hogan, and R. B. Kaiser, 2007, *Leadership Quarterly*, *18*(3), 176–194. Copyright 2007 by Elsevier. Reprinted with permission. (see Appendix B)

Conflict Style in Healthcare

Toxic Leadership in Healthcare

The influence physicians command creates an imbalance in power. The physician's power position dramatically influences the hospital's organizational culture and floor unit (Danielsson et al., 2018). As leaders of the care team, the physicians affect the private clinic's culture and work environment (Katz et al., 2020). Incivility, such as DPB, leads to undue stress and cultivates dissatisfaction among the support staff (Klingberg et al., 2018; Wang & Sung, 2016). This behavior is especially problematic in the subspecialty of oncology, where consistency, patient satisfaction, and familiarity play a vital role in the care of oncology patients (Berglund et al., 2015).

Conflict Style in Healthcare

Conflict in a healthcare environment can present a unique set of challenges and can be detrimental to the practice if left unmanaged. Hocker and Wilmot define conflict as "two of more interdependent parties who perceive incompatible goals, scarce resources, and interference from others in achieving that goal" (2018, p. 13). Conflict is inevitable and can be both positive and negative. Although it is not possible or advised to eliminate conflict completely, it is important for today's healthcare leaders to have a strategy when confronted with conflict.

The healthcare leader needs a keen awareness of the styles or types of conflict. Healthcare leaders can either inspire a team or can impede the creativity and engagement. Balancing operational objectives and team strategies and development can be challenging. Understanding conflict style and resolution allows the leader to confront issues and review strategies available to them. A manager unable to identify conflict and utilize the conflict is unable to help their team and the organization grow. There are five basic conflict styles found in

the clinical environment: accommodating, avoiding, forcing, negotiating, and collaborating (Lussier & Achua, 2014).

Accommodating Conflict

In the accommodating style of conflict, the leader attempts to succumb to the demands of the other party by giving in or conceding to the other party's desires or goals. When teams are unable to resolve their conflict effectively, the teams become prone to continuous problems because the team members lose sight of the result and lose focus on the task at hand (Behfar et al., 2008). No accommodations are to made to come to a mutual resolution.

Avoiding Conflict

The second style of conflict—avoiding—creates an environment where solutions, goals, and conflict are ignored. Many times, leaders create this style of conflict because of the unwillingness to devote the time necessary to resolve a conflict. Failure to address difficult issues often leads to the dissatisfaction of both the leader and the employee and can create an uncomfortable working environment (Phillips et al., 2014). This adds to the conflict and the turmoil and will rapidly escalate if left unaddressed.

Forcing Conflict

Third is the forcing conflict style. The forcing conflict style can best be described as a dominating or competing style of conflict and is characterized by aggressive behavior, lack of cooperation, and doing whatever it takes at the expense of others (Lussier & Achua, 2014). In a healthcare organization, this style of conflict can become crippling when the result of the behavior affects the patient experience or the patient's perception of the care they receive.

Negotiating Conflict

The fourth style of conflict is the negotiating style. Negotiating requires a compromising approach. Both parties must be willing participants and willing to cooperate. This style is best served when the issues are complex and there are no simple solutions in sight. Negotiating also becomes useful when time is critical, and all parties involved have a clear goal to pursue (Lussier & Achua, 2014).

Collaborating Conflict

The final style of conflict is the collaborating style. Collaboration requires cooperation and problem solving on all sides of the team. In healthcare, that may be the physician, the ancillary staff, and the patient. In a clinical setting, it is important to involve each member of the care team, physician, staff, patient, and even the patient's caretaker. In collaboration, letting the staff define the issues and the possible resolutions will move the resolution forward. This demonstrates the importance of placing the focus on the problem, not the individuals (Morreim, 2015). According to the toxic triangle theory, focus is placed not only on the leader and the followers but also the setting. A leader with a high level of emotional intelligence will engage all parties, keep their emotions intact, and encourage independent, critical thinking (Augusty & Mathew, 2020).

All styles of contact require clear and concise communication that respects all individuals. Failure for a physician provider to communicate appropriately results in the perception of disruptive behavior. People in positions of power can abuse their communication style and add to the toxic environment. The staff perpetuates this environment by accommodating the provider, adding to the conflicting situation.

Communication Accommodation Theory

The communication accommodation theory is built upon the premise that one's identity strengthens when others validate them through mimicking or aligning with the characteristics that make that individual unique. In 1973, Howard Giles posited that people would generally adjust their communication behaviors to mimic those in a small group so that they will either converge into the group in which they are communicating or diverge to separate themselves from the group (Jones et al., 2018; Pines et al., 2021; West & Turner, 2018). Individuals of different social status divert their linguistic style to increase social power and accommodate each other when asked to problem solve (Jones et al., 2018; Pines et al., 2021; West & Turner, 2018). The member of the team with the least amount of perceived influence or power was motivated to adjust their speech and behaviors to gain the approval of the higher-ranked worker (Muir et al., 2016). Giles found that cross-culturally, people would adjust or modify their behavior to gain the favor of another (Pines et al., 2021). In the clinical environment, this plays out as different individuals of varying responsibility and importance shift their communication efforts to accommodate the leader. As the theory grew in understanding, researchers Tajfel and Turner further determined that each follower in the clinical team shaped their identity according to personal and social traits (as cited in West & Turner, 2018).

Assumptions in Communication Accommodation

Four assumptions exist in the communication accommodation theory. The first assumption relates to the similarities and dissimilarities that exist between all people. Past experiences, whether similar or dissimilar, will determine the amount of accommodation an individual will inflect into their communication to converge with or diverge from others (Jones et al., 2018; Pines et al., 2021). These will be spotted by observing a group staff gathered around

the watercooler. Most likely, they will be dressed similarly, have similar tonal intonation, and utilize phraseology that is influenced by their environment.

The second assumption states that we all make assumptions during a conversation that will determine the outcome of our feelings about that conversation (Jones et al., 2018; Pines et al., 2021). Consider a senior-level employee in a medical clinic joining into a conversation when the physician is not present. When the senior-level member speaks ill of the provider, the two juniors evaluate the situation and determine if it is a comfortable conversation to join. What type of consequences will result if they join, what if they remain silent? These interactions contribute to the workplace environment, whether positive or negative.

The third assumption says that the social status of a group determines the speech patterns and behaviors exhibited (Horodilla-Vatamanescu & Pana, 2010). This is seen when the provider is present. The language and inflections change to match the most senior-level or favored employee. This accommodation can add to a toxic work environment that fosters disruptive behavior.

Last, West and Turner (2018) proposed that not all accommodation is appropriate. Overaccommodation or indirect stereotyping will result in a negative reaction (West & Turner, 2018). These conflicting goals and forms of communication are factors that create an unstable environment.

Since 2015, the healthcare industry has undergone substantial change, adding to the instability. One area is the change of reimbursement structure and payment structure that rewards value and quality over procedures and quantity, all implemented to try to create a higher value proposition for the consumer. Change is magnified in the small group setting, such as the clinical healthcare team.

Disruptive Physician Behavior in the Small Group Setting

Faced with the dilemma of deciding, whether in a personal or organizational setting, most people will fundamentally go with the method they are most comfortable with (Moreiera et al., 2020). Researchers have found that the brain breaks decision-making patterns into two categories: system-1 that relies on the auto-response reaction, and system-2 that relies on a more deliberative, thoughtful approach (Bazerman & Moore, 2013). Bago et al. (2018) determined that system-1 thinking processes critical decisions based on conflicting situations utilizing heuristic belief-based responses, increasing the sensitivity in a quick decision over deliberate system-2 thinking.

Small group processes consist of features, dynamics, communication, and other characteristics of a group of three or more individuals working toward a solution to create, form, and interact as they work together (Nicolini, 2018). Small groups are dependent on the social interaction of the members of the group (Zanlungo et al., 2019). For this reason, small groups utilize system-2 thinking when situated in a position where a decision must be made. Davenport (2013) investigated small group processes and examined responsibilities that create solutions. These processes allows the group to thoroughly investigate and explore different options when landing on a decision to be made. In the clinical environment characterized by DPB, system-1 thinking presides, and the position of power generally emerges victorious. Groupthink occurs when one member of the small group is dominant and forceful in their opinion (Kelman et al., 2017). The rest of the group is prone to base their decisions on the most vocal member. This behavior can lead to making ill-advised decisions and conflict (Kelman et al., 2017).

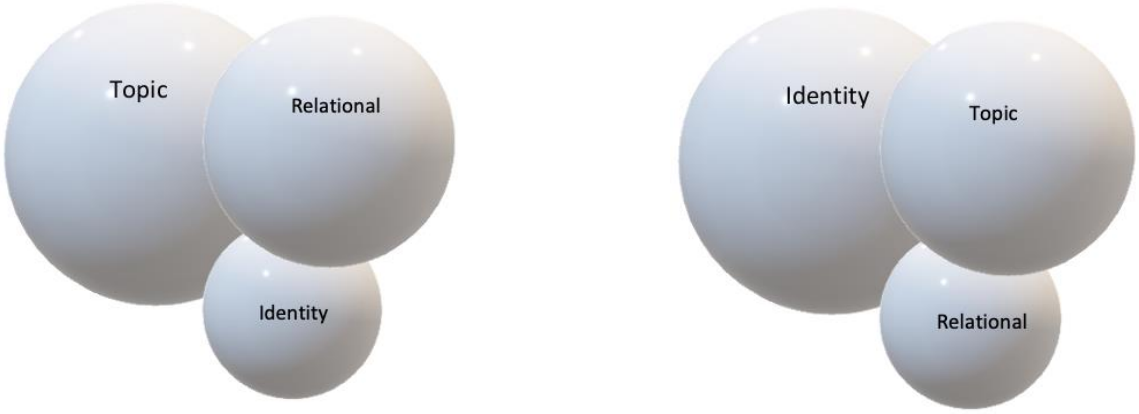
Disruptive Physician Goals in Conflict

In private practice, disruptive physicians focus on winning. For this mentality to exist, two or more parties must have incompatible goals (Hocker & Wilmot, 2018). Generally, when conflict exists, four goals are at play to gain the winning advantage: topic, relational, identity, and process. These four goals overlap and shift throughout the conflict and are named for the first letter of each goal: TRIP. Topic goals focus on what is wanted (Hocker & Wilmot, 2018). In the case of DPB, the provider's focus is on their topic goal of creating change. The physician provider wants to influence the working conditions of the clinical environment to accomplish their desire, whereas the emotionally intelligent physician wants to change the dynamic and looks to gain a peaceful resolution.

The emotionally intelligent physician has a higher level of relational goals than the disruptive physician provider (Hocker & Wilmot, 2018). The emotionally intelligent provider's predominant goal is seeking a peaceful atmosphere. They choose this option because of the power they wield in the clinical setting. The staff will comply and maintain peace. The physician provider also focuses on their identity goal to influence the compliant workers. The disruptive physician also relies on their identity goal; however, their identity comes from being the physician provider, a position of power. This identity goal often coincides with saving face (Hocker & Wilmot, 2018). The disruptive provider perceives their position of authority as the primary decision-maker and the leader. If things do not go their way, they see themselves as an inadequate leader. In this respect, the disruptive physician provider places a higher emphasis on his identity goals. Neither the disruptive physician provider nor emotionally intelligent physician provider focuses primarily on the process. The two entities exhibit varying forms of the TRIP goals to differing extents (Figure 2).

Figure 2

Emotionally Intelligent Physician and Disruptive Physician TRIP Goals Illustrated



Note. These figures illustrate the TRIP goals. The figure on the left represents an emotionally intelligent physician whose main goals are represented by topic, relational, then identity goals. The figure on the right represents the disruptive physician whose main goals focus on identity, followed by topic, then relational.

The conflict in goal priorities creates an environment conducive to conflict resulting in instability and a lack of checks and balances. In this setting the communication becomes vital to function in a productive manner. To remain functional, staff often accommodate the disruptive provider, adapting to their level of demands and communication. The communication accommodation theory demonstrates this behavior.

Statement of the Problem

As leaders of the care system, physicians influence the culture and work environment in the clinic, deterring from or building an environment of instability in health care organizations (Katz et al., 2019; Simpson, 2017). DPB can contribute to a stressful working environment and negatively influence the organizational structure (Galdikeine et al., 2019; Rosenstein et al.,

2016), leading to increased nursing turnover (Heidari et al., 2018), compromised patient care, and diminished clinical team dynamics (American Medical Association, 2011).

Incivility, such as DPB, can create an environment that cultivates dissatisfaction among the support staff (Klingberg et al., 2018; Wang & Sung, 2019), which can result in increased staff turnover and lack of continuity of care. In addition, it is not a conducive health environment for patients with illnesses that require prolonged and consistent treatments. This behavior is especially problematic in the subspecialty of oncology, where consistency, patient satisfaction, a positive caregiving environment, and familiarity play a vital role in oncology patients' health and wellness (Berglund et al., 2015). In addition, DPB can impact interprofessional relationships between the physicians and clinical staff (Bowles et al., 2016; Cullen et al., 2017; Katz et al., 2019), impacting patient safety and quality of care (Danielsson et al., 2018; Katz et al., 2019).

Purpose Statement

The purpose of this quantitative multivariate regression analysis was to examine the nature of DPB from the perspective of clinical staff and patients. Specifically, the aim of this study was the following:

1. To understand the impact of DPB on staff turnover rates in the private oncology practice;
2. Its effect on patient satisfaction in the provider's clinic; and
3. Compare the staff turnover rates and the patient satisfaction scores of physicians that display DPB with physicians that do not show this behavior.

Research Questions

The aim of the research was to determine if the presence of DPB in the oncology clinical setting has direct impact on staff satisfaction and job turnover and does it have a direct impact on patient satisfaction scores.

The following research questions directed this quantitative descriptive study:

RQ1: Does the presence of disruptive physician behavior in the oncology clinical setting directly impact staff satisfaction?

RQ2: Does the presence of disruptive physician behavior in the oncology clinical setting correlate with staff job turnover?

RQ3: Does the presence of disruptive physician behavior in the oncology clinical setting correlate with patient satisfaction scores?

Significance of the Study

Continued stressors like governmental regulations of healthcare costs, the cost efficiency measures, and value-based programs to improve the patient experience have resulted in less autonomy from the private sector (Owaid, 2017), producing a shortage of physicians entering subspecialties, such as oncology (Paiva, 2018). These shortages lead to stress-related outbursts that often leave the clinical staff debilitated and unable to efficiently fulfill their roles (Schuh et al., 2019). In some cultures, the perception of positional power is synonymous with a desirable leadership style. Hutchinson and Jackson (2015), in their cross-sectional, open-ended study of over 3,000 individuals in the public sector, found that individuals are silenced when confronted by a person of authority, such as a physician. Finding themselves in a place of vulnerability in specialties such as cardiology and oncology, patient satisfaction often run high because of the severity of the disease and the fact the patient believes the physician can control their outcome

(Hutchinson & Jackson, 2015). Imagine your life is hanging in the balance of someone's hands, would you want to tell them you do not like their behavior?

Compromised turnover combined with staffing shortages contribute to difficulty in recruiting and retaining the qualified talent to care for patients and ensuring optimal patient care. In an environment where more competent and qualified nurses are needed, the number of nurses has decreased dramatically since 2017 (Snavely, 2016). DPB contributes to a substandard environment where staff turnover and patient satisfaction are compromised (Piper, 2003). Examining the impact of DPB on staff and patients will help to reduce and mitigate its effects.

Understanding the impact DPB has on employee turnover, patient satisfaction, and patient outcomes will benefit oncology practices by revealing the consequences that incivility has in the healthcare environment (Klingberg et al., 2018; Wang & Sung, 2019). The number of physicians practicing has diminished dramatically over the course of the last two decades (Owaid, 2017). Understanding the impact of DPB on the private practice can provide a valuable understanding of how physicians can thrive in a volatile environment (Owaid, 2017). Accountability for the actions and behavior of physicians is the primary characteristic of organizations that experience sustainable change (Engl et al., 2019). Private oncology practices will benefit from this knowledge where disruptive behavior is especially problematic because the workplace environment thrives on consistency, patient satisfaction, and familiarity in the oncology patient (Berglund et al., 2015). Staffing levels for physicians have reached a dangerously low level (Kuwata, 2017; Haddad et al., 2020). A better understanding on the impact DPB has on the oncology workplace environment will assist in creating a successful organizational culture for oncology practices like the one used in this study.

Rationale for Methodology

Quantitative multiple-choice survey questions provide a realist perspective and uncover the existing reality (Muijs, 2011) within the healthcare system. The realist worldview states that the truth is out there; the researcher locates and analyzes it through the natural sciences. (Muijs, 2011). The quantitative multivariate regression analysis allowed me to study and compare the variables and provide insight into the impact DPB had on employee satisfaction, job turnover rates, and patient satisfaction rates.

Ethical Considerations

The participants in the study were from my place of business. This practice is the largest privately-owned oncology and hematology clinic in North America. I used the entire practice where I work with 11% of the practice physicians. My epistemological position is one of objectivity (Lincoln & Guba, 2013). The researcher must practice neutrality, tabling any bias or feelings toward any participants or outcomes (Leavy, 2017). Ethical standards assure that sufficient data collection minimizes participant risk and protects their identity (Zyphur & Pierides, 2017). A third-party maintained all anonymity and ensured ethical treatment of all participants and the organization.

Definition of Terms

The following terms and concepts were used operationally in this quantitative secondary analysis study:

Abusive behavior. Any action exhibited by a provider that creates a substandard level of treatment and impedes on the organization's ability to meet their mission of patient care (Piper, 2003).

Destructive leadership. Displaying behaviors common to narcissism, that assume the leader intends to cause the breakdown of a follower, a group, or an organization through influence or coercion that results in a selfish gain created to achieve the desired individual's outcome (Padilla et al, 2007).

Disruptive physician behavior. Abusive behavior characterizes any action exhibited by a physician that creates a substandard level of treatment and impedes the organization's ability to meet their mission of patient care, and by nature, is designed to destroy (Piper, 2003).

Multivariate regression analysis. The use of existing collected data used for a different purpose from its original intent where multivariable models are used to establish the relationship between a dependent variable and more than 1 independent variable (Krippendorff, 2019).

Outpatient oncology clinic. A clinic that is visited by a patient that does spend the night in a hospital that is solely specializes in the diagnosis and treatment of cancer (NIH, n.d.).

Quantitative-descriptive analysis. The correlation of two or more variables, collected through data that describe a certain phenomenon discovered through the mathematical analysis of the data (Muijs, 2016).

Toxic leadership. Leadership characterized by destructive behavior that results in adverse reactions by the followers and negative attitudes toward the leader and/or the organization (Schyns & Schilling, 2013).

Toxic triangle. An environment characterized by destructive behavior created by destructive leader that use their personalize power, susceptible followers possessing unmet needs that either conform or collude, and a conducive environment where perceived threats and instability fail to adhere to a series of checks and balances creating a destructive environment (Padilla et al. 2007).

Summary

Chapter 1 began with a definition of DPB and discussed the dynamics between the physician, the clinical staff, and the patient. The chapter continued the discussion of the impact change has on the care team and explored how changes in the payment structure have affected the dynamics and culture within the healthcare setting. New payment structures, like the value-based care model, have placed an importance on interprofessional relationships because they can impact the patient experience. As the leader of the practice, the physician often sets the tone for the environment and organizational culture. Toxic leadership exists when the provider enforces their will based on their position of power. Padilla et al. (2007) posited that a toxic leader, combined with susceptible followers and a conducive environment creates a triad of toxicity that leads to conflict in the work environment. I discussed conflict styles found in the clinical private practice. The susceptible staff accommodates the toxic leader through assumptions found in the communication accommodation theory. When communication breaks down, disruptive behavior can ensue in the small group setting of the clinical practice. Conflict heightens as each member of the care team works to accomplish their agenda.

As the leaders of the care team, physicians are responsible for the working environment. Interprofessional relationships and patient relationships deteriorate when the physician displays this disruptive behavior. There exists a gap in the research to study whether DPB has a profound impact on employee satisfaction, employee turnover rates, and patient satisfaction rates in the subspecialty of oncology. Understanding this impact would benefit the oncologic private practice and ultimately benefit the patient's journey. The purpose of this study was to empirically investigate the impact of DPB on staff satisfaction, staff job turnover, and patient satisfaction scores.

To better understand these results, I investigated the relevant literature that exists in Chapter 2 that comprehensively reviews the existing factors that contribute to the theoretical framework of this study. Chapter 3 lays out the quantitative methodology, instruments, research questions and hypotheses, data collection, and data analysis process. Chapter 4 analyzes the data, and Chapter 5 discusses the outcomes, conclusions, recommendations, and suggestions for further research.

Chapter 2: Literature Review

The elements of this overview include the cost of healthcare, toxic leadership, the toxic triangle, toxic leadership in healthcare, conflict style in healthcare, communication accommodation theory, assumptions in communication accommodation, DPB in the small group setting, disruptive physician goals in conflict, the statement of the problem, the purpose statement, research questions, significance of the study, assumptions and limitations of the study, rationale for methodology, and the definition of terms for the quantitative descriptive analysis methodology. In studying the impact of DPB on employee satisfaction, turnover, and patient satisfaction in a physician-owned oncology clinic in the Southern United States, the goal was to assess whether correlations exist between DPB and employee satisfaction and turnover rates, and the correlation between DPB and patient satisfaction rates. Roles defining the care team include nurses and medical assistants.

This chapter presents a detailed identification of the existing literature as well as the gap which exists. The review of literature provides a comprehensive overview of the existing body of knowledge regarding the toxic triangle theory, communication accommodation theory, and DPB. During research for this study, I accessed a variety of peer-reviewed databases, including EBSCO, ERIC, Journal Finder, ProQuest, Sage Premier, and Science Direct.

The themes associated with toxic triangle theory include subsections reviewing the literature pertaining to both the antecedents and response strategies of toxic triangle theory. Toxic triangle theory themes included organizational culture, toxic leadership, the followers' role in conflict, and the toxic triangle theory. Themes related to communication accommodation theory include communication culture, leadership communication, and communication accommodation theory. Healthcare and DPB themes include change in healthcare, value-based

care, toxic triangle theory in healthcare, communication accommodation theory in healthcare, employee burnout and turnover, patient satisfaction, and DPB.

Toxic Triangle Theory

Toxic leaders create an unstable environment, susceptible followers foster this environment, and the organizational culture contributes to the dysfunction of the team. In 2007, Padilla et al. researched these topics and created the toxic triangle theory. In this theory, a conducive environment must exist between the leader and the followers, giving the triangle its three sides. Synonymous with toxic leaders, the destructive leader displays characteristics of narcissism, an ideology of conflict. This type of leader is focused on the personalization of their power and dwells on the negative aspects of the organization (Padilla et al., 2007; Milosevic et al., 2019). Julmi (2021) wrote about the dark side of leadership and coined the phrase "paratoxical" leadership. This term accentuates the fact that toxic leaders put followers in situations where they must decide to do the wrong thing, placing themselves and their team in a compromising position. It begins with the leader. Padilla et al. (2007) first outlined the role of toxic leadership in the triangle.

The definition of toxic leadership that Padilla et al. (2007) used for the theory focused on the persuasive characteristics of the leader to coerce their followers for personal gains. In this theory, the leader must possess the traits that cause followers to comply, and in most cases, build upon the negative impact caused by this form of leadership. The toxic manager often utilizes forms of micromanaging, narcissism, and bullying (Stoten, 2015). In some rare cases, those found typically in the role of follower can persuade the leader to act accordingly, manipulating the narcissist attitude of the leader. In one extreme incident at the Bristol Royal Infirmary, the parents of a pediatric patient suffered from Munchausen syndrome by proxy. To understand how

the three sides of the triangle work as a synchronic symphony, each spectrum of the triangle will be viewed through the lens of the toxic triangle theory using this case. Munchausen syndrome by proxy is a disorder that manifests as the caretaker fabricates ailments to gain the attention, in this case, of the physician. The physician, typically seen as the leader of the healthcare team, possessed grandiose narcissistic behavior and exploited the syndrome, using it as an opportunity to gain power within the healthcare system (Fraher, 2014). This case displays the toxicity and the darkness associated with the toxic triangle. In this case, all three sides of the triangle came together to exasperate the physician's disruptive behavior.

The second side of the toxic triangle is susceptible followers. Followers fall into the category of colluders and conformers (Padilla et al., 2007). To collude, a follower must possess ambition, have a compromised values system, and share a similar worldview as the leader (Northouse, 2016). In the above case, the parents of the patient colluded with the physician to further compromise the health of their child. Followers also conform to contribute to the toxic triangle. To conform, the susceptible follower possesses unmet needs, low-core self-esteem, and typically displays a low level of organizational maturity (Padilla et al., 2007). Relativistic and idealistic fundamental dimensions comprise the ethical ideological approach chosen by the followers (Forsyth, 1992). Relativism refers to the fundamental adherence to universal moral standards. Conversely, idealism relates to the distance which the follower will go to comply, no matter how much harm impacts the situation (Forsyth, 1992). The caretakers at the Bristol Royal Infirmary exhibited idealistic dimensions of adherence of societal norms enabling the dysfunctional relationship between the physician (leader) and the parents (colluding followers). The destructive leader and the susceptible follower make up two of the three sides of the toxic triangle.

The final side of the toxic triangle is a conducive environment. A conducive environment exhibits instability through unstable cultural values and the lack of a checks and balances system. These characteristics create a perceived threat to the stability of the organization and complete the toxic triangle (Padilla et al., 2007). Change-related leadership commonly encompasses the environment conducive to disruptive behavior (Moutousi & May, 2018). Culture also plays a large role in the conducive environment when results-driven data become the catalyst for behavior (Stoten, 2015). The win-at-all-costs mentality, prevalent in many alpha-driven organizations, usurps the energy for any positive change that would make a difference in the toxic dynamic (Matos et al., 2018). A perceived organizational culture contrary to the departmental values creates an environment primed to create dysfunction. Followers gravitate to leaders that will rebel against such an environment, giving the narcissistic leader an opening to obtain compliance. To place the final side of the triangle on the infirmary case, there an environment conducive to vulnerability brought about the ultimate death of a patient.

The Bristol Royal Infirmary is a well-respected institute in United Kingdom. The culture there promoted success and innovation. The physicians working with the family felt heavy pressure to perform and bring notoriety to the infirmary (Fraher, 2014). The destructive leaders along with the colluding followers, together in a highly competitive, win-at-all-costs environment created the perfect formula to complete the toxic triangle. This example provides insight into how the toxic triangle impacts the healthcare sector. Beyond the toxicity, communication contributes to DPB.

Organizational Culture

Corporate culture plays a pivotal role in the success or failure of an organization. The dynamics within an organization and its culture remain the most significant factor that impacts

organizational change implementation (Slack & Singh, 2018). When things go wrong, people generally point to leadership for accountability (van Rooij & Fine, 2018). Large companies implement culture committees to address the toxic elements in the workplace and incorporate change (van Rooij & Fine, 2018). Often management and key stakeholders make up these committees, adding to the complexity of creating active change agents.

Leaders in positions of influence and power create the overall cultural profile of the organization that consists of three cultures: a leadership culture consisting of organized and efficient team members; a strategic culture, defined by power, stability, engaged, and tenured influencers; and the dominant culture, characterized by control and structure (Slack & Singh, 2018). Positive or negative influence follows leadership behavior and determines the level of compliance.

Mungaray and Curtin (2021) identified the leadership culture as a heteronormative paradigm where the ideal leader possesses strong, charismatic personality traits that are often viewed as a leader-teacher (Mungaray & Curtin, 2019). Strong vision and missional foundations characterize the leadership culture (Mungarary & Curtin, 2019). Leadership culture is prevalent in disciplines such as education (Parlar et al., 2017; Latta, 2021) and nurse-led groups (Demorest et al., 2017; Swamy et al., 2020). Researchers have documented the benefits of the leadership culture, however, one discipline lacking research is the privately-owned physician-run practice. Institutions and hospital systems are easily studied because of the access to individuals and the breadth of these organizations, but what happens when the organizational culture is compromised and those left to steer the helm fail?

Toxic Leadership

Leadership and leadership development occupy a large section of the organizational landscape. Northouse (2016) defines leadership as "the process whereby an individual influences a group of individuals to achieve a common goal" (p. 6). The leader within a community or organization wields the power to influence both positively and negatively. Northouse (2016) breaks leadership down into three main factors: influence, groups, and common goals. The influence impacts the group of followers and creates the setting for the group.

Many definitions surface regarding toxic leadership. Behery et al. (2018) included "abusive supervision, authoritarian leadership, narcissism, self-promotion, and unpredictability" as the primary factors that define the toxic leader (p. 797). Milosevic et al. (2019) described toxic or dark leadership as possessing "leadership focused on maintaining position of control via toxic influence attempts, whose harmfulness, although relatively unintentional, causes serious harm by reckless behavior, as well as incompetence" (p. 118). In addition, toxic leaders "work for themselves or against the goals of their organizations, resulting in a dysfunctional environment" (Winn & Dykes, 2019). Seemingly, the array of toxic leadership definitions equals the number of authors that have devoted time to researching this phenomenon. Evidence exists that toxic leadership spans a variety of specialties and results in negative outcomes.

The toxic leader can be found in any organizational type and among all levels of management. Labrague et al. (2021) observed 240 nurse managers at ten hospitals in the Central Philippines to determine why 20% of the nursing population is leaving the country for opportunities in the United Kingdom, New Zealand, United States, and Australia, forcing emergent studies of turnover in this region. Labrague et al.'s study identified key predictors of

toxic leadership including lack of leadership experience, lack of preparedness, lack of training and professional development, and size of the units managed (2021). Not all of the nurses exited the field because of the key predictors, some may have considered the economic benefits of moving to and working in a developed country. In their correlational, cross-sectional study, Labrague et al. (2021) found that nurse managers that exhibited destructive behavior failed to acknowledge any wrongdoing. This would suggest that these nurse managers were oblivious to the impact of their behavior on the rest of the team.

Toxic leadership and its effect on the organizational team is not limited to the nursing profession. Naeem and Khurram (2020) found similar results in the financial industry, where the toxic influence of the leader had a direct impact of the psychological well-being of the team, resulting in high turnover intention. They demonstrated this by creating a tool that measured the relationship of toxic leadership compared with employee engagement. In their model, for every unit of toxic leadership observed, the turnover intention increased by a factor of 0.486 (Naeem & Khurram, 2020). In their large sample study (n = 329), they were able to correlate lower satisfaction scores for leaders with turnover intention. Matos et al. (2018) compared the effects of toxic leadership across a variety of organizational sectors to test the influence of the hypercompetitive style of leadership and mission. They found that organizations that possess a predominantly masculine culture, meaning highly competitive and a “win or die” mentality, create an environment where the toxic leadership influences the culture of the team and the organization (Matos et al., 2018). These studies imply that toxic leadership spans all organizations and result in leaders that negatively impact the followers and the organizational culture.

What is the impact on the followers? Paltu and Brouwers (2020) wanted to determine the impact on the followers and performed a cross-sectional quantitative study on 600 South African manufacturing workers that identified having toxic leaders. They wanted to test the theory of the toxic triangle theory by understanding the leader's intent for their behavior, the impact on the workers job satisfaction, the worker's intent to leave their job, and the organizational culture. With a large sample (n = 600), they determined that workers with leaders that were identified as toxic had higher job dissatisfaction, high job turnover intent, and lower commitment to the culture or the organization, thus checking the three main elements of the toxic triangle.

The Follower's Role in Conflict

The same characteristics that lead to negative outcomes from the leaders create a disruptive environment among the followers. Northouse (2016) wrote that toxic leaders foster unproductive outcomes in followers. Padilla et al. (2007) posited that toxic leaders combined with susceptible followers equals dysfunction in the organizational team. These followers conform and collude to strengthen the negative influence of a destructive leader (Northouse, 2016). Milosevic et al. (2019) devoted their entire study to understanding the relationship between the leader and the follower and focused on the active role a follower plays that enables a destructive leader. The followers enable the destructive leader, and their actions often result in negative consequences (Milosevic et al. 2019; Webster et al., 2016). One way in which followers enable the destructive leader to maintain control includes compliance. Thoroughgood et al.'s (2016) research showed that followers who comply abandon their moral obligations to protect others and satisfy their leader. This behavior creates an imbalance of power and gives the leader influence over the compliant follower that looks to maintain peace. This compliance begins to

intensify the dysfunction in the team as the followers begin to contribute to unproductive environment (Milosevic, 2019).

Once the toxic leader hooks the followers into their disruptive behavior, the followers add to the dysfunction. Psychosocial examples of this paradox include Mao Tse Tung's Red Guard, the Hitler Youth, and the Stanford Prison Experiment (Thoroughgood et al., 2016). When disruptive behavior exists and the followers contribute, toxic behavior becomes acceptable and justifiable. The Stanford Prison Experiment took young, middle-class, men and placed them in roles of guard and prisoner. The two-week experiment was stopped after six days because of the danger presented as groupthink and toxic behavior escalated, endangering the subjects. Onishi and Hebert (2014) posited the similarities in this experiment to the healthcare professions, acknowledging that similar results created toxicity in the culture of the clinical team and ultimately, in patient care.

Communication Accommodation Theory

The communication accommodation theory utilizes the idea that one's identity strengthens when other people validate them through mimicking or aligning with the characteristics that make that individual unique. In 1973, Howard Giles argued that people would generally adjust their communication behaviors to mimic those in a small group (West & Turner, 2018). Linguistic style diversion was shown to increase social power when two workers were told to solve a problem together. The lower social caste placement motivated the worker to adjust their speech and behaviors to gain the approval of the higher-ranked worker (Muir et al., 2016). Giles found that cross-culturally, people would adjust or modify their behavior to gain the favor of another (West & Turner, 2018). As the theory grew in understanding, researchers Tajfel and

Turner further determined that each follower shaped their identity according to personal and social traits of the leader (as cited in West & Turner, 2018).

Disruptive Physician Behavior in Healthcare

Leadership behavior plays a significant role in strategic organizational outcomes. Influential leaders within an organization possess the ability to evoke sustainable change (Johnstone & Lindh, 2018). These change agents influence the culture for good or bad, depending on the magnitude of their reaction. Hayibor (2017) posited that key stakeholders and influencers affect organizational outcomes. The stakeholder theory places importance on the organizational values and how well the key stakeholders uphold those organizational values. This draws a lot of focus onto the stakeholder's behavior. Certain personality traits, such as minimal sociability, emotional outbursts, and low levels of trust, result in physicians that display noncompliant behavior and deteriorate employee morale (Fibuch & Robertson, 2019).

On the other hand, organizational citizenship behavior can just as easily be positively influenced by a powerful message sent by a leader of influence (Adame & Bisel, 2019). When physicians communicate with ancillary staff, staff engagement and morale increase (Yusuf et al., 2018). Ultimately, accountability for physicians' actions and behavior is the primary characteristic of organizations that experience sustainable change (Engl et al., 2019). External pressures, such as increased government oversight, increased liability, and knowledgeable patients, have led to increased emotional outbursts from the physician (Rosenstein, 2002). Positively charged emotional outbursts documented in the operating room showed that surgeons are more likely to channel these emotions to their support staff (Keller et al., 2019). These outbursts are not exclusive to surgeons and cross the barriers of all subspecialists practicing healthcare (Keller et al., 2019). The *Journal of Medical Regulation*

reported that dramatic tantrums lead to poor patient outcomes because of the ancillary staff's stress.

These eruptions continue to occur despite the negative impact, notably in the general practitioner, where this behavior goes unaddressed in 76% of occurrences (Arnold, 2019). The event of abusive physicians toward their staff is widely ignored, as indicated by the repeated allegations reported to state medical boards across the United States (Teegarden & Norder, 2019). The expense of training physicians represents the highest deterrent for addressing these behaviors (Teegard & Norder, 2019).

Research indicates that disruptive behavior in the clinic is not limited to DPB. Boateng and Adams (2016) identified internal division and sources of tension resulting from intra-personal conflict that occurred among members within the same profession. The researchers wanted to identify coping mechanisms for nurses but limited their study to registered nurses and looked solely at race and age factors. Boateng and Adams (2016) determined that an internal reporting structure was the most effective method of identifying incivilities within the same profession. They did not compare these findings to the application of DPB.

Researchers have looked at the systemic problem of DPB across many disciplines. No studies review the impact on employee satisfaction, turnover rates, and patient care in the oncology environment. This information needs to be studied to address physicians' behavior in a discipline where patient care is paramount for patients battling a terminal illness.

Factors Leading to Disruptive Physician Behavior

Changes in Healthcare. In healthcare organizations, the middle manager, and the stakeholder, usually an administrator or physician, pair together to implement the vast array of changes. Conflict results when physician choices, based solely on their clinical insight, differ

from administrative directives (Tariman et al., 2020). This conflict leaves the middle manager caught between the administration and the key stakeholder; the physician weakens the middle manager's authority as a change agent. In healthcare organizations, the mid-level manager usually exists as a clinical employee that advances into management with little or no management experience (Bennett, 2017). This career path creates weak leadership and supports the need for physicians of influence to align their ideals with corporate culture.

Consistency and communication increase understanding during the information exchange, which resonate with healthcare organizations that have compliant physicians within their culture (Hamidi et al., 2017). McAlearney et al. (2018) determined that a thriving culture in healthcare is rooted in accountability, responsibility, and engaged physicians. Marshall and Hurtig (2019) found that a culture rich in communication creates a thriving environment that increases the quality of patient care. The change agents and influencers work together to create the culture of the organization that exists. Physician behavior often dictates the engagement and morale of an organization. This influence either supports or competes with the organizational culture.

Value-Based Care. Dating back to the early 1990's, it became evident that health care in the United States was an issue. The pervasive issue was the quality in, what was then, a new managed-care system. Managed care was supposed to create a system that managed costs. Instead, issues became more prevalent as physicians found ways to utilize the system to increase expenditures on the patient and decrease the quality. Casting the net wide, some physicians would order a tremendous amount of diagnostic studies and exams that increased the cost of healthcare and diminished the quality. Competition, instead of increasing the value, had a negative impact as some participants took advantage of the system profiting more than others,

leaving an imbalance that was not reconcilable (Porter & Teisberg, 2006). As technology continued to grow, new therapies evolved, but the healthcare system did not evolve at the same pace.

Payers began to question the services and began to implement a change in payment models from a fee-for-service model, in which physicians were paid a set fee for services rendered to the patients, to episodes-of-care type models, where a set fee was given for the entire course of treatment. This opened the door for physicians to let quality suffer to provide the most cost-effective plan of care for the patient (Cutler & Ghosh, 2012). Where costs were beginning to be contained, the value to the the patient remained relatively unchanged. A system was needed that would continue to maintain costs while improving the quality and the value of care for the patient.

With the thought of creating a more cost-efficient payment model that is dependent on quality measures and a higher value for the patient, the CMS developed the oncology care model (OCM) for the oncology sector of healthcare. Innovative in its approach, the OCM focuses on a multipayer model that provides higher quality and more coordinated care for the oncology patient. Under the OCM, the physician provider groups enter an arrangement that holds them accountable for the quality of care they provide their patients and bases payments on results from a list of core measures that are defined that include patient input. For the first time, with the OCM, oncology physicians are being paid to treat their patients well in a cost-effective manner (CMS, 2016).

The OCM consists of 12 core quality measures that affect the performance-based payments made by CMS to the provider (Figure 3). Of the 12 measures; OCM-1, OCM-2, OCM-3, and OCM-6 all have ending values and end results that are dependent on feedback and

measures. This creates a moving target for the physicians. The first three measures rely on outcomes of the practices participating in the OCM. Each quarter CMS provides a ranking, so percentages met are scored on a system that compares the individual practice to the sum of the whole. Although there are baseline numbers to be reached, the ranking and percentile of the individual practice varies from quarter to quarter. This determines the percentage of bonus payments made to the practice. The ability to adjust practices and processes to affect outcomes plays a key role in the results. The patient-reported experience (OCM-6) is measured solely on the feedback of the patients and their experience. CMS surveys the patient independently of the practices and reveals the results to the practices in quarterly results. The results of the patient survey determine the score the practice receives, thus affecting their payment structure.

Figure 3

Oncology Care Model Measures

OCM #	Measure Description	Source
OCM-1	Risk-adjusted proportion of patients with all-cause hospital admissions within the 6-month episode	Claims
OCM-2	Risk-adjusted proportion of patients with all-cause ED visits that did not result in a hospital admission within the 6-month episode	Claims
OCM-3	Proportion of patients who died who were admitted to hospice for 3 days or more	Claims
OCM-4a	Oncology: Medical and Radiation – Pain Intensity Quantified (NQF 0384/PQRS 143)	Practice
OCM-4b	Oncology: Medical and Radiation – Plan of Care for Pain (NQF 0383/PQRS 144)	Practice
OCM-5	Preventive Care and Screening: Screening for Depression and Follow-Up Plan (NQF 0418/ eCQM CMS2.6.3)	Practice
OCM-6	Patient-Reported Experience	Survey
OCM-7	Prostate Cancer: Adjuvant Hormonal Therapy for High or Very High Risk Prostate Cancer (NQF 0390/PQRS 104)	Practice
OCM-8	Adjuvant chemotherapy is recommended or administered within 4 months (120 days) of diagnosis to patients under the age of 80 with AJCC III (lymph node positive) colon cancer	Practice
OCM-9	Combination chemotherapy is recommended or administered within 4 months (120 days) of diagnosis for women under 70 with AJCC T1cN0M0, or Stage IB - III hormone receptor negative breast cancer (NQF 0559)	Practice
OCM-10	Trastuzumab administered to patients with AJCC stage 1 (T1c) – III and human epidermal growth factor receptor 2 (HER2) positive breast cancer who receive adjuvant chemotherapy (NQF 1858)	Practice
OCM-11	Breast Cancer: Hormonal Therapy for Stage I (T1b)-IIIC Estrogen Receptor/Progesterone Receptor (ER/PR) Positive Breast Cancer (NQF 0387/eCQM CMS140v5.0)	Practice
OCM-12	Documentation of Current Medications in the Medical Record (NQF 0419/eCQM CMS68v6.1)	Practice

Note. Figure 3 illustrates the OCM measures. OCM-6 is the Patient-Reported Experience, measured by survey. Reprinted from *Oncology Care Model,* by Centers for Medicare and Medicaid Services, 2015. In the public domain. Reprinted with permission. (see Appendix C)

Staffing Shortages. A literature search for *nursing shortages* yields an abundance of results among a variety of specialties. Research articles reveal shortages in pediatric, nephrology, clinical oncology, medical-surgical, aged care, and even nursing school enrollment (Challinor et al. 2020; Kuwata, 2017; Sheidt et al., 2021). Globally, in 2018 the WHO reported a shortage of 5.9 million nurses worldwide (Challinor et al., 2020). According to the U.S. Bureau of Labor Statistics (2021), the demand for registered nurses will increase by 7% in the 2020's and the number of treating practitioners will grow by 10%, outpacing the 4% growth total of all occupations. By the year 2029, it is projected that more than 3.3 million registered nurses will be needed to care for the aging population while the participation rate is expected to decline by 1.8%, leaving a gap in the number of healthcare professionals (U.S. Bureau of Labor Statistics, 2021). Of the 10 fastest growing occupations in the 2020's, six are found in the healthcare arena. The intersection of increased demand and a decrease in workers entering these fields produces a stressful working environment that relies on fewer workers to perform more tasks. The COVID-19 pandemic exacerbated this shortage, decreasing staffing numbers and creating more difficult working conditions.

Prior to the pandemic, healthcare staffing shortages created a demand that largely went unfulfilled. Factors creating the staffing shortage, specifically the shortage of registered nurses, included the number of baby boomers retiring from the field, the increase of advanced practice physicians, and most recently, fatigue from the COVID pandemic (Buerhaus, 2021). This is particularly concerning in oncology nurses; Challinor et al. (2020) argued that the layers of stress listed above plus the additional stress of a complex work environment led to more oncology nurses leaving specialty or profession.

Registered nurses have voiced concerns regarding the patient/nurse ratio and safe working conditions. Presently, there are no federal regulations that address the nurse-to-patient ratio, although H.R. 2581 in the 116th Congress in 2019 was introduced and failed, which would have required a minimum nurse to patient ratio (Congress.Gov, n.d.). The little regulation that exists is written in such vague language that most employers can work around rules with very little room for accountability. Specialties like pediatric care, neurology, and oncology rely heavily on the attentive care that is required from skilled professionals (Sheidt et al., 2021). Kim et al. (2016), in a large sample of 1,070 hospitals and 339,379 hospitalizations over the course of 10 years, found that the readmission rate of patients suffering from major pulmonary deficiencies increased dramatically in hospitals that failed to provide adequate nurse-to-patient staffing levels. Oppel and Mohr (2021) determined that the increased workload from inadequate staffing levels created high levels of nursing turnovers and an unfavorable working environment. The multilevel analysis reviewed 20,330 nurses and determined that staffing levels, work environment, and perceptions were key indicators for turnover and work-related stress (Oppel & Mohr, 2021). With numbers of workers leaving healthcare completely, the shortages in specialties like mental health, nephrology, and oncology, specialties that are stressful because of the patient population, create a new kind of crisis in the clinic (Turale & Nantsupawat, 2021). The stressors of a diminishing workforce on clinical employees outlines the importance of understanding working conditions and relationships and how these factors impact satisfaction and turnover rates.

Toxic Leadership in Healthcare

Toxic leadership leads to low satisfaction rates across the workforce, with results including increased absenteeism, decreased employee engagement, increased turnover (Behery et

al., 2018; Milosevic et al., 2019; Winn & Dykes, 2019), and an increased level of alcohol and drug use in the staff (Behery et al., 2018). In their multiple case article, Milosevic et al. (2019) looked at how the increased toxicity of leaders affect the outcomes and quality of the staff's work. Their research defined toxic leadership as unintentional behavior that seeks to maintain control, whereas they described destructive leadership as those that create both positive and negative outcomes but were premeditated in their behaviors. Finally, in their study, Milosevic et al. (2019) observed that leaders that demonstrate abusive behavior lack an awareness of the social impact. The three cases determined that toxic leaders had a direct impact on the outcomes of their support staff.

To study this question in the hospital setting, Keller et al. (2019) observed 137 elective operations in 30 operating rooms (OR) at three hospitals. They found that uncivil behavior in the OR often originated from the physician and was also focused on the support staff. The study looked at the frequency and its effect on the performance of the individual to which the conversations and outbursts were directed. The results showed that the support staff frequently perceived the quality of their work higher than the surgeon's perceptions. The results were dependent on the individual physician and the seniority of the physician. Applying the communication accommodation theory, it could be conjectured that the abusive behavior would cascade down through the levels of staff and reduce the perceived quality of the outcome. This research focused on systems networks and hospital organizations. There is no research to substantiate the impact of disruptive behavior on support staff in a private oncology practice. Would the size of the practice determine correlate with the impact on the staff or the outcomes? Would the number of physicians in the practice make a difference?

What determines whether toxic behavior will occur? Can this behavior be predicted? LaBrague et al. (2021) studied 240 nurse managers to understand their toxic leadership behavior. Unlike the physicians in the Keller et al. study (2019), the nurse managers did not perceive their behavior as an issue (LaBrague et al., 2021). As the nurse managers matured in their experience, the frequency of occurrence was reduced. The greatest indicator was the number of patients assigned to the nurse manager. In this study, it led to abusive behavior, for employees' excessive volumes of patients equate to employee burnout and turnover (2021).

Employee Burnout and Turnover

Employee satisfaction plays a crucial role in staff turnover rates. Utilizing the Maslach Burnout Inventory (MBI), Bridgeman et al. (2018) examined the factors that cause a pharmacy healthcare worker to reach a point of burnout that resulted in depression. Applying the concepts of the MBI, researchers have discovered that burnout occurs when any one of the following factors—workload, control, reward, community, fairness, or values—are mismatched, resulting in a decline in employee job performance (Bridgeman et al., 2018, Dall'Ora et al., 2020). The MBI has become the gold standard among researchers seeking to study burnout's causes and symptoms (Dall'Ora et al., 2020). Mashlach and Jackson created a scale to measure the correlation between work stress and burnout. Brady et al. (2020) utilized the MBI in a broad, multispecialty review that looked at the emotional exhaustion and depersonalization of over 6,600 U.S. physicians. Of this large group, less than 1% were oncologists. Brady et al. (2020) determined that the average physician experienced a minimum of one emotional exhaustion episode weekly. It is at this level of exhaustion when disruptive behavior is most common.

In their theoretical review, Dall'Ora et al. (2020) sought to identify research that pinpointed the factors that led nurses to burnout and leave their practice. Reviewing 91 studies,

they determined that adverse job conditions were associated with burn out and turnover. Further research is needed to determine if DPB would create an adverse job condition strong enough to result in burnout or leaving the practice. Gleason et al. (2020) sought to determine the burnout ratio among surgical residents over five years. They defined a burned out worker as someone that scored high in both depersonalization or emotional exhaustion. Their study focused on disruptive behavior, emotional intelligence, job resources, and demographics (Gleason et al., 2020). Their findings included disruptive behaviors among coworkers and healthcare professionals that contributed to increased burnout rates.

Patient Satisfaction

Value-based reimbursement models place a high emphasis on patient satisfaction rates. CMS and private insurance companies established *episode of care* that tracks patient satisfaction metrics and compensates according to the results (Johansen & Saunders, 2017). Gaining the perspective of workplace bullying through the lens of DPB could provide insight into the impact incivility in the workplace has on patient care and satisfaction. Schoville and Aebersold (2020) defined bullying as "repeated, unwanted harmful actions intended to humiliate, offend and cause distress in the recipient" (p. 16). They set out to determine the impact this type of behavior among nurses would have on patient safety, care, and satisfaction. The students in the study reported that patient care was compromised among cohorts who had been victims of workplace incivility. They also found that bullying increased costs for the organization (Schoville & Aebersold, 2020). Copanitasanou et al. (2017) performed a systematic review of 10 articles, including four cross-sectional studies, to determine the impact workplace incivility had on patient outcomes. Their review consisted of nursing workplace incivility and did not include how physician behavior affected the same patient outcomes. Copanitasanou et al. (2017) found that

workplace incivility, along with staffing shortages, resulted in poor patient outcomes. The question remains, does this translate to a compromised patient experience and low patient satisfaction scores? Disruptive behavior impacts the employee and patient experience and affects patient care costs, and has potential litigious consequences (Rosenstein et al., 2016).

Gallagher and Levinson (2013) looked at the issue of disruptive behavior from a different angle. They set out to provide guidance to those physicians that find it difficult to have civil relationships with their patients. Input came from patient complaints. Gallagher and Levinson (2013) found that the same physicians that found it difficult to have civil relationships with patients struggled to interact in a civil manner with their colleagues and their staff. The impact DPB garners on employee turnover and patient satisfaction, specifically in the oncology setting, is vital to this subspecialty's future that continues to experience shortages in physicians and clinical workers.

Summary

This literature review provided a comprehensive overview of toxic triangle theory and the role the organizational culture, toxic leader, and the follower play to create the triangle. Next, it explored the communication accommodation theory and how the influence of a leader sets the tone for the team, whether positively or negatively. It explored DPB and its impact in the healthcare environment. It looked at how changed conditions within the healthcare industry have created an atmosphere of uncertainty. Finally, in this chapter I discussed how toxic leadership, along with susceptible followers and a conducive environment creates dysfunctional interactions in the organizational setting (Padilla et al., 2007), specifically in healthcare. These disruptive healthcare teams impact the staff and the patients, but a gap exists in understanding the impact this behavior has on employee satisfaction, turnover, and patient satisfaction in the physician-

owned oncology practice. Chapter 3 will offer a detailed account of the research and design methodology for this quantitative descriptive analysis exploring the impact DPB has on employee satisfaction rates and turnover and patient satisfaction rates.

Chapter 3: Methodology

The central purpose of this quantitative secondary analysis was twofold: to examine whether the perceptions and behaviors of staff correlate with DPB, and to investigate whether the perceptions of patients regarding their care correlates with the presence of DPB. This chapter details the methodology that I utilized to examine these relationships. It consists of four sections. The first section describes the population of the study and the process of sample selection. The second section presents the instruments used in the study. The third section provides the statistical methodology that I used to link the data sets and analyze the research questions. The final section reviews the trustworthiness, reliability, assumptions, and limitations of the study.

Research Design

A quantitative research design was used for this study. I conducted a secondary data analysis of quantitative data to examine the relationship between staff satisfaction scores, staff turnover rates, and patient satisfaction scores as they relate to DPB in an oncology-hematology setting. I chose this method because it allowed for a broad range of an insight and feedback that correlates to DPB in the hematology-oncology setting. The care team plays a significant role in the patient experience, so understanding the relationships in this environment through secondary data analysis will give a broad perspective of the influence DPB has on patient and staff satisfaction.

Research Questions

RQ:1 Does the presence of disruptive physician behavior in the oncology clinical setting directly impact staff satisfaction?

RQ2: Does the presence of disruptive physician behavior in the oncology clinical setting correlate with staff job turnover?

RQ3: Does the presence of disruptive physician behavior in the oncology clinical setting correlated with patient satisfaction scores?

Population and Sample Selection

The population for this study consisted of three groups, which come from a network of 191 physician-owned oncology clinics with 678 unique physicians in the Southwestern United States. The three groups are the clinical and non-clinical staff, patients, and physicians. The first group, the nonclinical and clinical support staff at each site, consisted of registered nurses, medical assistants, radiologic technologists, clinical reviewers, patient benefit representatives, patient services representatives, and schedulers. The second group were all patients that received care in any of the facilities. The final group represented the physicians. The following section details the sampling procedure used for each group.

Sampling Procedure

Clinical and Nonclinical Staff. All clinical and nonclinical staff who completed the Employee Opinion Survey (EOS) in March 2021 were included in this study. On March 1, 2021, EOSs went to all 5,529 CSS full time and part time employees via email. Originally scheduled to be completed on March 18, 2021, the survey period was extended an extra week to compensate for participants that were unable to complete, because the deadline fell within the traditional week that schools close for spring break accounting for more than usual absences from the clinic. The survey was extended and remained open until March 23, 2021.

Inclusion criteria of all staff was the following:

1. The participant completed and submitted the survey.
2. The participant was employed, full time or part time, by CSS with an employed status as of January 1, 2021.

3. The participant was over the age of 18 years old.

Exclusion criteria of all staff was the following:

1. The participant worked in a site that had more than 20 physicians.
2. The participants was among contingent or temporary staff hired to serve as screeners during the pandemic.
3. The participant was an employee on leave of absence.

For this study, the sample size for the EOS was 5,529. Using G*Power to estimate the sample size with a moderate effect size and a power of 0.80, the minimum sample size of 500 would be needed. For this study, the sample consisted of 5,529.

Patients. All patients who had an appointment scheduled and completed the appointment at a CSS facility between January 1, 2021, and June 30, 2021, were included in this study. As part of the process to ensure patient satisfaction, all patients received a patient satisfaction survey via email or patient portal upon completion of their appointment using the Relatient Patient Survey platform.

Inclusion criteria of the patients was the following:

1. The patient was older than 18 years.
2. The patient was an active patient with an appointment with a physician.
3. The patient completed and returned the patient satisfaction survey.

Exclusion criteria of patients was the following:

1. The patient did not show up for their appointment.
2. The patient failed to provide an email address.
3. The patient chose not to participate or receive any correspondence via email or the patient portal.

There were a total of 18,000 completed patient satisfaction surveys. Using a moderate effect size and a power of 0.90, the minimum sample size needed for this study was 800.

Physicians. Physicians included in the study were classified as a partner at CSS before March 1, 2021. A partner is defined as a physician that has achieved a level where collections exceed their compensation draw for a sustained period of time. Partnership is determined by the CSS board of directors and typically occurs within 18–24 months of joining the practice. All shareholder physicians that are practicing at the site where the survey was administered during the survey period was included. Excluded from analysis were those physicians that worked at clinics that had more than 20 physicians practicing at the location or the physician was on leave or did not reach the status of partnership.

The balance of physicians that worked at CSS equaled 524. These 524 physicians work at 161 unique sites within the entire practice. Of the 161 sites used in this study, 108 of them had three physicians or less. The remaining 53 sites had more than four and less than 20 physicians at the practice location.

Materials and Instruments

This section describes the instruments that I used for each group of participants. It describes the purpose of the instrument and the items that were used in the study. All materials and instruments used were archival. Prior to obtaining the archival data, permission was granted for the study by the Institutional Review Board (IRB) at Abilene Christian University to proceed as nonhuman research (Appendix A). The dataset was collected from multiple sources. The materials and instruments belonged to four categories: clinical and nonclinical staff instruments, DPB instrument, patient instrument, and site characteristic instrument.

Clinical and Nonclinical Staff Instruments

To understand the opinions and longevity of staff employment, two datasets were used: the EOS and the Employee Turnover Report. The reports were obtained from the human resources department at CSS. This section describes each of the instruments and how I utilized the responses.

Employee Opinion Survey (EOS). The EOS was created by an internal task force at CSS. The purpose of the survey was to gather feedback from all employees regarding what they think about their experience at work, their leaders, and their workplace culture. Additionally, staff shared their perspectives and helped the organization act on things that matter most to the employees. The EOS presented results from 4,491 employees at 187 sites of service where the survey was administered during February 2021.

The survey in its entirety contains 30 core questions measuring ten dimensions: (1) collaboration, (2) compliance and ethics, (3) development, (4) empowerment, (5) engagement, (6) goals and feedback, (7) rewards and recognition, and (8) my manager/supervisor, (9) physician leadership, and (10) practice leadership. Each question response is on a scale of 1 to 6, where 1 = *strongly disagree* and 6 = *strongly agree*. For this study, I used the items in the physician leadership dimension. This dimension consists of the following prompts used to measure staff satisfaction: (a) respect—physicians are open and respectful in communication, and (b) organizational values—the behavior of our physicians is consistent with this organization's values.

Employee Turnover Report. The Employee Turnover Report was created by the human resources department of CSS. It provides a rolling 12-month report of the employee turnover ratio for each clinical site. For each site and for the sections of each site, the staff turnover rate

was calculated and provided by the human resources department at CSS. Staff turnover was calculated by the number of voluntary separations divided by the number of employees for the year and multiplying the result by 100 for each site. The Site Turnover Report provided aggregate voluntary and involuntary termination for each site within CSS reported monthly from January 2020 through November 2021 at the 81 unique locations.

Disruptive Physician Behavior Instrument

To assess DPB, the CSS leadership anonymously submitted the names of physicians that displayed a tendency to exhibit disruptive behavior in the clinical setting. These submissions were based on prior reported incidents, behavior patterns, and prior counseling patterns. The names of all physicians and their affiliated sites were de-identified by an assistant that possessed access to all rosters within the organization and once compiled, the list was given to me and was named the DPB Report. The report contained 738 physician entries from 195 unique locations. Some physicians worked at more than one location making the total number of physicians larger than the total number of unique physicians. Yes/No criteria was employed for all physicians at CSS, if the physician appeared on the DPB report, they met the criteria for DPB.

Patient Instrument

To assess perceptions of patients, I used a longitudinal survey administered across all clinics. The Patient Satisfaction Survey was obtained through the Data Analytics team at CSS. The team provided raw data for nine requested survey questions totaling 124,945 datapoints, representing answers from 180 independent CSS sites. The surveys were administered during the months of January through June 2021. An internal task force at CSS developed the survey. The survey is based on the consumer assessment of physicians and systems (CAHPS) survey developed by the CMS to provide insight into the patient experience. This survey was designed

to measure the experience of a large volume of patients in the healthcare environment (CMS, 2020). Patients that completed the survey were linked to the clinical site where they received care and to the clinical provider that administered care. CSS modified the CAHPS survey to incorporate the value-based care objectives outlined by CMS in their OCM reimbursement structure and their organizational cultural initiatives that focus on patient-centeredness and integrity.

The survey consisted of 41 items measuring seven dimensions. The dimensions were the following: our staff, overall satisfaction, Telehealth, your appointment, our communication, our facility, and your visit with the provider.

Each patient that visited the clinic and participated in an office visit with their physician or received treatment in the clinic received the survey within 48 hours of their appointment. Each question response was on a scale of 1 to 6, where 1 = *strongly disagree* and 6 is = *strongly agree*. For this study the following variables were used:

Quality. I measured quality using a single response that measured the patient's perception of the quality of care by the physician.

1. The quality of your medical care (referred to as Quality).

Communication. Communication elements consisted of three prompts that reflect the physician's ability to communicate with the patient.

1. Takes time to answer your question;
2. Willingness to listen carefully to you;
3. Amount of time spent with you.

For this study, the items in the Communication section were added together (ranging from 1 to 18) and categorized as low (a score of 1 to 6), moderate (a score of 7 to 12), and high (a score of 13 to 18) communication.

Satisfaction.

1. Satisfaction of care overall.

Facility.

1. The caring concern of our nurses/medical assistants.

Staff.

1. The friendliness and courtesy of the receptionists.

Physicians.

1. Overall rating of care from your provider.
2. Likelihood of recommending the provider to family/friends.

The items composing the physicians' scores were added together and categorized as low, moderate, and high provider ratings. The score ranged from low provider rating ranges from 1 to 4; moderate provider rating ranges from 5 to 8; and high provider rating ranges from 9 to 12.

Site Characteristic Instrument

To assess the level of DPB at each site of service, a site instrument was developed. Every site was listed with their physicians. The DPB instrument used a yes/no criteria for each provider at the site. Each site was categorized in accordance with the level of DPB. The level of DPB was represented by the percentage of physicians that displayed DPB, where 0% = none, 1%–25% = minimal, 26%–50% = moderate, and 51% and greater was rated as severe.

Data Cleaning

It was evident upon receiving all data that varying amounts of physicians and locations were represented in the different reports. I searched for commonalities in each report so that sites of services used would be consistent among all datasets. Each report was broken down by site to produce a list of sites that appeared on each report. Some locations that appeared on all reports had values missing; these sites were eliminated. Some sites were newly acquired in-market affiliates that did not have completed data; these sites were eliminated. The final count of locations that appeared on all four reports and had all datapoints populated in each category was 81.

Data Analysis

To address the research questions, this secondary analysis created one dataset with 21 dependent variables:

- *Total number of doctors*
- *Total number of disruptive doctors*
- *Number of disruptive doctors at the site*
- *Total turnover rate average*
- *Favorable communications*
- *Neutral communications*
- *Unfavorable communications*
- *Favorable behavior*
- *Neutral behavior*
- *Unfavorable behavior*
- *DPB*
- *DPB category*
- *Patient caring*
- *Patient friendliness*
- *Patient likelihood*
- *Patient our practice*
- *Patient overall*
- *Patient quality*
- *Patient time spent*
- *Patient answers questions*
- *Patient listens carefully*

The dataset consisted of variables from EOS, DPB, site-characteristics instruments, and the patient satisfaction survey.

For each data set, I computed descriptive statistics on variables used for the corresponding research questions. I summarized continuous variables using the means and standard deviations, and I summarized categorical variables using frequencies and percentages. The following presents the analysis for each research question. The level of significance was $p \leq .05$ for all statistical tests, unless otherwise stated.

Research Question 1: Assumptions for the ANOVAs

RQ1: Does the presence of disruptive physician behavior in the oncology clinical setting directly impact staff satisfaction?

To address this research question, I tested the following null and alternative hypotheses:

$$H0_{11}: \mu_{Respect\ of\ minimal\ DPB} = \mu_{Respect\ of\ moderate\ DPB} = \mu_{Respect\ of\ severe\ DPB}$$

$$H1_{11}: At\ least\ \mu Respect\ is\ different$$

$$H0_{12}: \mu_{Org\ Values\ of\ minimal\ DPB} = \mu_{Org\ Values\ of\ moderate\ DPB} = \mu_{Org\ Values\ of\ severe\ DPB}$$

$$H1_{12}: At\ least\ \mu Organizational\ Values\ is\ different$$

Chi-square tests were used to examine the proportional difference in the distribution of responses from the staff satisfaction surveys between sites with and without DPB based on respect and organizational values, respectively. I used the Bonferroni Post Hoc tests to test for significant differences in staff ratings of physicians for the categorical sites of DPB of those with none, minimal, moderate, and severe classifications of disruptive physicians.

To ensure that these data satisfied the criteria for enabling the use of parametric tests as the one-way ANOVA, I conducted Levene's tests to evaluate the equality of variances for the samples being compared. If the assumption for homogeneity of variances was violated ($p \leq .05$),

then I used nonparametric tests to determine statistically significant differences between groups on score (Nimon, 2012).

Research Question 2: Assumptions for the ANOVAs

Histograms, Q-Q plots, and box plots revealed no evidence against normality on the data sets. Many of the data points approximate a normal distribution for most of the data except for a few outliers. According to Royston (1982), Shapiro and Wilk's tests do not accurately analyze large numbers of samples (larger than 50 samples) for normality and, hence, were not used in this study. Skewness and kurtosis measures are based on sample averages and not reported here as these measures are very sensitive to outliers leading to the impact of being significantly accentuated (Kim & White, 2003). I investigated all the outliers to determine if they were valid measurements. They were found to be valid as they met the inclusion and exclusion criteria for the study and were included in the study.

RQ2: Does the presence of disruptive physician behavior in the oncology clinical setting correlate with staff job turnover? To examine the relationship of DPB with staff turnover, DPB for each site was categorized in accordance with the level of DPB represented by the percentage of physicians that display DPB, where 0% is none, 1%–25% is minimal, 26%–50% is moderate, and 51% and greater is severe. The null and alternative hypotheses that I tested were the following:

$$H0_{21}: \mu_{turnover\ of\ minimal\ DPB} = \mu_{turnover\ of\ moderate\ DPB} = \mu_{turnover\ of\ severe\ DPB}$$

$$H1_{21}: At\ least\ one\ average\ of\ turnover\ is\ different$$

ANOVA was used to assess the average differences in staff turnover between the categorized site DPB percentage.

I used chi-square tests to examine the proportional difference in the distribution of responses between DPB and respect, and organizational values, respectively. I used the Bonferroni Post Hoc tests to test for significant difference for categorical sites of DPB of those with none, minimal, moderate, and severe classifications of disruptive physicians.

To ensure that these data satisfied the criteria for enabling the use of parametric tests as the one-way ANOVA, I conducted Levene's tests to evaluate the equality of variances for samples being compared. If the assumption for homogeneity of variances was violated ($p \leq 0.05$), then nonparametric tests were used to determine statistically significant differences between groups on score (Nimon, 2012).

Research Question 3: Assumptions for the ANOVAs

Histograms, Q-Q plots, and box plots revealed no evidence against normality on the data sets. Many the data points approximate a normal distribution for most of the data except for a few outliers. According to Royston (1982), Shapiro and Wilk's test are inaccurate for analyzing large numbers of samples (larger than 50 samples) for normality and, hence, were not used in this study. Skewness and kurtosis measures are based on sample averages and not reported here as these measures are very sensitive to outliers leading to the impact of being significantly accentuated (Kim & White, 2003). All the outliers were investigated to determine if they were valid measurements. There were found to be valid as they met the inclusion and exclusion criteria for the study and were included in the study.

RQ3: Does the presence of disruptive physician behavior in the oncology clinical setting correlate with patient satisfaction scores?

To examine the differences in the presence of DPB in the site, I calculated ANOVAs. The following are the null and alternative hypotheses:

$$H0_{31}: \mu_{Quality\ of\ minimal\ DPB} = \mu_{Quality\ of\ moderate\ DPB} = \mu_{Quality\ of\ severe\ DPB}$$

$$H1_{31}: At\ least\ one\ average\ of\ Quality\ is\ different$$

$$H0_{32}: \mu_{Answers\ of\ minimal\ DPB} = \mu_{Answers\ moderate\ DPB} = \mu_{Answers\ of\ severe\ DPB}$$

$$H1_{32}: At\ least\ one\ average\ of\ Answers\ time\ is\ different$$

$$H0_{33}: \mu_{Listens\ of\ minimal\ DPB} = \mu_{Listens\ of\ moderate\ DPB} = \mu_{Listens\ of\ severe\ DPB}$$

$$H1_{33}: At\ least\ one\ average\ of\ Listens\ is\ different$$

$$H0_{34}: \mu_{Time\ of\ minimal\ DPB} = \mu_{Time\ of\ moderate\ DPB} = \mu_{Time\ of\ severe\ DPB}$$

$$H1_{34}: At\ least\ one\ average\ of\ Time\ is\ different$$

$$H0_{35}: \mu_{Our\ Practice\ of\ minimal\ DPB} = \mu_{Our\ Practice\ of\ moderate\ DPB} = \mu_{Our\ Practice\ of\ severe\ DPB}$$

$$H1_{35}: At\ least\ one\ average\ of\ Our\ Practice\ is\ different$$

$$H0_{36}: \mu_{Caring\ of\ minimal\ DPB} = \mu_{Caring\ of\ moderate\ DPB} = \mu_{Caring\ of\ severe\ DPB}$$

$$H1_{36}: At\ least\ one\ average\ of\ Caring\ is\ different$$

$$H0_{37}: \mu_{Friendliness\ of\ minimal\ DPB} = \mu_{Friendliness\ of\ moderate\ DPB} = \mu_{Friendlienss\ of\ severe\ DPB}$$

$$H1_{37}: At\ least\ one\ average\ of\ Friendliness\ is\ different$$

$$H0_{38}: \mu_{Overall\ of\ minimal\ DPB} = \mu_{Overall\ of\ moderate\ DPB} = \mu_{Overall\ of\ severe\ DPB}$$

$$H1_{38}: At\ least\ one\ average\ of\ Overall\ is\ different$$

$$H0_{39}: \mu_{Recommend\ of\ minimal\ DPB} = \mu_{Recommend\ of\ moderate\ DPB} = \mu_{Recommendof\ severe\ DPB}$$

$$H1_{39}: At\ least\ one\ average\ of\ Recommend\ is\ different$$

I utilized the site instrument to categorize the level of DPB, represented by the percentage of physicians that display DPB (*none*, *minimal*, *moderate*, or *severe*). I calculated ANOVAs to examine the quality, communication, and satisfaction for each provider according to their patient. To understand if differences exist solely with the provider or at an organizational level, I

calculated a series of ANOVAs to determine the correlation between the quality, communication, satisfaction, and categorical sites.

Chi-square tests were used to examine the proportional difference in the distribution of responses between DPB and respect, and organizational values, respectively. I also used Bonferroni Post Hoc tests to test for significant difference for categorical sites of DPB of those with *none*, *minimal*, *moderate*, and *severe* classifications of disruptive physicians.

To ensure that these data satisfied the criteria for enabling the use of parametric tests as the one-way ANOVA, I conducted Levene's tests to evaluate the equality of variances for samples being compared. If the assumption for homogeneity of variances was violated ($p \leq 0.05$), then nonparametric tests were used to determine statistically significant differences between groups on score (Nimon, 2012).

Assumptions for the ANOVAs

Histograms, Q-Q plots, and box plots revealed no evidence against normality on the data sets. Many the data points approximate a normal distribution for most of the data except for a few outliers. According to Royston (1982), Shapiro and Wilk's tests do not accurately analyze large numbers of samples (larger than 50 samples) for normality and, hence, were not used in this study. Skewness and kurtosis measures are based on sample averages and not reported here as these measures are very sensitive to outliers leading to the impact of being significantly accentuated (Kim & White, 2003). I tested all the outliers to determine if they were valid measurements. There were found to be valid as they met the inclusion and exclusion criteria for the study and were, therefore included in the study.

Ethical Considerations

The participants in the study were from my place of business. This practice is the largest

privately-owned oncology-hematology clinic in North America. More than this one practice, as the COVID-19 pandemic continues to increase demands on staff and shortages continue, the physicians benefited from understanding the impact they have on staff and patient satisfaction as a clinical leader. All staff satisfaction surveys were administered by a third-party survey organization devoid of personal identifiers. The third-party organization gathered, reported, and clustered the data into reports according to location. Provider care teams were not identified to maintain the confidentiality of the staff answering the surveys. I utilized the entire practice where I work with 11% of the practice physicians. Patient satisfaction scores were listed by location and by provider and were gathered by a third-party independent organization. Data were entered by human resources without any identifiers. All data are archival, and all identifiers were removed.

Organizational executives identified and submitted disruptive physicians to a third-party representative in the site's human resources department. My epistemological position is one of objectivity (Lincoln & Guba, 2013). The researcher must practice neutrality, tabling any bias or feelings toward any participants or outcomes (Leavy, 2017). At risk in this study were the individual physicians that work in this practice. Also at risk were the clinics that operate without the knowledge of the impact that everyone makes on the clinical environment. All physicians were de-identified and provided a randomly assigned computer code using Random Code Generator, a Mersenne Twister web-based platform. A pseudo-random alpha code was generated to protect the physician provider's identity. For the staff survey, the EOS used the Qualtrics platform, submitted to the IRB for approval, to assure staff anonymity and the right to decline participation. Ethical standards assured sufficient data collection minimized the participants' risks and identities (Zyphur & Pierides, 2017). A third-party maintained all anonymity and

ensured ethical treatment of all participants and the organization. All participants in the research signed informed consent to provide ethical treatment and behavior.

Assumptions and Limitations

Assumptions of the Study

Assumptions help to critically focus and guide the researcher in their arguments, evidence, and conclusions. In this study, all personal information shared was protected and all participants were de-identified. I did not disclose any participant responses and the third-party organization also did not disclose any responses. To complete this study, the following assumptions were made. I assumed all participants would provide honest and forthright responses, removing any bias. The use of the EOS was appropriate and participants responded to it honestly. It is assumed that patient information was a representative sample of the patients at CSS. As this was one practice located in the Southwest United States, it was assumed that similar results would follow in a practice of the same specialty in the same region of the United States. The final assumption was that all data-gathering methods and tools would be reliable and accurate and report accurate and reliable results.

Limitations of the Study

CSS is a large hematology oncology practice with a variety of clinic sizes. The clinics with more than 20 physicians have a larger opportunity to have physicians that display DPB. I eliminated these sites from the study. The number of physicians at these sites made it difficult to provide specific responses correlating to the individual, creating a potential for skewed or misrepresented results. This disqualifies data from samples that could be useful. A second limitation was the archival datasets available. CSS did not complete an EOS in 2019, so the 2020 EOS was the baseline survey. The 2019 Turnover Report was used because it was unaffected by

pandemic influences. I would have preferred to have had data from the same year. Limitations are inherent in secondary analysis. For this study, I was unable to select the original survey questions, and questions for patient satisfaction were limited in quantity.

Delimitations to the Study

This study observed the correlation of staff satisfaction, staff turnover ratio, and patient satisfaction on physician behavior in an outpatient community oncology clinic. CSS is part of a larger, nationwide network of hematology oncology clinical practices. This study was limited to the physicians within one practice located in Southwest United States. The study was limited to three calendar years, 2019, 2020, and 2021, demarcated by the pandemic. The statistical analysis methods limit the linking of physicians and sites when a clinical site has a large quantity of physicians (20 or more). I eliminated these clinical sites from the study.

Summary

The purpose of this quantitative multivariate regression analysis was to determine whether multiple variables, such as employee satisfaction scores, employee turnover rates, and patient satisfaction scores, can be used to predict the presence of DPB in a privately-owned oncology practice in the Southwestern United States. This study used quantitative methodology and a multivariate regression design to address the research questions. Three valid, reliable instruments were used to collect and analyze data. The instruments were administered in an independent online survey and conducted by an independent third-party organization. The data analysis procedure was completed by the most current version of SPSS software. I tested dependent variables for assumption violation to determine the appropriateness of the correlational data.

Existing research demonstrated the impact DPB plays in the clinical setting and often leads to compromised staff satisfaction and patient satisfaction (Bridgeman et al., 2018). However, the same research did not report the same predicted outcomes of DPB in an outpatient oncology setting. In Chapter 4, I explore the data and analyze the regression to provide results of this study.

Chapter 4: Presentation and Analysis of Data

Team dynamics are a critical component of a functional care team in the oncology setting. The leader of the care team sets the tone for the dynamics that the support staff and the patients experience. Problematic disruptive behavior, most notably in the subspecialty of oncology, leads to undue stress among staff and cultivates dissatisfaction among the support staff (Berglund et al., 2015; Klingberg et al., 2018; Wang & Sung, 2019). Adding external stressors, such as the COVID-19 pandemic and a shortage in healthcare workers that existed prior to the worldwide pandemic, exacerbates an already stressful clinical environment. This stress combined with the disruptive behavior creates difficult working conditions for the support staff (Hekel et al, 2021; U.S. Bureau of Labor Statistics, 2021) and can translate into inadequate patient care.

The purpose of the quantitative secondary analysis was to examine the nature of DPB from the clinical staff and patient's perspective. Specifically, the aims of this study were the following: (a) to assess the impact DPB had on staff satisfaction in the private oncology practice, (b) to assess the impact DPB had on staff turnover rates in the private oncology practice, and (c) to assess the impact DPB had on patient satisfaction in the private oncology practice.

The purpose of this chapter is to report the findings of the data analysis and to answer the three research questions posed for this study. It consists of five sections. The first section describes the sample of the clinical locations used in the analysis. The second section examines the impact of DPB on staff satisfaction. The third section explores the presence of DPB on staff turnover. The fourth section addresses the impact of DPB on patient satisfaction. The final section includes the conclusion and summary of the chapter.

Sample

Clinical Locations

I obtained archival data from three departments at CSS: Human Resources, Executive Leadership, and Data Analytics. There were 195 CSS clinical locations of service. One hundred fourteen clinical locations were eliminated from analysis. Forty-six were different specialties that did not include oncology or hematology. Forty-four were different cost centers located within a main practice, their results rolled into the main cancer center at the shared address. Twelve locations were administrative offices that did not have any clinical employees or care for patients. Seven locations were inactive or had recently moved to new addresses, and five were distribution centers that did not have any clinical employees or care for patients. A total of 81 clinical locations were included in the analysis.

A total of 476 physicians provided services in the 81 clinical locations. A summary of the physician characteristics is provided in Table 1. The number of physicians at each location ranged from one to 17. It is important to note that some physicians provided services at more than once clinical location. Thirteen of the 81 clinical locations shared disruptive physicians. In all but four clinical locations in which the disruptive physicians provided services, the disruptive physicians were the only physicians that displayed disruptive characteristics. The clinical location sizes ranged from one single physician at the clinical location to 10 physicians. On average, there were six (SD = 4) physicians providing services at each clinical location. Using the DPB report, each site was identified with the total number of physicians that displayed disruptive behavior. The number of physicians that displayed DPB at each clinical location ranged from 0 to 3. The average number of physicians that displayed DPB at each clinical location was 0.6 (SD = 0.7). Most sites (n = 48; 57.8%) did not have a physician classified with

DPB (Table 2). On average, in clinical locations that contained physicians that displayed disruptive behavior, the average number of physicians classified as disruptive was 13.4.

Table 1

*Clinical Location Characteristics (*n = *81)*

Characteristics	Mean *(SD)*	Min	Max
Physicians at Clinical Location	6 (4)	1.0	17.0
Disruptive Physicians at Clinical Location	0.6 (0.7)	0.0	3.0
Percent of DPB in Clinical Locations with DPB	13.4% (23.5%)	0.0%	100%
Staff Turnover at Clinical Location	2.5% (1.7%)	0.0%	7.3%

Table 2

Summarization of Disruptive Physician Behavior Classifications

DPB classification	*n* (%)
None (0%)	45 (56%)
Minimal (1%–24%)	17 (21%)
Moderate (25%–49%)	12(15%)
Severe (50%–100%)	7 (9%)

Clinical locations were categorized into four categories using the percent of DPB. Locations that did not have DPB (the *none* grouping) had as few as one physician and as many as 15 physicians. The second classification of locations, *minimal* (1%–25%), had the second largest accumulation of physicians classified as disruptive: 17 (21%). This classification had clinical locations with as few as four physicians and as large as 15. The moderate category had 12 (15%) clinical locations and severe categories possessed seven (9%) of the clinical locations. The moderate clinical locations ranged in the number of physicians number from three to 10 in each clinical location, while the severe clinical locations were smaller clinical locations with one to three physicians. There were three clinical locations that displayed 100% DPB; these were

clinical locations that had one physician in the practice. There was no clinical location with more than one physician that had 100% DPB.

Staff Satisfaction

I analyzed staff satisfaction scores using the EOS across all 81 clinical locations. The physician's ability to display aspects of leadership in their behavior was measured using two questions. Table 3 provides a summarization of the scores for each question as rated by the patients that were surveyed. The first asked staff to rate the physician's ability to communicate in an open and respectful manner. The average score was for all 81 clinical locations was 80.68 (*SD* = 13.71). The minimum score was 36 and the maximum score was 100. The second question asked staff to rate the physician's behavior consistency with organizational values. The average score for all 81 clinical locations was 81.57 (*SD* = 12.96). The minimum score was 46 and the maximum score was 100. Response rate was high at 83%. This was in part due to metrics that were set by the practice linked to performance objectives for practice leadership.

Table 3

Summary of the Descriptive Statistics for Staff Satisfaction

Staff satisfaction	*n*	*M* (*SD*)	Min	Max
Physicians are open and respectful in communication	81	80.68 (13.71)	36	100
The behavior of our physicians is consistent with this organization's values	81	81.57 (12.96)	46	100

Staff Turnover

Staff turnover was present in all but four of the clinical locations during the six-month time frame observed for this study. Staff turnover represents the percentage of employees that voluntarily or involuntarily terminate their employment during the months of June 2021 through November 2021. CSS staffing at clinical locations ranged from as few as six employees working

at a clinical location to as many as 153 employees in the 81 clinical locations sampled. The average percent of staff turnover was 2.5% (*SD* = 1.75; see Table 1.) The minimum turnover was 0.0% and the maximum was 7.3%.

Patient Satisfaction Scores

Patient satisfaction was measured using the EOS based on the Qualtrics platform for each clinical location. It consists of three dimensions: quality, communication, and satisfaction. Each question was based on a scale of 1 to 5, with 1 = *strongly disagree* and 5 = *strongly agree*. Table 4 provides a summarization of the scores for each question as rated by the patients that were surveyed. The first question asked patients to score the physician on providing quality medical care. The average score for all 81 clinical locations was 4.79 (*SD* = 0.17). The minimum clinical location score was 3.75 and the maximum score was 4.96.

Table 4

*Patient Satisfaction Scores (*n = *81)*

Patient satisfaction		*M (SD)*	Min	Max
Quality	Quality	4.79 (0.17)	3.75	4.96
Communication	Answers question	4.80 (0.17)	3.88	5.00
	Listens carefully	4.79 (0.18)	3.92	5.00
	Time spent	4.71 (0.19)	4.02	4.97
Satisfaction	Satisfaction of our site	4.70 (0.13)	4.22	4.94
	Caring	4.80 (0.12)	4.45	5.00
	Friendliness	4.71 (0.18)	3.83	5.00
	Overall rating physician	4.80 (0.17)	3.75	4.97
	Likelihood of recommending	4.83 (0.12)	4.25	4.97

The physician's ability to communicate effectively with the patient was measured using three questions. The first statement asked the patients to rate the physician's willingness to take time to answer their questions. The average score was 4.80 (*SD* = 0.17). The scores ranged from 3.88 to 5.00. Two clinical locations obtained perfect scores of 5.00. Both clinical locations were

smaller practices with two physicians each. The lowest score was also obtained by a small location with one physician.

The second question focused on communication and the physician's willingness to listen carefully to the patient. The average score for was 4.79 (*SD* = 0.18). The minimum score was 3.92 and the maximum was 5.00. The maximum was scored at only one facility with two physicians.

The final question related to physician communication focused on the time the physician spent with the patient. The average score was 4.71 (*SD* = 0.19). The minimum score for this question was 4.02 and the maximum was 4.97.

The third dimension quantified the patient's satisfaction for the entire clinical location and the care they received. This dimension consisted of five questions. The first question asked the patients how satisfied they were with the overall care they received at the clinical location. The average score was 4.70 (*SD* = 0.13). The minimum score for satisfaction of overall care was 4.22 and the maximum score was 4.94. It is important to note that the lowest performing clinical location moved to a new address in the middle of the survey period.

The next question focused on the clinical staff, specifically the caring concern of the nurses and medical assistants. These employees work directly with the physicians as part of the care team. The average score was 4.80 (*SD* = 0.12), with a minimum of 4.45 and a maximum was 5.00. There was no differentiation in clinic size as it related to score. Small and large locations scored equally high on this question.

Next, the survey asked about the friendliness and courtesy of the nonclinical staff. These staff members often set the tone for the patient experience from the time the patient walks in the door or when calling the clinic to reach a clinical employee or nonclinical employee for

assistance. The clinical locations averaged 4.71 (*SD* = 0.18) with a minimum score of 3.83 and a maximum score of 5.00.

The next question rated the overall care of the physician, and the average for all clinical locations was 4.80 (*SD* = 0.17). The lowest score was 3.75 with the highest scoring clinical location at 4.97. Most of the scores fell around the mean with the lowest score, as an outlier, occurring at one clinical location.

The final question asked the patient the likelihood at recommending the physician to a family or friend. For this question the clinical locations averaged 4.83 (*SD* = 0.12). The minimum score was 4.25 and the maximum score was 4.97.

Assessing the Impact of DPB on Staff Satisfaction

This section presents the analysis of the staff satisfaction with physicians in each of the four DPB categories. The analysis is presented to address RQ1: Does the presence of disruptive physician behavior in the oncology clinical setting directly impact staff satisfaction? Additionally, is there a statistically significant correlation between clinical locations with no DPB and those with DPB categories when considering the physicians using respectful a communication style with staff and exhibiting respectful behavior? To examine this, staff satisfaction was measured using two questions. The first asked staff to rate if the physicians were open and respectful in their communication style. The second asked if the physician's behavior is consistent with their organizational values.

DPB and Staff Satisfaction

Initially, locations with DPB were compared to locations without DPB. Table 5 provides the average score and the minimum and maximum score for clinical locations with and without DPB for each question asked of the support staff.

Table 5

Summarization of Disruptive Physicians as Reported by Support Staff

Clinical comparisons	*n*	*M (SD)*	*t* test	*p*-value
Physicians are open and respectful in communication.			6.75	< .001
With DPB	36	72.2 (15.9)		
Without DPB	45	85.16 (10.7)		
The behavior of our physicians is consistent with this organization's values.			6.42	< .001
With DPB	36	75.50 (12.0)		
Without DPB	45	85.00 (12.2)		

Each of the 81 clinical locations were classified with or without DPB. If a physician practiced at a location and was classified as disruptive, that clinical location was designated as *with DPB.* Support staff at each of the clinical locations were asked questions regarding behavior patterns of all physicians at the clinical locations at which they worked. The first question asked the staff whether the physicians open and respectful in communication? The range of values were 36 to 100. Thirty-five of the 81 clinical locations contained physicians that were classified as disruptive. The average score for these clinical locations was 72.2 (*SD* = 15.9). The minimum score at these clinical locations was 36 with the maximum score being 95. For the remaining 45 sites that did not have physicians that were classified as disruptive, staff scored these physicians at 85.16 (*SD* = 10.7). The minimum score for these clinical locations was 50 and the maximum score was 100. The results from the independent sample *t* tests (6.75) comparing the physicians with DPB to physicians without DPB were statistically significant ($p \leq .001$) confirming the alternate hypothesis.

The second question asked the staff to score the physician's behavior based on the consistency with organizational values. The range of values were 46 to 100. Thirty-six of the 81 clinical locations contained physicians that were classified as disruptive.

The average score for these clinical locations was 73.90 (*SD* = 12.4). The minimum score at these clinical locations was 54 with the maximum score being 95. For the remaining 45 sites that did not have physicians that were classified as disruptive, staff scored these physicians at 85.86 (*SD* = 12.4). The minimum score for these clinical locations was 46 and the maximum score was 100. The results from the independent sample *t* tests (6.42) comparing the physicians with DPB to physicians without DPB were statistically significant ($p \leq .001$) confirming the alternate hypothesis.

Table 6 provides the results of the ANOVA summary of RQ1, which asked if the presence of DPB in the oncology clinical setting directly impacts staff satisfaction? To answer this question, two survey questions were used.

Table 6

ANOVA for the Presence of DPB and the Impact on Staff Satisfaction

Communication	*n*	*M (SD)*	*F*	*p*-value
Physicians are open and respectful in communication.				
No DPB	45	85.16 (10.7)	6.75	< .001
Minimal DPB	17	79.12 (11.1)		
Moderate DPB	12	73.0 (25.0)		
Severe DPB	7	64.5 (13.8)		

The first question, and its results as shown in Table 6, focus on the physician's ability to remain open and respectful in communication. There was a statistically significant difference in the open and respectful communication by DPB level ($F_{3,77} = 7.126$; $p < .001$). On average, locations without DPB had a score of 85.16 (*SD* = 10.7). Locations with minimal DPB had an average of 79.12 (*SD* = 11.1). Six moderate clinical locations and six severe clinical locations reported scores of 73.0 (*SD* = 25.0) and 64.5 (*SD* = 13.8), respectively.

I conducted a Bonferroni Post Hoc analysis and found a statistically significant average difference between moderate and no DPB (p = .02) with a mean difference of 19.14. On average, no DPB had a higher score than moderate DPB. There was a statistically significant average difference between severe and no DPB (p = .002) with a mean difference of 14.64. There was no statistically significant difference between the minimal category and no DPB (p = .561) with a mean difference of 6.05. On average no DPB had the highest average of all categories and minimal had a higher average than moderate and severe.

To examine if the behavior of the physician is consistent with organizational values, I conducted ANOVA calculations. Table 7 provides additional results of the ANOVA summary of RQ1, which asked if the presence of DPB in the oncology clinical setting directly impacts staff satisfaction? The second survey question asked the staff at the clinical locations whether the behavior of the physicians is consistent with the organizational values. In addition, it asked if there is a statistically significant difference in staff satisfaction ratings between the DPB classifications of physician's behaviors and their alignment with organizational values. There was a statistically significant difference in the ratings of the staff satisfaction between the DPB classifications ($F_{3,77}$ = 7.03; p <.001).

Table 7

ANOVA for the Presence of DPB and the Impact on Staff Satisfaction

Behavior	*n*	*M (SD)*	*F*	*p*-value
The behavior of our physicians is consistent with this organization's values.			6.42	< .001
No DPB	45	85.86 (12.34)		
Minimal DPB	17	79.88(8.65)		
Moderate DPB	12	70.82 (11.21)		
Severe DPB	7	71.0(17.4)		

The 45 clinical locations without DPB had an average score of 85.86 (*SD* = 12.34). The 17 clinical locations with minimal DPB had an average score of 79.88 (*SD* = 8.65). The moderate category posted an average score of 70.82 (*SD* = 11.21) for these six clinical locations. Last, the six clinical locations that reported severe DPB had an average score of 71.0 (*SD* = 17.4).

A post hoc analysis was performed using Bonferroni adjustments to address all pairwise comparisons of the physician's consistency with values of the organization for each of the DPB categories. The comparisons between locations with *no* DPB were compared with *minimal*, *moderate*, and *severe* DPB locations. The first comparison between the clinical location without DPB and minimal DPB did not show a statistical significance. The mean difference of 6.11 was not significantly different ($p = .27$). When comparing the sites with a moderate number of physicians that display DPB in the clinic to no DPB, there was evidence that supported statistical difference ($p = .002$) in the model with a mean difference of 16.30. On average, locations with no DPB were rated higher than locations with moderate DPB. Last, the severe category was compared with no DPB and the average difference in score was 19.96. This difference was statistically significant ($p = .03$). No two categories had the same average.

Summary

The analysis results show that there was a statistically significant difference in the staff rating of physician's open and respectful communication between no DBP and the other DBP categories. The mean average was 85.08 for physicians at no DBP clinics and 67.75 at severe DPB clinics, representing a 17.73 margin in rating. In a clinical environment, where team members must trust each other, this creates a barrier that results in decreased productivity, morale, and staff satisfaction. The results suggest that staff felt similarly about the behavior of the physician when compared to the organizational values. In an organization like CSS, where the culture is established through a culture compact, these results suggest staff believe there are physicians within the organization that do not abide by its organizational values and culture.

Assessing the Impact of DPB on Staff Turnover

This section presents the analysis of the staff turnover rate with physicians in each of the four DPB categories. The analysis is presented to address RQ2: Does the presence of disruptive physician behavior in the oncology clinical setting correlate with staff job turnover? In addition, is there a statistically relationship between clinical locations with no DPB and with DPB categories and the turnover rate of their staff?

DPB and Staff Turnover

To assess the impact of DPB on staff turnover, this section provides the results of the ANOVA summary of RQ2, which asked if the presence of DPB in the oncology clinical setting correlate with staff job turnover?

The results of the ANOVA testing the impact of DPB on staff turnover is provided in Table 8. Overall, the model was statistically significant ($F = 7.44$; $p < .001$). There is a statistically significant difference in staff turnover by DPB classification.

Table 8

ANOVA for the Presence of DPB and its Impact on Staff Turnover

Staff turnover	*n*	*M (SD)*	*F*	*p*-value
Entire Model			7.44	.001
No DPB	45	2.2% (1.4%)		
Minimal DBP	17	2.4% (1.3%)		
Moderate DBP	12	2.3% (1.8%)		
Severe DBP	7	4.6% (2.2%)		

The distribution of average staff turnover per month for each of the four DPB categories was 3.1% (*SD* = 1.8%). Clinical locations with no DPB had an average staff turnover over 2.2% (*SD* = 1.4%). The minimum percentage was 0.0% terminating in the six-month period and the maximum was 7.0%. The maximum occurred at a small clinical location with 10 employees. This percentage was the result of one employee terminating during the six-month observation period.

Clinical locations categorized as minimal DPB (1%–24%) had a minimum termination percentage of 0.0% and the maximum was 5.7%. The average was 2.4% (*SD* = 1.3%). In this grouping, the clinical location that possessed the highest turnover rate was a mid-sized clinical location located in a suburb of a metropolitan city where one would think employment might be easier to find.

The moderate category of clinical locations average turnover percentage was 2.3% (*SD* = 1.8%). The minimum turnover rate was 2.3% and the maximum was 5.2%. The clinical location that recorded the highest percentage was a small clinical location with two physicians and a total of nine employees. The final category that was observed was the severe DPB category. The average turnover was 4.6 (*SD* = 2.2%) with a minimum of 0.8% and maximum of 7.0%.

A post hoc analysis was conducted using Bonferroni adjustments to assess statistical significance of the turnover rate between the DPB categories and to address the question if disruptive physician behavior in the oncology clinical setting correlates with support staff job turnover. Comparisons of turnover percentage were made using the four categories of DPB: none, minimal, moderate, and severe. Clinical locations with no DPB compared to clinical locations that had minimal DPB showed no significant difference with a mean difference of 0.16 (p = .86). Comparing clinical locations with no DPB to those with moderate DBP showed no statistically significant difference (p = .44) with an average difference of 0.89. The severe category demonstrated a statistically significant difference (p = .002) compared with no DPB, and the average staff turnover difference was 2.38. Severe DBP exhibited a statistically significant difference across all categories.

Summary

Results demonstrated that there was a difference in staff turnover for clinical locations that have no physicians that are classified as disruptive compared to clinical locations that have physicians that demonstrate disruptive behavior in severe clinical locations. Severe DPB clinics had an average monthly turnover rate of 4.6% as compared to the no DPB with 2.2%. Contributors to higher turnover rates are problematic at a time when health care staffing is in short supply and support staff are exhausted. Management-implemented morale-boosting initiatives are thwarted when physicians treat the members of the care team disrespectfully. This study showed that DPB can lead to higher percentages of voluntary and involuntary terminations.

Impact of DPB on Patient Satisfaction

This section presents the results assessing the impact of DPB on patient satisfaction, addressing the RQ3: Does the presences of disruptive physician behavior in the oncology clinical

setting correlate with the patient satisfaction rate? Additionally, is there a statistically significant correlation between clinical locations with no DPB and those with DPB categories concerning the patient's perception of their physician's quality, communication, and satisfaction of their services? To analyze this research question, the patient satisfaction ratings were compared between the DPB categories.

To assess the impact of DPB on patient satisfaction, patient satisfaction surveys were broken into three dimensions: quality, communication, and satisfaction. Each dimension consisted of a question or questions to assess patient satisfaction.

Quality

The first dimension of the patient satisfaction survey was quality, which consisted of one question to assess the level of quality. Table 9 provides the results of the ANOVA. The overall model was not statistically significant ($F_{3,77} = .20$; $p = .90$). There was no difference in the average quality of care as rated by the patients.

Table 9

ANOVA for the Presence of DPB and its Impact on Quality of Care

Quality of care	*n*	*M (SD)*	*F*	*p*-value
The quality of the medical care by your physician			.20	.90
No DPB	45	4.78 (0.20)		
Minimal DBP	17	4.79 (0.13)		
Moderate DBP	12	4.76 (0.15)		
Severe DBP	7	4.83 (0.14)		

Communication

The second dimension assessed from the patient satisfaction survey was communication. Communication consisted of three questions that focused solely on the patient's perspective of the communication skills of their physician: time to answer questions, willingness to listen

carefully, and spending adequate amount of time to listen. Table 10 provides the results of the ANOVA assessing the patient's rating of time the physician takes to answer their questions in relation to each DPB category. Overall, there was no statistically significant difference ($F_{3,77}$ = .467; p = .72).

Table 10

ANOVA for the Presence of DPB and its Impact on Communication With the Patient

Physician communication	*n*	*M (SD)*	*F*	*p*-value
The physician takes time to answer your question.			.47	.72
No DPB	45	4.80 (0.16)		
Minimal DBP	17	4.83 (0.67)		
Moderate DBP	12	4.77 (0.18)		
Severe DBP	7	4.74 (0.42)		

Table 11 provides the results of the ANOVA assessing the patient's rating of the physician's willingness to carefully listen between each DPB category. Overall, there was no statistically significant difference ($F_{3,77}$ = .37; p = .78).

Table 11

ANOVA for the Presence of DPB and its Impact on Quality of Care: Carefully Listens

Physician listens	*n*	*M (SD)*	*F*	*p*-value
The physician demonstrates the willingness to carefully listen to you.			.37	.78
No DPB	45	4.80 (0.21)		
Minimal DBP	27	4.82 (0.07)		
Moderate DBP	12	4.80 (0.17)		
Severe DBP	7	4.74 (0.38)		

Table 12 provides the results of the ANOVA assessing the patient's rating of the physician's willingness to carefully listen between each DPB category. Overall, there was no statistically significant difference ($F_{3,77}$ = .17; p = .92).

Table 12

ANOVA for the Presence of DPB and its Impact on Quality of Care: Amount of Time

Physician spends time	*n*	*M (SD)*	*F*	*p*-value
The physician spends an adequate amount of time with you.			.17	.92
No DPB	45	4.80 (0.21)		
Minimal DBP	17	4.73 (0.09)		
Moderate DBP	12	4.69 (0.22)		
Severe DBP	7	4.72 (0.17)		

Satisfaction

Satisfaction was the final dimension assessed by the patient satisfaction survey. This dimension asked patients to rate the physicians, the clinical staff, and the nonclinical staff. Satisfaction was measured through five questions that included the following: care overall, caring concern of nurses, friendliness of receptionists, overall rating of physician, and the likelihood of recommending their physician to a family member or friend.

Table 13 provides the results of the ANOVA for the presence of DPB and its impact satisfaction of the patient's overall experience in the clinical location. Overall, there was no statistically significant difference ($F_{3,77} = .22$; $p = .88$).

Table 13

ANOVA for the Presence of DPB and its Impact on Satisfaction: Care You Received

Overall care	*n*	*M (SD)*	*F*	*p*-value
You were satisfied with the care you received overall.			.22	.88
No DPB	45	4.73 (0.14)		
Moderate DBP	12	4.70 (0.19)		
Severe DBP	7	4.73(0.08)		

Table 14 provides the results when patients were asked to rate the nurses and medical assistants and their caring concern. Overall, there was no statistical significance ($F_{3,77} = .33$; $p = .80$). On average there was no difference from the patient's perspective in the care they received from the nurses and medical assistants.

Table 14

ANOVA for the Presence of DPB and its Impact on Satisfaction: Caring Concern of Nurses

Nursing care	*n*	*M (SD)*	*F*	*p*-value
You were satisfied with the caring concern of your nurses and medical assistants.			.33	.80
No DPB	45	4.80 (0.12)		
Minimal DBP	17	4.81 (0.09)		
Moderate DBP	12	4.76 (0.15)		
Severe DBP	7	4.84 (0.06)		

Table 15 provides the results when patients asked to rate the friendliness of the receptionists at the cancer center. Overall, there was no statistical significance ($F_{3,77} = 1.12$; $p = .35$). On average, patients did not perceive a difference in the friendliness of the receptionists between the DPB classifications.

Table 15

ANOVA for the Presence of DPB and its Impact on Satisfaction: Friendliness of the Receptionist

Friendliness of staff	*n*	*M (SD)*	*F*	*p*-value
You were satisfied with the friendliness and courtesy of the receptionist.			1.12	.35
No DPB	45	4.71 (0.21)		
Moderate DBP	12	4.73 (0.17)		
Severe DBP	7	4.84 (0.06)		

Table 16 provides the results when patients were asked to rate the overall care of their physician. Overall, there was no statistically significant difference ($F_{3,77} = .52$, $p = .67$). On average, patients did not perceive a difference in care between the DBP classification.

Table 16

ANOVA for the Presence of DPB and its Impact on Satisfaction: Overall Care From the Physician

Physician care	*n*	*M (SD)*	*F*	*p*-value
You were satisfied with the overall care from your physician			.52	.67
No DPB	45	4.78 (0.21)		
Minimal DBP	17	4.82 (0.07)		
Moderate DBP	12	4.78 (0.18)		
Severe DBP	7	4.84 (0.13)		

Table 17 provides the results when patients were asked to rate the likelihood of recommending their physician to family members or friends. Overall, there was no statistical significance ($F_{3,77} = .18$, $p = .91$). Regardless of where patients received care, they were equally likely to recommend the physician to family members or friends.

Table 17

ANOVA for the Presence of DPB and its Impact on Satisfaction: Likelihood of Recommending the Physician

Recommend to friends	*n*	*M (SD)*	*F*	*p*-value
What is the likelihood of recommending your physician to your family or friends.			.18	.91
No DPB	45	4.82 (0.14)		
Minimal DBP	17	4.85 (0.07)		
Moderate DBP	12	4.82 (0.14)		
Severe DBP	7	4.84 (0.17)		

Summary

The results of the analysis suggest there is no difference in the patient satisfaction scores when comparing clinical locations with no DPB and the other DPB classifications. Oncology patients are among the most vulnerable patients because of their diagnosis. They are dependent on their physician and the entire care team. The findings suggest either the patient's dependency overshadows their willingness to score their physicians low or the physician and their care team can put their own discord aside for the good of their patients. Close margins in each category of questions imply that the teams in this sample were working toward making the patient experience positive independent of any conflict that may or may not be happening within the dynamics of the team.

Conclusion

Given the nature of DPB and its impact on the quality the care of the patients, the results of the first two research questions provide support that DPB impacts staff who directly work for the physicians in terms of job satisfaction and job rate turnover. There is insufficient evidence to support that DPB impacts patient satisfaction for the patients seeking treatment in a private hematology oncology practice.

Chapter 5 will provide discussion of the findings, draw conclusions from the research, and recommend future research in this subject matter.

Chapter 5: Discussion

Healthcare has shifted from fee-for-service to a value-based model. This change requires alternate workflow processes and adherence to predetermined guidelines established by governing authorities. Add to these changes the global healthcare staffing shortage, and what remains is an environment rich with conflict. One way some physicians choose to cope with these stressors is to display behavior classified as disruptive in the clinic. The purpose of this study was to determine the relationship that this disruptive behavior had on staff satisfaction, staff turnover rates, and patient satisfaction. Results found that DPB had a statistically significant impact on staff satisfaction rates and staff turnover rates. However, the results did not reveal the same impact on patient satisfaction rates. This chapter discusses the summary of the results, the findings from a past and current research perspective, interprets the results from a staff satisfaction, staff job turnover rate, and patient satisfaction overview. It considers the implication of leadership, explore the limitations and delimitations, and make suggestions for future research.

Summary of Results

What follows is a summary of the results from the analysis I performed in this study. If the primary purpose of this study was to examine the relationship of the presence of DPM in the oncology clinical setting had on staff satisfaction, then the following can be stated:

1. In general, there was a significant relationship between DPB and staff satisfaction, for both ratings of respectful and open communication and consistency with organizational values. Staff at locations without DPB were more satisfied than staff at locations with DPB.

2. Further examination of the relationship between DPB and the staff ratings of physicians being open and respectful suggested that as DPB increased, the staff satisfaction decreased. There was no significant difference between moderate and severe levels of DPB.
3. On average, there were significant differences between locations without the presence of DPB and locations with moderate and severe DPB in staff ratings of the physician's consistency of organizational values. There was no difference between minimal DPB and no DPB.

If the primary purpose of this study was to examine the relationship of the presence of DPM in the oncology clinical setting had on the staff turnover rate, then the following can be stated:

1. There is a significant relationship between staff turnover rate and presence of DPB. On average, locations with DPB had higher staff turnover rates.
2. The overall results of the levels of DPB affecting staff turnover suggested there was a significant difference, but the moderate level scored significantly higher than the other DPB groupings. However, the moderate level had one location with nine staff and 7% attrition. When this location was removed, there was no statistical significance between DPB groupings.

If the primary purpose of this study was to examine the relationship of the presence of DPB in the oncology clinical setting had on patient satisfaction; then the following can be stated:

1. Overall, there were no differences in the patients' perception of care received.
2. There was no significant difference in the quality of care between locations with DPB and without DPB.

3. There was no significant difference in the physicians' communication with the patient.
4. There was no significant difference in the patients' perception of the physician's willingness to carefully listen to them.
5. There was no significant difference in the patients' perception of the time the physician spent with them.
6. There was no significant difference in the satisfaction with the care received overall by the patient.
7. There was no significant difference in the level of satisfaction with the caring concern of the nurses and medical assistants by the patients.
8. There was no significant difference in the friendliness and courtesy of the receptionist.
9. There was no significant difference in the overall satisfaction of care from the physician.
10. There was no significant difference in the likelihood of recommending the physician.

Discussion of Findings

The communication accommodation theory states that subordinates adjust to accommodate the leader's perspective (Giles et al., 1973; Muir et al., 2016); the findings in this research were inconclusive and require further examination. According to this theory, the subordinates adjust their communication style to accommodate to the physician leader (accounting for dissatisfaction) but potentially tolerate this behavior and would not voluntarily score the physician lower, which could account for the tight range of scores in the patient satisfaction scores (Muir et al., 2016). Research that investigates whether DPB physicians utilize

linguistic accommodation would confirm these findings. The lower staff satisfaction scores among the DPB clinics confirmed Muir et al. (2016), who stated that subordinates find themselves adjusting to the person in the level of authority leading to dissatisfaction in their role.

The analysis of staff satisfaction revealed that as DPB increased in the clinic, the staff satisfaction rate decreased. This is problematic in clinics that have a small number of physicians. Through analysis, this study showed that the severe category had statistically significant differences from clinics without DPB in staff satisfaction and in job turnover rates. Once the proportion of disruptive physicians reach 50%, results seemed to indicate that the environment lacked stability and was conducive to toxicity.

The toxic triangle theory posits three equal sides that create dysfunction within a team: the toxic leader, susceptible follower, and the conducive environment (Padilla et al., 2007). The DPB Report, which stated that 42.2% of the physicians in this study were classified as disruptive, confirmed the existence of toxic leaders within the organization. The study results revealed that the DPB physician's communication style was disrespectful as rated on the survey. This aligned with Padilla et al.'s (2007) characteristics of a destructive leader. Similarly, the DPB physicians displayed behavior that did not align with the cultural values of the organization. This confirms the defining characteristic of the conducive environment in the toxic triangle, which states there is a perceived threat to the cultural values (Padilla et al., 2007). The quantitative results of this study found a statistically significant difference in the job satisfaction rating of employees at locations with DPB opposed to no DPB and confirmed previous research (Paltu & Brouwers, 2020). The third side of the triangle, the susceptible follower, is inconclusive and requires additional investigation into the feelings and opinions of support staff.

Despite the consequences, DPB exists. LaBrague et al. (2021) examined disruptive behavior through the lens of health care leaders in the hospital setting and relied on self-reporting for the toxic behavior. The LeBrague et al. study had a lower incidence of toxic leadership at 3%. The current study relied on organizational leadership to identify toxic leadership resulting in a higher percentage (42.2%) of toxic leaders generated on the DPB Report. Self-reporting is listed as a limitation in the LaBrague et al. study (2021). Patient satisfaction scores are listed as a limitation in this study's research. LaBrague et al. results are inconclusive and require further investigation. Therefore, choosing a different method for selecting the sample for this study was successful in securing results that were conclusive and yielded outcomes that provide significant results. Choosing the right method of sample gathering is paramount in securing adequate results.

Interpretation of the Results

This research found that DPB influenced both staff satisfaction ratings and staff turnover. This was consistent with previous research that presented results in both staff satisfaction or outcomes and turnover rate or intention (Keller et al., 2020; Labrague, 2021).

Staff Satisfaction

This research found that DPB influenced both staff satisfaction ratings and staff turnover. Previous research found similar large gaps between transformational leaders and toxic leaders (Labrague et al., 2021), and surgeons in the operating room (OR) who made disruptive outbursts and those that did not make any disruptive outbursts (Keller et al., 2020). Previously, Keller et al. (2020) found that these disruptive outbursts were limited to inside the OR and only considered the impact on the surgical team. Keller et al. (2020) determined the staff that endured such

outbursts believed their work was inferior, resulting in lower morale and less perceived value in their work performance.

When an oncology patient goes to each appointment, their emotions can be volatile from day to day. Each day can be good news or bad news. Every person they meet in the clinic can influence their experience in a positive or negative way. Physicians interact with the entire team. The entire team is an extension of that physician to the patient. To understand the impact across the entire hematology oncology clinic, it was important to incorporate the entire care team, therefore the results found in this study were from a systems approach and considered all support staff's input. Focusing on one area may provide different results.

Turnover Rate

Keller et al. (2020) and LaBrague et al. (2021) made the connection between staff satisfaction, poor staff outcomes, and higher staff turnover rates. They found that toxic staff who worked with toxic leaders had higher intent to leave the organization and had higher turnover rates. Consistent with Keller et al. (2020) and LaBrague et al. (2021), the results of this study suggest that DPB affected staff turnover rates when DPB was present in 50% or more of the physicians practicing in the clinical location. Clinical locations with fewer physicians are susceptible to a toxic environment because of the small number of staff in the workplace.

Consequently, a higher turnover rate is problematic during this unprecedented time of healthcare staffing shortages (Buerhaus, 2021). Specialties, such as oncology, have historically been considered to experience higher levels of stress because of the nature of the specialty. In addition, a global shortage of employees and a global pandemic create a delicate balance where any additional stressor can be the tipping point for a registered nurse to leave the specialty or

worse, leave the profession (Buerhause, 2021; Challinor et al., 2020; Turale & Nantsupawat, 2021).

DPB and Patients

Finally, an important issue this research addressed was the correlation between DPB and patient satisfaction scores. Patient satisfaction has become an important metric tracked by all physicians because most payors are shifting from fee-for-service to value-based-care models of payment (CMS, 2020). In this study, there were no trends suggesting patient satisfaction scores were impacted by DPB. This is consistent with Marcotte et al. (2021), who suggested that implicit bias plays a key role when patients rate their physicians. It may come from the patient's belief that the physician still has control over their health and well-being and finds it difficult to give a low rating of their provider. The subjects in this study were all held to the inclusion and exclusion criteria and no bias was found. In this study, the margins were tight (the largest was 0.16), indicating patients did not perceive a difference in their communication, quality of care, or the level of satisfaction, regardless of DPB category. However, this was inconsistent with Gallagher and Levinson (2013), who studied physicians that had uncivil relationships with their patients.

Implications for Leadership

Through the past century, the term leadership has continued to evolve to fit a wide scope of behaviors and styles. Whicker (1996) was among the first to research the negative aspects of leadership and used the term toxic to describe this behavior. Padilla et al. (2007) developed the toxic triangle theory building on Whicker's research by visualizing an equilateral triangle made of leader, follower, and environment. All three contribute to the toxic culture of an organization. The increase in the number of physicians that display behavior characterized as disruptive

increases the dissatisfaction among employees. When more than one disruptive physician provides services within the same clinic, the frequency of staff turnover increases. There is now evidence of the toxic triangle beginning to form as the toxic leader, along with the follower, begin to coexist in the environment that begins to thrive in dysfunction and, at times, chaos. Eliminating one side of the triangle would collapse the triangle and create a more productive, healthy environment (Padilla et al. 2007). Focusing on the leadership side of the toxic triangle, the physicians classified as disruptive might consider leadership training. Creating a leadership culture for physicians and staff provide strong vision and missional foundations that establish accountability throughout the organization (Mungarary & Curtin, 2019; Painter, 2019). Leadership training may be an option for an organization that could expose the consequences of the behavior and potentially reverse the trend of DPB and its effect on staff satisfaction scores and turnover rates.

A second side of the toxic triangle is an environment conducive to toxic behavior (Padilla et al., 2007). Results from this study confirmed the cultures in the clinical locations were conducive to toxic behavior as demonstrated through the lower average staff satisfaction scores and the higher turnover rate in the clinics with DPB. A refresh of the organizational culture through the mission and values would benefit all clinical locations and could bring about an awareness of the values that the organization considers important. Focus groups, task force groups, and leadership training can be used to help align and define cultural norms and accountability to address disruptive behavior. Van Rooij and Fine (2018) suggest the implementation of a cultural committee in large organizations to address toxic elements in the workplace. Evidenced through the results of the analysis, a refresh of the culture committee with strong governance capabilities would be useful.

Physician communication plays a key role in the relationships of the staff and the patients. This study confirmed Yusuf et al. (2018), who stated that by engaging with staff, physicians raise the level of morale and staff engagement. Physicians may be unaware of their role as a leader and do not realize the level of influence they have on staff morale and engagement. In locations that do not have the organizational structure of operational leadership, physicians are often placed in the role of leader through their position of power (Giles et al., 1973). Most physicians find themselves in the position of authority as the leader of the care team. They are the common denominator that interacts with each member of the entire staff. This authority and connection give them a unique opportunity to influence the culture.

Limitations

The direct impact of DPB on staff and patient satisfaction was not measured. In this study, I investigated whether DPB had an impact on staff satisfaction rates, job turnover rates, and patient satisfaction rates, but I did not measure the result of the impact.

This study was limited to one organization with multiple locations. All the data collected reflected the information and results were assessed from one practice, albeit a large practice with more than 100 locations. The results reflect the culture of one organization. Gathering data from multiple organizations may provide different insight when comparing different organizational cultures. The results for this study reflect the organizational culture of a privately held, physician-owned, hematology oncology community practice located in the Southwest United States.

The global pandemic (COVID-19) may have influenced survey results. The pandemic created new situations that will need to be studied. All data were collected during the same period to create baseline levels and consistent conditions. This was my attempt to create a

consistent environment for all clinical locations that were considered in inclusion and exclusion criteria.

The identification of physicians that displayed disruptive behavior was limited to the input of experienced leadership of CSS. A better means to quantify DPB may have yielded more physicians considered disruptive, which could alter the results. A more sophisticated tool to identify DPB could be developed and used for future research to better quantify physicians that display disruptive behavior.

It is important to note that any clinical location falling within the 100% category because it had 1 physician was only counted once despite the number of locations. If 1 physician practiced independently at multiple locations, all locations were eliminated from the study.

Delimitations

The original study was to include patient satisfaction survey ratings from before the pandemic struck in March 2020, but a different survey was used that did not capture adequate data, so the decision was made to use data from a six-month period of time when patient volumes were restored to prepandemic volumes.

During the observation period, CSS had a large subspecialty join their practice that added additional physicians, staff surveys, and patient surveys. The information from this practice was excluded and not used in the analysis.

Recommendations for Future Research

A qualitative study with a small sample size may reveal more understanding of the relationship dynamics between the physician and the support staff. Specifically, phenomenological research that studied identified DPB practices that caused high turnover rates

and low staff satisfaction to identify the role played by the physician as care team leader would reveal deeper understanding of the significance of DPB in different types of clinical practices.

A duplicate study to confirm the results of this study in other physician subspecialties would be useful for future research. It would be useful to choose subspecialties that are typically considered high stress, such as a surgical practice, as well as a subspecialty where the patient may provide the stress, such as pediatrics. Continued quantitative research across different disciplines in healthcare that investigates multiple practices would allow for greater understanding of the depth of the impact of DPB. This would reveal if the problem of DPB exists based on organizational culture, subspecialty, or if it is a systemic problem that reaches broadly across all specialties in healthcare.

Healthcare would benefit from the continuation of this research through a quantitative study that analyzes the results of DPB in the outpatient clinical environment. How does DPB affect the goals of the organization at the micro- and macro-levels through systemic and individual outcomes?

An interventional study that attempts to identify disruptive physicians and attempts to provide leadership training that educates them on the results of disruptive behavior and trains the physicians to help them change their behavior would be useful in advancing physician leadership. The results could be used to incorporate into a medical school curriculum to help educate new physicians.

Finally, a study that would focus solely on the individual physician, rather than the practice would be beneficial. This could be a quantitative or qualitative study that would track the impact the individual physician has on support staff satisfaction and turnover ratio, unrelated to the other physicians within the same practice. Tracking the physician’s individual impact and

comparing through statistical analysis would provide insight to the level of influence DPB provides in the inverted disruptive triangle.

Conclusion

In conclusion, this research found that there was a statistically significant relationship between DPB and staff satisfaction rates and staff turnover rates. There was not a statistically significant relationship between DPB and patient satisfaction rates. I measured staff satisfaction rate variables (communication and behavior) with chi-square tests and were found to be consistent with previous studies that also found significant gaps in satisfaction rates (Challinor et al, 2020; Keller et al., 2020; Labrague et al., 2021). Staff turnover rate variables (favorable, neutral, and unfavorable communications; favorable, neutral, and unfavorable behavior) were measured with chi-square tests and were consistent with previous studies that also found significant turnover rates (Buerhaus, 2021; Challinor et al., 2020; Turale & Nantsupawat, 2021). I also measured patient satisfaction rate variables (caring, friendliness, likelihood, our practice, overall, quality, time spent, answers questions, and listens carefully) with chi-square tests and these were found to be not consistent with previous studies that found significant gaps in satisfaction rates (Gallagher & Levinson, 2013). In addition, I made recommendations to continue this important research in this field.

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Appendix A: IRB Approval Letter

ABILENE CHRISTIAN UNIVERSITY
Educating Students for Christian Service and Leadership Throughout the World

Office of Research and Sponsored Programs
320 Hardin Administration Building, ACU Box 29103, Abilene, Texas 79699-9103
325-674-2885

October 26, 2021

Mike Marino
Department of Graduate and Professional Studies
Abilene Christian University

Dear Mike,

On behalf of the Institutional Review Board, I am pleased to inform you that your project titled "The Impact of Disruptive Physician Behavior on Support Staff Satisfaction Rates, Site Turnover Ratios and Patient Satisfaction Rates",

(IRB# 21-145)is exempt from review under Federal Policy for the Protection of Human Subjects as:

☐ Non-research, and
☑ Non-human research

Based on:
The research does not involve obtaining information about living individuals [45 CFR 46.102(f)]

If at any time the details of this project change, please resubmit to the IRB so the committee can determine whether or not the exempt status is still applicable.

I wish you well with your work.

Sincerely,

Megan Roth

Megan Roth, Ph.D.
Director of Research and Sponsored Programs

Appendix B: Padilla Approval Letter

Art Padilla [redacted] Jan 10, 2022, 7:40 PM

to me

Yes, of course, and thank you for your courtesy in asking.
Good luck with your interesting work!
AP

Sent from my iPhone

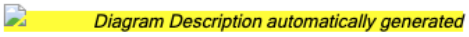
On Jan 10, 2022, at 6:38 PM, Mike Marino [redacted]

Dr. Padilla:

It is indeed an honor to reach out to you. My name is Mike Marino. I am pursuing my doctoral degree in Organizational Leadership at Abilene Christian University. My research of interest is The Correlation of Disruptive Physician Behavior on Support Staff Satisfaction and Turnover Rates and Patient Satisfaction. In my dissertation I would like to use your illustration of the Toxic Triangle. Below is an excerpt from Chapter 1 where I discuss the Toxic Triangle and its role in the healthcare clinical environment. The image did not copy, but the image is displayed about the citation. Do I have your permission to use this image in my dissertation?

Termed the toxic triangle, groups displayed negative outcomes when a combination of three factors were present, destructive leaders, susceptible followers, and a conducive environment (Padilla et al..2007). Each side of the triad possessed characteristics that defined the factors as shown in Figure 1. These three factors exist in congruency to form a dysfunctional group often incapable of creating desired outcomes. Healthcare requires continuity of care and cooperation from all three factors to establish trust and confidence in the healthcare provider.

The Toxic Triangle



Note: "The Toxic Triangle: Destructive Leaders, Susceptible followers, and Conducive Environments," by A. Padilla, R. Hogan, and R. B. Kaiser, 2007, Leadership Quarterly, 18(3), p. 176-194. Copyright 2007 by Elsevier.

Conflict Style in Healthcare

Toxic Leadership in Healthcare

Thank you for your consideration,

Mike Marino

Appendix C: CMS Approval Letter

[redacted] - Permission to use graphic External Permissions for Dissertation/Approved Permissions ×

CMS Services <[redacted]> Jan 13, 2022, 9:46 AM

to me

Good morning Mr. Marino,

Thank you for contacting the Centers for Medicare and Medicaid Services' (CMS) Oncology Care Model (OCM) Support Team.

Thank you for your interest in the Oncology Care Model (OCM).

The OCM Quality Reporting Measure Specifications are available on the Innovation Center website [redacted] under the "Data Reporting" section.

Please see the attached document with the updated quality measures list, available on the public domain.

Additional information for the public on the OCM program and its requirements is available on the CMS Innovation Center website at [redacted] under the Additional Information section.

Case number [redacted]s been resolved.

To help expedite future inquiries, please provide your OCM ID number in the Subject line.

We are available Monday through Friday from 8:30 a.m. to 7:30 p.m. EST, except federal holidays.

If there are remaining questions or concerns, please contact OCM Support at [redacted] option 2 or by emailing [redacted]

Sincerely,

CMS OCM Support Team

E-mail: [redacted]

We take great care in protecting Protected Health Information (PHI) and Personally Identifiable Information (PII). Please DO NOT email any confidential data (e.g., Taxpayer Identification Numbers (TINs), patient names, Health Insurance Claim Numbers (HICNs), Social Security Numbers (SSNs), etc.) to CMS.

[redacted]

Reply Forward