

Review Article

Disruptive Behavior In Health Care Setting- Reasons, Implications And Remedial Measures

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Abstract

Introduction: Disruptive behavior of health care providers is common in most health care settings. It is more commonly observed among junior doctors. Common forms of disruptive behaviour are using abusive language, yelling at patients and colleagues, indisciplined behavior and at times physical abuse. The present study was carried out to review the literature on disruptive behaviour among health care providers in regards to its nature, incidence, possible reasons, implications and the remedial measures.

Methods: An electronic search of 32 published articles in the Medline, Pubmed and Psych Info databases was carried out covering a period from 1992 to 2009 using the keywords disruptive behavior among physicians, surgeons, health care provider, nurses, horizontal violence in combination to its incidence, implications and remedial measures.

Results: Disruptive behaviors were a common occurrence in the perioperative and emergency care units. These types of behaviors were most prevalent in junior physicians, surgeons and nurses. Disruptive behaviors increased levels of stress and frustration, which impaired concentration, impeded communication flow, and adversely affected staff relationships and team collaboration. These events were considered to increase the likelihood of medical errors and adverse events and to compromise patient safety and quality of care.

Conclusions: Disruptive behavior has significant effect on patient care. Organizations need to recognize the prevalence and significance of disruptive behaviors and develop policies to address the issue. Key areas of focus include recognition and awareness, organizational commitment, implementation of appropriate codes of behavior policies and procedures, and provision of education and training programs to discuss the issue among health care providers.

Keywords: Disruptive behavior among health professionals, Patient safety, Medical errors, Nurse retention programme, Quality of health care, Horizontal violence

1. Introduction

Disruptive behavior of health care providers is common in most health care settings. It is more commonly observed among junior doctors.¹ Common forms of disruptive behavior include using abusive language, yelling at patients and colleagues, not performing duties as per norms, attending patients under influence of alcohol, indisciplined behavior and at times physical and sexual abuse.^{2,3} It is an important cause of disharmony and work place related stress. Many doctors and

nurses think of leaving the job or request for change of workplace. Disruptive behavior also has negative influence on quality of health care and patients satisfaction about the health services.⁴ The problem of disruptive behavior is mainly seen among junior doctors working at places providing emergency care like casualty, intensive care unit, operation theatre and labour room complex.^{5,6} The causes of disruptive behavior are related to work related stress, personal factors, personality related issues, long working hours, inadequate rest and addictions. The present study was carried out to review the literature on disruptive behaviour among health care providers in regards to its nature, incidence, possible reasons, implications and the remedial measures.

2. Method of the Review

An electronic search of 32 published articles in the Medline, Pubmed and Psych Info databases was carried out, covering a period from 1992 to 2009; using the keywords disruptive behavior among physicians, surgeons, health care provider, nurses in combination to its incidence, implications and remedial measures. Additional searches were conducted using references cited in the published literature on the subject. Disruptive behavior was considered when the inappropriate behavior of health care provider resulted in increase in the risk of medical errors, impaired staff retention, disrupted the smooth working of the hospital and resulted in confrontation or conflict, ranging from verbal abuse to physical and sexual harassment.⁴

3. Results of the Review

Many research workers have studied different aspects of disruptive behavior among health care providers. Different studies have highlighted the findings related to the nature and incidence of disruptive behaviors, the possible reasons, its negative influence on quality of health care in regards to rise in medical errors, disturbed team dynamics, poor patient outcome and rise in patient and relatives dis-satisfaction. The literature in regards to remedial measures undertaken by various health institutional authorities was also reviewed.

3.1 Nature and incidence of disruptive behaviour

Disruptive behavior is not unique to physicians. The survey results of Rosenstein AH revealed a high prevalence of disruptive behavior among nurses as well as physicians. And disruptive behavior affected not only nurse-physician relationships but also relationships between physicians and between nurses. Of particular significance are the findings that nearly half of the physicians witnessed disruptive behavior in other physicians and nearly three-quarters of the nurses witnessed disruptive behavior in other nurses. This suggests a serious problem within and across disciplines.⁷

Disruptive behaviors are either readily recognizable by colleagues, team members or administrative officers or at times they are less severe in nature. Common forms of disruptive behavior include use of loud and foul language, rude and demeaning attitude, use of abusive and threatening words, reporting to duty under the influence of alcohol. Other forms of disruptive behavior include poor performance at duty, indis disciplined behavior, not following safety norms, ignoring norms of infection control policy, administration of medicines without prescription on the case sheet, gender bias and sexual harassment.³

The disruptive behavior may be expressed in the form of anger. It is reflected through yelling, cursing, throwing things, slamming doors, rolling of eyes, failure to respond to phone calls, delay in reporting when called to see patients, inappropriate documentation in case sheets, blaming others for bad outcome, unnecessary sarcasm and criticism and erratic work habits (absentism on flimsy grounds, late reporting, inability to finish work, writing notes a day prior)¹ Some physicians feel that they are above the rules, behavioural standards and social etiquette to which others are held. Some physicians are allowed to act in disruptive manner, just because of their high reputation and money making capacity.⁸ It is reported that the age group of the physicians have the influence on their behaviour. Younger generations in their 20s and 40s were observed to have disruptive behavior more often than their elder counterparts.^{5,6}

Rosenstein AH, O'Daniel M in their extensive study titled "Disruptive behaviors and clinical outcomes: Perceptions of nurses and physicians" expressed the quantitative data presented as numbers and percentages based on the number of respondents who provided an answer to each questions on the occurrence of disruptive behavior among nurses and physicians. Of the 965 respondents to the question Have you ever witnessed disruptive behavior from a physician at your hospital? nearly three-quarters said yes. Of the 675 nurses who responded to the question, 86% said they had witnessed it, and of the 249 physicians who answered the question, almost half said they had witnessed it in their peers. Of the 960

respondents who answered the question Have you ever witnessed disruptive behavior from a nurse at your hospital? 68% (653) said yes. Notably, of the 664 nurses who answered this question, 72% (481) reported having seen other nurses' disruptive behavior, while 47% (116) of the 245 physicians who answered this question said they had. When asked What percentage of physicians would you say exhibit disruptive behavior at your hospital? more than half of the 1,452 who responded thought that the percentage of physicians who exhibit such behavior was in the 1%-to-3% range. And 60% of the 1,447 respondents to What percentage of nurses would you say exhibit disruptive behavior at your hospital? thought the percentage was in that range.⁷

In order to assess providers' perceptions of the influence of gender on disruptive behavior, respondents were asked Do you think that gender influences the tendency to exhibit disruptive behavior? as well as Which gender do you think has a greater tendency to exhibit disruptive behavior? Of the 950 respondents who answered the question about whether male or female physicians had a greater tendency to exhibit disruptive behavior, 57% (543) reported a greater tendency in male physicians, 2% (17) reported a greater tendency in female physicians, and 41% (390) said gender makes no difference. Asked the same question with respect to nurses, 40% (372) of the 935 respondents reported a greater tendency in female nurses, 7% (63) a greater tendency in male nurses, and 53% (500) said gender makes no difference. Nearly half of the respondents thought that gender played a role in disruptive behavior, and slightly more than half thought it didn't. A majority (57%) of respondents thought that male physicians had a greater tendency to exhibit disruptive behavior, and 40% thought female nurses also had this tendency.⁷

Longo J and Sharman RO in their article titled "Levelling horizontal violence"- defined horizontal violence as an act of aggression that is perpetrated by one colleague towards another colleague. It is usually a verbal or emotional in nature, but at times it can turn into physical abuse. Horizontal violence may be in the form of talking bad behind ones back, belittling or criticizing a colleague in front of others, blocking information or chance of promotion, and isolating or freezing a colleague out of group activities. Repeated acts of horizontal violence against another are often referred to as bullying. It has been described as an expression of oppressed group behaviour evolving from feelings of low self esteem and lack of respect from others. Horizontal violence is a result of job dissatisfaction, having been oppressed by senior colleagues or physician, low self esteem and feeling of powerlessness. The horizontal violence is likely to become a norm and continues from one batch of nurses and doctors to next batch. Horizontal violence is expressed through nonverbal behaviours like raising eyebrows or making faces in response to comments by colleagues, a verbal remark that could be in the form of mockery, being non co operative, with holding an important information from colleague so as to affect ones performance related to patient care, an act of sabotage so as to create negative situation for colleague, attributing all wrongs to the colleague and failure to respect the privacy of others.⁹

3.2 Implications of disruptive behavior

There are negative **consequences** of physicians acting out behaviour. These physicians get isolated from his colleagues and other staff members and hospital administration. It affects quality of patient care, persons other privileges may be stopped and one may lose the job if the behavior continues. The hospital is likely to face law suits filed by dissatisfied patients on the grounds of poor quality of care or poor outcome of patients. It may cause increased legal cost to hire legal experts. The disruptive physician indirectly has to work more as his or her colleagues fail to help or co operate him.¹

Nurse-physician relationships have been shown to have a significant impact on the job satisfaction and retention of nurses^{10,11}; in combination with other workplace factors, disruptive behavior contributes significantly to increased workplace stress and burnout and strongly influences nurses' job satisfaction and decisions to leave the profession. One of the studies, published by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), reported that 24% of sentinel events defined as "unanticipated events that result in death, injury, or permanent loss of function"¹² could be attributed to a problem with either nurse staffing, communication gaps, a lack of teamwork, or other "human factors"

A 2002 study in the New England Journal of Medicine showed that nurse staffing and nurses' time at the bedside affect lengths of hospitalization and the incidences of urinary tract infections, gastrointestinal bleeding, sepsis, pneumonia, and failure to rescue.¹³ The number of studies reporting the effect of working relationships and team dynamics on outcomes is relatively small. Several studies have demonstrated the benefits of effective collaboration among team members, finding a relationship between improved teamwork and improved outcomes, but these studies were limited to ICUs and EDs.^{14,15} Other studies, not specific to unit or department, have shown a link between improved communication and collaboration

and improved patient outcomes.^{16,17} Do you think that disruptive behavior could potentially have a negative effect on patient outcomes? Most answered yes. How often does disruptive behavior result in the following [psychological and behavioral effects]? A list of seven variables followed: stress, frustration, loss of concentration, reduced team collaboration, reduced information transfer, reduced communication, and impaired nurse–physician relationships.

The main objective of the survey carried out by Rosenstein AH was to evaluate the impact of disruptive behavior on psychological and behavioral variables and clinical outcomes, according to what physicians, nurses, and hospital administrators perceived. The participants of the survey reported that disruptive behavior had a significant negative impact on levels of stress, frustration, and concentration and on team collaboration, information transfer, communication, and nurse–physician relationships. Written comments included the following.

- “There are several MDs on the staff who have rude and intimidating personalities. These physicians do not respect the nurses and make for a very stressful environment.”
- “Disruptive behavior is not unique to physicians. Some nurses exhibit an air of superiority which makes communication difficult.”
- “Physicians who are disruptive are usually chronic disrupter and have run-ins with several nurses. There are also nurses who are chronic disrupter. These people are often avoided by other staff which leads to lowered communication. I am sure that a serious incident is just around the corner.”

The following are representative responses to the open-ended questions.

- “The environment of hostility and disrespect is very distracting and causes minor errors. I have caught myself in the middle of mislabelling specimens after confrontations that have been upsetting.”
- “Disruptive behavior resulting in negative patient outcomes is not just a potential problem, I think about it 80%–90% of the time. It creates problems.”
- “Employee stress as a result of a physician yelling resulted in decreased patient safety.”
- “Intimidation of RN led to lack of communication and patient intervention.”
- “Delay in patient receiving meds because RN was afraid to call MD.”
- “Most nurses are afraid to call Dr. X when they need to, and frequently won’t call. Their patient’s medical safety is always in jeopardy because of this.”

There are very few published studies documenting the ill effects of disruptive behavior on psychological and behavioral variables and the resulting impact on patient care. As mentioned above, research conducted by the IOM, JCAHO, and other organizations that promote patient safety have shown a strong correlation between human factors and medical errors and adverse events¹⁸⁻²⁰ Bates and Gawande, in their excellent article, “Improving Safety with Information Technology,” cite several studies that focus on “failures of communication, particularly those that result from inadequate ‘handoff’ between clinicians” as being among “the most common factors contributing to the occurrence of adverse events.”²¹

Longo J and Sherman RO in their article “Levelling horizontal violence” have reported many negative effects of horizontal violence on the affected staff members. The affected individuals get a feeling of job dissatisfaction and develop psychological and physical stress. They get problems like insomnia, develop low self esteem, have poor morale, feel disconnected from other staff, exhibit depression and consume excessive sick leaves. All these result into negative impact on staff retention, new recruitment problems and patient care and satisfaction. Poor team work at work place results in more number of medical errors, sub-optimum patient outcome. It ultimately results into bad publicity about the hospital by the affected individuals.⁹

3.3 Remedial measures

There have been various protocols/policies developed at institutional levels to deal with disruptive behaviors of health care providers. In general, it is suggested that all cases of disruptive behavior must be investigated without delay after getting a complaint from hospital staff (doctors, nurses), patients or its relatives. The head of the investigation committee must interview the concerned staff first and document the findings of the interrogation and should maintain confidentiality

at all levels. After confirming the occurrence of disruptive behaviour, the physician is counselled and warned for the same. More serious actions are taken by the hospital administration in case of repeated incidences of disruptive behaviour.¹

Staff relationships are an important element in health care delivery. Having the right number of staff members, the optimal staff mix, and strong communication and collaboration can have enormous effects on health care delivery and its outcomes. Disruptive behavior is one of the most important influences on the quality of staff relationships. Strategies employed by some organizations had two main themes: education and leadership support. Raising physicians' and nurses' awareness and offering specific educational programs on such topics as mutual respect, sexual harassment, diversity, team collaboration, and anger management played important roles in improving nurse-physician relationships.^{22,23}

Other studies support the notion that strong leadership and commitment to changing an organization's culture, as well as the development of well-defined code-of-conduct and disciplinary policies and special committees charged with intervening when disruptive behavior arises, are critical to reinforcing appropriate standards.²⁴⁻²⁷

Given the potential of disruptive behavior to result in adverse events, health care organizations must recognize the importance of addressing this issue practically, developing strategies that support appropriate behavior, and implementing policies that deal effectively with disruptive incidents when they occur. Initial strategies for improvement include the following.

conduct an organizational self-assessment, increase staff awareness of the nature and severity of the issue., open up lines of communication between affected parties in order to create a non antagonistic environment in which important issues can be discussed. The next step in the process is to promote opportunities for collaboration. This can be accomplished either in informal meetings or discussion groups or in more structured committees or task forces where these issues are addressed. Courses focusing on communication skills, conflict management, and team building provide a forum for improving "people skills." For example, phone etiquette classes have been particularly effective because many disruptive events are precipitated by telephone calls to physicians. As one physician respondent said, "Nurses should receive better clinical training. When calling a physician, they should know what the doctor expects her to know, which includes a basic amount of information, such as the patient's name, vital signs, the diagnosis, and the type of surgery the patient has had or is scheduled for. She should also identify herself by name and position."

Improving physicians' receptiveness and responsiveness to calls and improving nurses' competency in presenting information to physicians will help improve communication and information transfer. The organization must also be committed to improving staff relations. This commitment must include creating a culture in which respect and integrity are valued, unacceptable behavior isn't tolerated, and the reporting environment is nonpunitive. The organization must develop a fair process for evaluating and acting on staff complaints. It must have a well-defined code of behavior that's applied consistently to all members of the organization.

The organization must also develop an effective disruptive behavior policy to deal with those members of the organization who are constant abusers of the system and do not improve after education and counseling. Another suggestion for improvement: having a well-placed "clinical champion," such as the chief of staff, vice president of medical affairs, or chief medical officer, who supports and takes responsibility for the process of transforming the institution's culture, is an extremely valuable asset. A clinical champion who takes a leadership role and who is passionate about both improving staff relations and clinical outcomes could mean the difference between the program's success and failure.

Improving relationships among clinicians is the most important factor in reducing the unwanted effects of disruptive behavior on clinical outcomes. The first step in implementing a successful improvement strategy involves increasing awareness of the seriousness of the problem. The best way to accomplish this is to perform an organizational self assessment to determine the extent of the problem and identify areas of need. Results of the assessment should be discussed with the clinical and administrative teams. A concerted effort should be made to increase the understanding of individual values, roles, and responsibilities and address any underlying barriers or resistance before moving forward.⁷

Kramer M and Schmalenberg C in their article titled "Securing good nurse physician relationships", suggested steps to improve doctor-nurse relationship. According to them ,the responsibility for improvement falls on nurse managers. They should play lead role to develop, nurture, and support equal power relationships between nurses and physicians. The nurse manager clarifies the vision and supports collegiality through role modelling and formalized interdisciplinary interactions.

1. Plant and nurture the “equal but different” seed. At meetings with staff nurses, explain how nurses’ knowledge is different but as important as the physicians’.
2. Create a culture that values, expects, and rewards collegial nurse/physician relationships. To achieve this goal, one nurse manager orients new residents, interns, and staff physicians to the “different but equal knowledge base” concept. She tells them that the nurses know what they’re talking about, and that, at this facility, nurses respect physician and physicians respect nurses.
3. Foster, support, and encourage educational programs of all types. The basis of the “equal power” working relationship is clinical competence. Nurses must keep their practice current, and physicians must know this. Managerial support is mandatory for creating an equal power environment, reinforcing desired behavior, and creating opportunities for nurses to showcase their competence.²⁸

Managing horizontal violence among physicians and nurses in a health care setting is an additional responsibility of medical superintendent and nurse managers. They must be aware about its occurrence and the causes. Some of the following steps can help in reducing the horizontal violence and its implications. Analysis of work culture, Encourage reporting of incidences of horizontal violence during staff meetings and breaking the silence, establish the mechanism to address the issue, training of staff about stress management, conflict management and defend themselves against bullying behavior. A culture of zero tolerance for horizontal violence is the most effective leadership strategy to prevent its occurrence.²⁹ American association of critical care nurses developed a set of standards for establishing and sustaining healthy work environment. They have recommended that organizations should devise and enforce policies to address and eliminate abuse and disrespectful behaviour in the workplace.³⁰ Nursing research indicates that exposure to horizontal violence drains nurses of their enthusiasm for the profession and undermines the attempts of organizations to create a satisfied workforce.³¹

In response to the felt need of improving communication between junior doctors and the staff nurses for better coordination, patient care, satisfaction and outcome, a resident orientation programme was designed by nurse managers. A brief session was attended by the residents newly recruited in particular health unit, nursing staff and the nurse manager. The routine protocol of the unit and the working culture is explained to the junior doctors, so as to improve their communication with the nurses. The doctors felt increased confidence and the knowledge about the specifics of the unit, such as correct paperwork to fill out. Residents felt connected to employees just by meeting a few nurses during the orientation process. Surveys of both nurses and residents provide evidence that the informal meetings had a positive effect on nurse–physician communication. The resident orientation succeeded in meeting the goals of increased staff satisfaction and improved coordination of care.³²

4. Conclusion

Providing safe, error-free care is the number-one priority of all health care professionals. Disruptive behavior has been shown to have a significant effect on patient outcomes of care. Although the overall percentage of physicians, nurses, and other members of the health-care team who exhibit this type of behavior are relatively small, they can have a profound overall effect on team dynamics, morale, and patient care. These effects are dramatically intensified in the operating room suite and other high intensity areas, because of the high stress level and intensity of services provided. In view of the growing concerns about accountability for providing high-quality outcomes and patient safety, manpower shortage, institutional reputation, and legal liability, hospitals can no longer afford to be silent regarding disruptive behavior of their staff.

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