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Violence from Within: Doctors vs. Nurses

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Abstract

This paper is part of an effort to understand the direct cause or causes of the nursing crisis in the United States. The study examines this issue using official and self-report data from the NURSEWEEK/American Organization of Nurse Executives Survey and numerous literature reviews. The analysis addresses the magnitude of the relationship between physicians' violence against nurses and nurse turnover rates. While the general image of physicians is almost always one of gentleness and helpfulness, it is ironic that the results of this study suggest that physicians' violence against nurses is directly related to the high rate of nurse turnover. The study indicates that physicians are receiving training only in patient management, but not enough training in collegial management in environments where there are nurse professionals in the healthcare organization.

KEYWORDS: Physicians' violence, nursing shortage, nursing changing role, patient care

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Violence from Within: Doctors vs. Nurses

Nursing as a profession is facing an unprecedented shortage by the year 2020, and this nursing shortfall will influence the future health care environment. The number of unfilled nursing positions in the United States is estimated at 126,000 and growing. In the state of Washington recently, about 10% of all job vacancies statewide were for registered nurses, more than any other occupation in the state (Clements, 2003; Buerhaus, Auerbach, & Staiger, 2009; Aiken, Cheung & Olds, 2009).

According to the Associated Press, in the next seven years the number of sick people in Indiana will likely stretch beyond the capacity of the hospital nursing staff that cares for them (AP, 2003). In Michigan, like much of the nation, people travel farther for life-sustaining kidney dialysis treatments because of a lack of nurses and nursing home residents face delays in getting the help they need. The population 65 and older in Michigan may increase by 30% by 2020, creating an even greater demand for nurses. In addition, thousands of nurses have left the profession and over 15% are expected to retire in the near future (Martin, 2003; Rother & Lavizzo-Mourey, 2009). Both the employment director at Sparrow Hospital in Lansing, Michigan, Gale Rosen, and the president of the Care Association of Michigan, Reginald Cater, believe that the situation will get worse and that, in Rosen's words, "It can't help but affect the quality of care. The shortage of nurses means you're not able to attend to residents the way you'd like to." (Martin, 2003 para.3; Kutney-Lee, McHugh, Sloane, Cimiotti, Flynn, Neff, & Aiken, 2009)

In New Hampshire, Governor Craig Benson said, "The problem we have is that there are not enough nurses, not only for right now but for the future" (Haberman, 2003:3). This article could continue citing the issue of a nursing shortage from state to state throughout the entire continental United States, but it is not necessary at this point because even the federal government's Health Resources and Services Administration has stated that the nurse supply

and demand gap is more than 20% and that the shortage number could climb from an estimated 125,000 to 800,000.

At the same time that the nursing shortage is a major issue in health care, the U.S population 65 and older is expected to grow by 54%, or 50 million people, by 2020 (AP, 2003; Aiken, Cheung, & Olds, 2009). The study shows that the United States is in a situation of crisis—within the hospital system, in the health care profession, in the states, and in the nation at large—that needs serious responses.

Study Methodology

Study Design

The study of doctors' violence against nurses used qualitative methods, believing they are the most appropriate for gathering exploratory data. Several issues were of importance in the use of qualitative methods in this study including the respondent's status, sampling, interviewing, and data analysis.

The respondents and literature (secondary data) were selected on the basis of their active employment status and content related to the health-care services, respectively. In addition, purposive sampling was applied in the selection of respondents and the literature.

Data collection was done using two techniques: conversational interviewing and secondary data from other literature. Interviews were unstructured, informal communication by telephone and/or e-mails over a period of time. The interviewing instruments contained open-ended, unstructured, conversational, research-related topics aided by the use of probes, and the topics changed with each subsequent conversation, with the aim of pursuing further exploration. In every conversation, the participants' specific remarks were used to further establish the reliability and validity of major points of the conversation. Comparing physician and nurse information allowed the researcher to create professionally appropriate instruments to enhance the reliability and validity of the data. The telephone conversations were not

taped, but note-taking was normal practice by the researcher to facilitate successful probing and a free flow of conversation. In an effort to solicit more in-depth answers from the respondents, the researcher highlighted main points in the conversations to allow appropriate responses. In cases of e-mail conversations, two or three follow-up conversations were usual practice and were conducted on a specific-issue basis to double-check the accuracy, validity, and reliability of the information.

A constant comparative method of data analysis grounded in the “melting fat” concept of behavior was used. Some of the issues that were not appropriately answered by the available literature were re-measured through e-mail and/or telephone conversations. The researcher used a comparative method to analyze every consecutive conversation to produce *in vivo* codes out of the data that allowed for valuable, sociologically constructed results.

Findings

This research is focused on why a nation that is highly developed, a technological super-power, and academically advanced would have so many problems with recruiting, training, and retaining nurses. Data are utilized that were collected over many years, from the NURSEWEEK/American Organization of Nurse Executives Survey, as well as numerous journal, magazine, and newspaper articles and information gathered through telephone and e-mail conversations with 37 physicians, hospital administrators, and nurses, all of whom were, at the time, actively working in health-care facilities. The conversations were unstructured and entirely voluntary, and the researcher promised anonymity to all participants. The bases for choosing participants were experience, willingness, and availability to participate. About thirty articles were acquired from available written records.

In this study, researchers concluded through many individual conversations and numerous article reviews that have concluded that the problems of recruitment and retention are complex. The United States health care system is spending millions of dollars on

advertising, recruiting internationally, and giving sign-on bonuses, and still there is a nursing shortage. The question is why this problem continues to exist. Even with employers' new training techniques, technologically advanced work places, and employer-sponsored job fairs, nurses' turnover rates are still very high. For these reasons, it is important to look from the inside out and also to find out if there may be a criminological component to what seems to be purely a labor problem.

The lead researcher made a serious effort to separate a few individuals' opinions from many concurring opinions supported by documented facts and data in articles. Many articles provided important facts and suggestions that relate directly to the issue of physician-nurse relationships. Examples of articles include: "Nurses Top Washington State's List of Greatest-Demand Occupation", "Indiana Nursing Shortage Getting Worse", "Doctors and Nurses: Doing It Differently", and many others (Clements, 2003; AP, 2003; Salvage & Smith, 2000). It is understandable that it may be difficult to generalize the results to countries other than the United States, but over 40% of those interviewed have worked in countries other than the U.S., and some have witnessed similar situations.

Problems

According to social structure, societies segregate and discriminate their members into groups, sometimes according to race, class, professional power, and/or more. Such groupings can have important impacts on both individual lives and society at large. Likewise, the relationships that physicians have with nurses can have a profound effect on whether nurses choose to stay in the profession or not, a decision that affects not only individuals but also society (Mckinney, 2002).

Physicians and nurses are professionally related in a system that is grounded in a hierarchical and ideological power structure. This power structure can cause problems when

it is not well managed and supervised. The relationships within such a structure should be based on respect and accountability regardless of individuals' status or authority.

Alan Rosenstein surveyed 1,200 nurses, physicians, and senior hospital administrators who were affiliated with the Veteran Health Administration (VHA). They represent over 26% of U. S. hospitals, and the results were shocking. More than 90% of the survey respondents said they had witnessed physicians' disruptive behavior and stated that it had a direct impact on job satisfaction; and, finally, that it had a direct impact on nurses' decisions to continue with that employer or in the profession. Over 30% of Rosenstein's research respondents said they knew at least one colleague who had resigned because of physicians' disruptive behavior (Rosenstein, 2002). Joanne Hambleton states that "Losing just one employee, particularly a nurse, can profoundly affect the hospital's ability to operate and can add to the already high cost of recruitment and replacement" (Uhlman, 2002:8, Kutney-Lee et al. 2009).

In addition to all of this, Doheny says that "Physicians who scream, curse, throw surgical instruments, or exhibit other bad behavior may be at least partly to blame for the nation's growing nursing shortage" (2002:3). It is important to understand that most of these physicians are unaware of the impact of their behavior. A physician, who was a target in a nurse's lawsuit alleging that he waved an instrument in her face and had been verbally abusive for years, was shocked when a hospital administrator handed him his personnel file full of complaints from disgruntled nursing staff (Lehmann, 2003).

One of the nurses in the research sample recalled an incident in which a physician waved an instrument in her face and ordered her out of the operating room. She said that she reported the incident to the hospital administration, but they did nothing. Instead, they reprimanded her for not obeying the physician's order to leave the operating room. She told me that she explained to the administration that she has a professional and legal responsibility to remain with her patient in the operating room, but that was not enough for the hospital

administration. There is no doubt that a lack of administration support is one of the factors affecting nurse/physician relationships. The good news about this particular situation is that the hospital has been sold to a new company that is reorganizing everything from the ground up (although the aforementioned physician is still working in the hospital). Another nurse in the same hospital complained of married male physicians having extra-marital relationships with some surgical technicians and how this has soured the work environment, impacted effective patient care, and on many occasions led to conflicts between physicians and nurses.

Thus, it is hypothesized that part of the cause of the high nurse turnover rate is within the health care profession (i.e. in the work place) itself. Healthcare professionals and researchers have long understood health-care professions “as a conventional nuclear family, with a doctor-father, a nurse-mother, and a patient-child; But our hope for total wisdom and protection from a father is forlorn, our wish for total comfort and protection from a mother is unachievable, and the child has to grow up” (Salvage, 2000 para.2). A dialogue to reestablish the roles for each profession and to revise the regulations/policies, training curriculums, and salaries may be the answer.

Issues

Historically, a double-standard principle begins because the gender role of the nursing profession used to be exclusively female. According to Jane Salvage, “the differences of power, perspective, education, pay, status, class and—perhaps above all—gender have led to tribal warfare” (Salvage & Smith, 2000:3). Also, the nursing profession used to attract mostly working class or immigrant women whose backgrounds fostered unquestioned obedience to authority (Ehrenreich, 1972). In contrast to nursing, which has always been dominated by females, the practitioners of medicine one hundred years ago were all male, and today it is still a male-dominated profession. In addition, physicians’ educations emphasize scientific

expertise, autonomy, and authority (Ehrenreich, 1972; Kalisch & Kalisch, 1977; Zelek & Phillips, 2003) and place less emphasis on such things as teamwork and collaboration.

In the early days, nurses would get coffee and vacate seats for physicians. However, what one nurse called the “long bone” days are over, and physicians and nurses now have to work together for a common goal which is patient care. Even today, however, hospital administrators often do not want to antagonize abusive, disruptive, and even violent physicians because they bring in a large amount of money to the hospital. Thus, hospital administrations’ lack of response to nurses’ complaints may be due in part to a particular physician’s status. If a physician brings in enough money and/or is highly respected in the profession, he or she can often do anything and get away with it (Wariono, 2003). But the administrators should understand that nurses, just like other professionals, resent being degraded by physicians, patients, etc. (Salvage & Smith, 2000).

According to Richard Doering, M.D., modifying a physician’s behavior should be the number one priority in any health care facility. When he took over Hoag Hospital in Newport Beach, California in 2001, a zero tolerance of physician’s bad behavior was instituted. He went on to note that when physicians do not get along with others well, they must learn to do so (Mitchell, 2002).

Theory

The violent, disruptive, and insulting behavior that physicians put forward in hospitals is not the “problem”—it is the consequence of the problem. Physicians’ violence is not only real, but it has been established that it is present in many health-care institutions. Every behavior carries information about the cause(s) of behavior. In the case of physician violence, this study reveals that hospital administrators, physicians, and nurses are all part of the problem and that the physicians’ bad behavior is the symptom.

Physicians who are motivated to abuse nurses have to take into account a number of relevant factors. They must consider the policy of the organization in terms of their ability to get away with their behavior. They must also consider how their job is defined relative to that of the nurses. Finally, they must consider the ability/willingness of the hospital administration to sanction their behavior and to set a precedent, if any, with regard to such behavior. The simultaneous assessment of policy, job definition, and precedent on which these character decisions are made is crucial to understanding and eliminating physicians' violence.

The "melting fat" concept of crime states that the melting process will not stop until the fat is removed from an inappropriate temperature. The melting fat idea sees human behavior as controlled by role definition and situations. Different fats melt at different temperatures, and some physicians define their role incorrectly and behave inappropriately. What controls acceptable human behavior is correct role definition, followed by appropriate behavior. When the temperature is incorrectly read, there is going to be improper response by the fat itself. According to this idea, it is the incorrect role definition that leads to inappropriate behavior. The literature shows that a longstanding "jurisdictional" dispute about roles and responsibilities, coupled with the reduction of junior doctors' hours is creating warfare in hospitals (Beecham 2000; Doya & Cameron, 2000).

Hospital administrators, physicians, and nurses are creating inappropriate "temperatures" in the hospital wards; and, as long as this persists, violence, disruption, and insulting behavior by physicians against nurses will continue to drive nurses away from the profession. In the hospital wards, when physicians incorrectly define their role (atmosphere) some of their behavior has to be inappropriate and may even be criminal. Each profession in the health care system has its own role, and role definition, and its own appropriate behaviors.

For example, hospital administrators are in administrative positions, otherwise known as management, which is defined as the "process by which the elements of a group are

integrated, coordinated, and/or utilized so as to effectively and efficiently achieve organizational objectives" (Carlisle, 1976:21). Management is a function that spreads throughout a hospital, from frontline nurses (RNs, LVNs, etc.) to the director of nursing, with the junior nurses managing and controlling patients and other staff. These management roles allow them to exercise some power in the process of achieving organizational goals. It is frontline staff's management abilities that should determine hospital policies because nurses deal directly with the clients (patients), but in reality it is not always true. For example, some nurses in the study said it was very difficult to please some physicians and that physicians were allowed to determine which nurse should stay or lose his or her job; in addition, the nursing director or manager was just a "rubber stamp". In other words, she or he (the nursing director) went along with any physician's administrative decision, even though the decision might be administratively wrong.

For the purpose of this paper, the researchers see management as a process that helps direct and mobilize people and their ideas toward organizational goals (Kotter, 1990). Studies have shown that many hospitals lack managers or directors who can create, protect, perpetuate, and maintain an appropriate system. Managers have to go out and recruit nurses, set up policies to protect the nurses and doctors, and set standards for different experts. There should be a policy on conflict management and a support system for victims of on-the-job conflicts. In addition, management should always remain neutral in resolving conflicts between physicians and nurses. The issue of whether or not the physicians or nurses bring in money to the hospital should not be a factor in deciding who is at fault in a conflict situation. Neither the physicians nor the nurses can work alone, and both are experts in their own fields. Above all, both nurses and physicians need the hospital in which to practice their skills, and they must adhere to the rules of the hospital.

All medical services providers, whether they are doctors, nurses, radiographers, laboratory technicians, etc., exist primarily to serve the patients (Kutney-Lee, 2009). In terms of professional power, physicians and nurses are hierarchically related in a disparity that is firmly grounded in the social structure (Telli-Nayak, 1984). In order to change the status quo, nurses have to “stand up” for themselves and understand that some of the abuses are violations of criminal law. According to Beth Ulrich, “Nurses also have a responsibility, and not reporting it only enables the abuser” (2001:4). Of course, the hospital management may not take any action against the abuser. For example, in one hospital in the cover research, a registered nurse and a physician (“ganged up”) to replace another nurse in the operating room. In another instance, a physician threatened a nurse with an operating instrument in the operating room and had the support of another nurse. The other nurse was supposed to be off-duty, but she had preplanned with the physician to replace the other nurse after the physician had completed his abuse of her. Ulrich believes that nurses should “watch each others’ backs,” rather than stabbing each other in the back (2001). Nurses should respond to physicians’ abusive behavior in a consistent and professional manner that does not interfere with patient care.

The relationships that physicians have with nurses can have a “profound” effect on whether nurses choose to stay in the field (Mckinney, 2002). According to Joanne Hambleton, “Doctors may no longer expect nurses to get coffee or vacate seats for them,” but nasty put-downs have not been eradicated from their behavior yet. Even though the number of disruptive physicians is considered to be low, their disrespect can affect the hospital work environment, inhibit teamwork, influence care, and even, on occasion, prompt nurses to flee either the institution or the profession (Uhlman, 2002).

In the case of the doctor mentioned earlier who was shocked at the number of complaints that had been lodged against him, administrators did not want to antagonize him

because he brought in to the hospital $2 million annually in revenue (Lehmann, 2003). Nursing staff were told not to deal directly with him. Finally, when the vice president of nursing complained to the administrators, she was told, in essence, "to suck it up" (Lehmann, 2003). Such incidents provide compelling anecdotal evidence that demeaning treatment from physicians is one of the factors driving nurses away from the profession (Uhlman, 2002).

Theory Implication

The findings from this study are consistent with both the "melting fat" concept and the punishment-according-to-culture theory. The study did not conduct direct tests of all the data but rather used secondary data. However, the findings support the general idea behind the melting fat concept. Defining the roles of health care professionals (doctors and nurses) to be role players and behave appropriately is very significant in the process of retaining nurses.

Also, the study findings are consistent with the proposition from punishment-according-to-culture theory that only culturally (professionally) appropriate punishment can deter future inappropriate behavior (Otu, 2000). These results support the idea that an effective punishment model should demonstrate some understanding of the values and behaviors considered essential to the medical profession. It is very simple for administrators to set a punishment that fits the medical profession for doctors who abuse their staff.

The logical and intriguing question at this point remains unanswered: What do doctors gain by abusing nurses? A simple answer would be, "A fish in the water does not know it is wet". In other words, when the doctors' role is inappropriately defined, then inappropriate behavior should be expected from them. Doctors tend to see themselves as the "all in all" of the hospital and their patients as their "personal property," and too often they fail to understand that they cannot treat their patients alone without the nurses' help—nor would they treat these patients satisfactorily in their private offices. "Research has also shown that nurses can perform some of the tasks that doctors do, and usually to the greater satisfaction of

patients" (Shum, Humphreys, Wheeler, Cochrane, Skoda, & Clements, 2000; Kinnersly, Anderson, Perry, Clement, Archard, Turton, Stainthorpe, Fraser, & Butler, 2000:1; Venning, Durie, Roland, Robert, & Leese, 2000; Iliffe, 2000). Physicians have to understand that a hospital is not a place to display power nor is a patient a tool to prove a "power" point. In the hospital setting, these professionals should share a common goal; they should collaborate and communicate in deep interrelationship for the good of the patient.

David Woodruff, a nurse with extensive experience in critical and emergency room care in inner-city hospitals, said, "Nurses are treated with hostility from physicians who don't value the work they do or to demonstrate the power of their positions. I once saw a nurse order an EKG on an ER patient because he was having chest pains. She took the results to the doctor and he grabbed it, crumpled it up, and tossed it in the trash. It was terribly demeaning to the nurse, but he hadn't ordered it. Of course, once he saw the patient, he walked out and ordered an EKG. It was nothing but a power play" (Orr, 2002:3).

In the U.S. and other western countries, the authority, income, and prestige reflect physicians' omnipotence in the health care profession. Their power seems to derive from academic knowledge and the class structure of society, coupled with the fact that their academic training emphasizes authority, autonomy, and scientific expertise. Even though recent medical education curriculums do mention teamwork and collaborating with other experts in general terms, this is not enough to alleviate the physicians' long-standing belief in autonomy.

According to Zelek and Phillips, when nurses and doctors are females the traditional power imbalances in their relationships diminish, which suggests that these imbalances are basically based on gender and not on professional hierarchy. In effect, doctors used to be part of a nearly all-male club, but with improvements in civil rights laws and an increasing number of females becoming doctors, their power is decreasing rapidly (2003). The erosion

of doctors' power is like melting fat, so a change in behavior and role definition is needed to accommodate the melting process. Accordingly, because society cannot and would not roll back the clock, it has to redefine and emphasize physicians' roles to include collaboration, teamwork, and mutual respect in health care facilities.

Historically, the gender role of nursing was almost exclusively women whose backgrounds fostered unquestioned obedience to authority (Ehrenreich & English, 1972; Peplau, 1966; Zelek & Phillips, 2003). But "nursing has changed substantially in the past 30 years, and nurses are more assertive, educated and competent than ever before" (Salvage & Smith, 2000:7).

Although times have changed, the doctor and nurse roles have not necessarily changed with time. This situation could be attributed to role ambiguity, civil rights laws, lack of regulatory mechanisms, and training styles. Some nurses and doctors are not well trained universally for their jobs, and although all registered nurses and medical doctors pass a licensing examination in the U.S before they practice, such examinations may only test some part of what is involved in the medical profession and may not test human relations skills or natural common sense. Testing alone is not a good measure of predicting success in medical practice for both physicians and nurses.

Another aspect of this problem is that all abused nurses may not be "innocent" victims of doctors' abusive behavior; some nurses initiate the abuse, either directed at themselves or at a fellow nurse. A nurse who calls the physician in the middle of the night to ask a question about a patient without reading the patient's progress report may be initiating confusion. According to Rosenstein's (2002) study, physicians rated the following as the causes of their abusive behaviors: "…orders not being carried out correctly or in a timely manner as the primary cause of disruptive behavior, followed by ill-timed calls to physicians, the need to question or clarify orders, and general communication breakdowns between

physicians and nursing staff" (Uhlman, 2002:5). Doctors and nurses may not be fluent in the same language; hence, either may have to repeat themselves several times. Nurses must take responsibility for miscommunication with doctors and vice versa, which can have serious consequences, including patient injury and/or lawsuit.

The "nurses vs. nurses" issue is also a major problem for the profession. The meaning of personal loyalty to the profession and to patients and colleagues is complex in the health care profession. The self-protective (protect your license) approach of healthcare agencies is a hindrance to complete loyalty, which here means "a life in which interaction with others becomes the primary means for solving problems" (Fletcher, 1993:12). Complaining of abusive behavior by doctors is one part of the problem; another part is nurses creating conflict among themselves.

Nurses with whom researchers talked in south Texas hospitals complained of "write-ups"—nurses filing a written complaint about minor mistakes that should or could be corrected without any long-term effect. This author believes that such behavior does not promote a healthy work environment. If there is a "minor" mistake, the individual can be told to correct it. There should be verbal warnings before a written complaint, which should be seen as a last resort depending upon the severity and consequences of the error.

Recommendations

In this study, researchers examined several pieces of literature on the nursing shortage, talked to many individuals in the health-care profession, mostly in South Texas, and visited several hospitals unofficially. Results of the present study suggest that physicians' abuse of nurses and poor or no intervention by hospital administrators negatively affect the retention rate of qualified medical staff. The study findings also suggest that some nurses are not "innocent" victims of doctors' abuse—i.e., they are either participants or they initiated the

abuse. Another implicated group is the administrators who sometimes care about the bottom line more than the well-being of employees.

Up to this point, the researchers have not provided a definition of abuse because it has been found to be difficult in a heterogeneous society. Since there is no universal definition on which all experts agree, the researchers' definition of physician-nurse abuse is *any act or omission by a physician and any consequences resulting from such act or omission that deprives a nurse or nurses of equal rights and liberty, and/or that negatively affects nurses' emotional well-being.* Abuse has turned some nurses into "patrol nurses," who move from one facility to another in search of professional job conditions. It is in the interest of the patients, doctors, nurses, hospitals, insurance carriers, and the judicial system to make sure that nurses remain in one hospital for as long as possible.

In this study, the researchers point toward a few recommendations, but in the final analysis, each hospital should set up a task force to study its particular situations, identify the underlying issues for their abuses, and enforce a policy of zero tolerance that addresses their concerns. In an effort to help hospitals decrease or eliminate doctors' abuse of nurses, the researchers recommend the following:

- Train administrators, doctors, and nurses on their specific responsibilities and human relations. Communication is absolutely necessary in the health-care profession because each individual brings his or her expertise to help the patient (Uhlman, 2002; Doheny, 2002).
- Train nurses and doctors on how to communicate effectively with one another (e.g., call a doctor only when it is an urgent and significant problem) (Rosenstein, 2002: Doheny, 2002), talk to a nurse as a colleague and not as one's slave. Teamwork requires different experts treating each other with mutual respect (Uhlman, 2002).
- Each hospital should set up a conflict-resolution department that handles conflicts between staff members. Conflicts between physicians and nurses should be treated according

to hospital-approved policies. Nurse/physician conflicts should be treated as conflicts between colleagues with different areas of expertise and not as a boss/subordinate conflict (Orr, 2002). The guilty party should be punished according to policies and procedures accepted by the medical profession.

- Set up a confidential report system. It is not easy for a hospital to replace the financial benefits or the big name brought in by an abusive physician, but it is equally not easy to replace an experienced nurse quickly (Ulrich, 2001). The cost of losing a nurse may, in fact, be higher than losing a physician if the hospitals have to take out two or three beds because no replacement is available (Wariono, 2003).
- Recruiting nurses from developed and developing countries may help to alleviate a nursing shortage, but retaining already-experienced nurses is also extremely important. Nurses are an important part of a medical team, and nurses as well as physicians should be invited or even mandated to attend medical staff meetings.
- Set up a department to oversee, treat, and counsel nurses and doctors who have a "burn out" problem. Give doctors and nurses adequate control over their workloads and work schedules. Patient care is a stressful job; therefore, administrators should do everything possible to reduce the stress (Rosentein, 2002). Doctors and nurses should be encouraged to seek help if they have a problem.

Discussion

In this study, the relationship between physicians' abusive behavior toward nurses and the shortage of nurses in hospitals is examined. Certainly, there are other factors that may contribute to a lack of nurses, but the major factor is a poor, stressful working environment. Reducing stress in the hospital is the leading answer to nursing shortage problems because the stress put on nurses by physicians is one of the major causes of nurses leaving the profession before retirement. According to Rosenstein, "It's now clear that physicians can

drive away nurses by their actions and words. The data now shows that disruptive behavior 'by doctors' is an important factor in whether nurses stay on the job or resign." Disruptive behavior by physicians had been seen by 92.5% of Rosenstein's 1,200 survey respondents (Doheny, 2002), and some of the worst attacks nurses undergo come from within; the nasty words, vicious threats, and even physical assaults arise from the physicians with whom nurses work (Orr, 2002). In addition, the Rosenstein survey shows that 30% of those surveyed knew of a nurse who had left a hospital due to a doctor's disruptive behavior (Doheny, 2002), and in general 2.4 nurses walked away from each facility each year because of bad physician behavior. Such facts, as these, lend credence to the significance and complexity of the nursing shortage problem.

Please note that the opinions expressed by authors represent those of the authors and do not reflect the opinions of the editorial staff of The Online Journal of Health Ethics, Editors, and Reviewers.

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