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Anger: The Mismatched Emotion

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Abstract and Introduction

Abstract

Mismatched anger is a significant problem in health care settings. Research-based information is presented on the angry emotionality that nurses frequently encounter. Gender differences in anger are examined. Strategies are presented for dealing with angry patients, physicians, and colleagues.

Introduction

Over 20 years ago, psychologist Carol Tavris (1982) wrote a popular book entitled **Anger: The Misunderstood Emotion**. She sought to dispel a number of myths about anger, such as the widespread but mistaken notion that "venting" for catharsis was a healthful thing to do. Anger is expressed in a variety of ways, from episodes of "road rage" on the streets to bursts of profanity in the workplace. It remains not only a misunderstood emotion but also a *mismatched* emotion. Too many people are using weapons or fists to express their angry feelings. New terms such as "desk rage" and "air rage" have been coined by the media to describe the ever-increasing tendency of Americans to erupt and lash out. To this list of trendy terms, nurse researcher Linda Aiken (Bergstrom, 2001) has added "ward rage" to describe the epidemic of anger and frustration in hospitals. In addition to the disastrous social consequences of such out-of-control behavior, this mismatched anger has significant consequences for Americans' physical health. Poorly regulated anger has been linked to hypertension, coronary heart disease, and a number of other conditions (Kawachi, Sparrow, Spiro, Vokonas, & Weiss, 1996; Sunn, 2001; Williams et al., 2000).

The "emotional intelligence" movement, spurred by Goleman's (1995) book, attempted to counter this spate of free-floating hostility and interpersonal violence. Drawing on the research of Salovey and Mayer, Goleman concluded that emotional intelligence -- the regulation of emotion in a way that enhances living -- may be more crucial to personal and professional success than IQ or proficiency at the tasks of an individual's job. While emotional intelligence involves several elements, this article focuses on just one: the effective regulation of anger. Tice and Baumeister (1993) showed that people have fewer successful strategies for controlling anger than for any other emotional state, including fear, anxiety, and sadness. Likewise, this research demonstrates that both men and women lack skill in anger management.

The causes and manifestations of anger in daily life, and differences between men and women are examined. Next, the types of angry emotionality that nurses commonly encounter in health care settings are considered. Finally, research-based anger management strategies that nurses can use and teach their patients are presented.

Causes and Manifestations

Why do people get angry? The author has conducted a program of research on anger since 1988, aimed at illuminating its causes, manifestations, and health consequences. Interest in the topic was sparked by a serendipitous finding of some gender differences between men and women in their ways of expressing anger (Thomas, 1989). After a literature search showed scant previous research on women's anger, a large-scale, comprehensive investigation was launched, guided by a conceptual model (Thomas, 1991). It was framed within the research strategy that Coward (1990) called "critical multiplism" (such as the use of multiple stakeholders to develop the research questions, probes of diverse issues within a single study, and multiple modes of data collection and analysis). In Phase I of the Women's Anger Study, conducted by a 14-member team from 1989 to 1991, an extensive battery of questionnaires was administered to more than 500 women, and new knowledge resulted about the correlations between women's anger and variables such as self-esteem, stress, and depression (Thomas, 1993).

Additionally, Phase I study participants were asked some open-ended questions about the precipitants of everyday anger episodes at home and work. Women's written responses to these questions were informative, but too brief to permit a thorough examination of the context in which anger episodes occurred and the complex meanings of these experiences. Thus, Phase II of the Women's Anger Study, conducted from 1993 to 1997, involved in-depth phenomenologic interviews with Caucasian women, African-American women, and French women living in France. These interviews yielded rich descriptions and deeper understanding of what women's anger is all about (duMont, Droppleman, Droppleman, & Thomas, 1999; Fields et al., 1998; Thomas, Smucker, & Droppleman, 1998).

Researchers learned that anger is a confusing emotion for women, intermingled with hurt and disillusionment. It is generated in their most important intimate relationships; women tell stories about family members, co-workers, and friends who have let them down in significant ways or expect too much from them. Violations of a woman's core values, beliefs, or principles provoke her angry feelings. But her anger, even when produced by a substantive violation, is often inhibited for fear of damaging relationships. The following example from the data is illustrative:

"I'm always angry with my father...[He] had an affair with another woman for 4 years before my mother found out about it...I'm still mad at him...I would never talk to my father about it...It'd be awful. He'd be angry with me...I walk on eggshells around him all the time. I try not to make him mad if I can" (Thomas et al., 1998, p. 316).

Triggers

Lack of relationship reciprocity is a frequent trigger of a woman's anger. The woman feels pressed, stretched, and almost pulled apart by multiple demands, and she wants someone or something to change but often feels powerlessness to make this happen. In many cases, she does not feel that the other person really listens to her requests. Cooking metaphors, such as "simmering," "stewing," or "slow boil," are often used to describe the undercurrent of unexpressed anger within her body. The suppressed anger sometimes "leaks" bit by bit, through passive-aggressive behaviors. Overt anger sometimes does emerge, usually as the culmination of a buildup of grievances over time. However, a volcanic angry outburst is not necessarily efficacious in bringing about the desired changes, and usually leads to self-recrimination over the loss of control. After all, the woman has learned during gender role socialization that direct anger expression is unfeminine and unattractive. Her female role models may have conveyed their feelings indirectly through sulking or sighing. Although relatively rare within the data, there are some examples of women using their anger in a more constructive fashion; they are able to ask assertively for what they need to address a problem or restore relationship reciprocity.

Themes

Using similar interview methodology, a study conducted over a 4-year period (1997-2001) revealed key themes of men's anger (Thomas, McCoy, & Martin, 2001). In essence, a man's anger emanates from a perceived affront to his sense of control and/or his views of right and wrong. Judgments of right and wrong are made regarding the behavior of others as well as about his own "right" and "wrong" anger behaviors in response to others. Abstract principles and standards about proper human conduct (truth, fairness, sportsmanship, professionalism) are invoked to explain angry feelings. Anger narratives pertain to a variety of societal issues ranging from the specific (President Clinton not doing the "right thing") to the global (politics, monopolies, environmental pollution, misuse of the disability system). Although study participants view anger as a tool for dealing with moral wrongs against the self and/or others, they are wary of its potentially overwhelming and dangerous force. Metaphors they use to describe their anger are illustrative: a runaway horse, fire, flood, or vortex. "Wrong anger" can involve over-reaction (hitting objects or people) or failure to act according to internalized norms of masculinity. "Right anger" is justified, proportionate to the offense, and successful in making its point, as shown in this example:

"The senior pastor had transgressed a significant ethical boundary, and I had an ethical obligation to let that be known. I was trying to do the right thing by putting my anger forward. I confronted him."

The word "control" is ubiquitous in study participants' anger narratives. Having and maintaining control is desirable but difficult to achieve. Men become angry when they do not have the ability to control or "fix" things, whether the things are inanimate objects (computers, cars, or boats) or work-related problems (demanding customers or incompetent co-workers). Illogical actions of other people that are out of the men's sphere of personal control (for example, other drivers) provoke considerable ire, consistent with an implicit "should" that human action should be logical and reasonable. When the initial attempt to gain control is unsuccessful (as when a teacher cannot control defiant students or a father cannot control an unruly child), withdrawal is a common tactic. Many men say they learned to withdraw from a scene of conflict to prevent disastrous actions. Although they had been forced to learn to fight in childhood (encouraged by fathers and peers to demonstrate their aggressive "manliness" and defend themselves from schoolyard bullies), this physicality no longer serves them well in adulthood. They continue to have strong bodily arousal when angry but few available mechanisms to safely discharge the tension. Throwing hammers and hitting computers provides little relief and leaves them feeling foolish afterward.

Commonalities and Differences

These studies demonstrated several commonalities between the anger experiences of men and women. Clearly, traditional gender role socialization for femininity and masculinity does not contribute to intelligent anger management. Both men and women are conflicted about anger, telling their anger stories with embarrassed hesitance and nervous laughter. Regardless of gender, guilt and self-recrimination are frequently reported, especially if anger outbursts caused others pain.

Some gender differences were observed as well. Women frequently used the word "hurt" and had difficulty separating their anger from feelings of "hurt," but very few men ever used the word. Women reported that crying was common while angry; men did not. The bodily experience of anger also differs, as depicted metaphorically. For women, it consisted of a slow-boiling internal agitation; for men, it was a fire or flood that swept them along with its force. While women's anger was provoked mainly within their closest relationships, men's anger was often provoked by strangers, faulty mechanical objects, or global societal issues in which a principle was at stake. These findings are consistent with Gilligan's (1982) conceptualization of differences in the moral reasoning of men and women. She concluded that the morality of men was principled and abstract, focused on obtaining justice, while the morality of women was based on caring relational values.

Nursing Implications

Findings of these studies about anger of men and women in daily life have implications for nurses' ability to interact with angry individuals in health care settings. The modern hospital is a particularly volatile

environment. In studies by this research team, both female and male nurses depicted the workplace as a virtual war zone, using numerous military metaphors: "I become very fatigued by having to do all these battles;" "I was getting flak;" "We feel sabotaged." Adversarial relationships were particularly evident between nurses "in the trenches" and their supervisors, who were perceived to have "deserted the troops" (Brooks, Thomas, & Droppleman, 1996; Smith, Droppleman, & Thomas, 1996). Time pressures, heavy work volume, sensory overload, and the anxiety of dealing with life-threatening crises combine to produce situations in which anger of both staff and patients is readily evoked.

Anger can be a healthy response by a patient whose needs are ignored or a nurse whose assignment is grossly inequitable. More often, however, anger in the health care setting is directed toward inappropriate targets and/or expressed too intensely (as in the common example of a physician yelling in the hallway at a nurse because a lab report is not on a chart). Nurses must be prepared to deal with the anger of patients, family members, physicians, and colleagues -- as well as their own anger. Paralleling the findings in the general population, nurses who were interviewed felt bad about the ways they handled their anger, whether they tended to "stuff" it or to "vent" it (Thomas, 1998).

Anger in Health Care Settings

Patient Anger

Patient and family complaints have been increasing since the ill-conceived staff downsizing and restructuring of the mid-1990s (Shindul-Rothschild, Berry, & Long-Middleton, 1996). When too few nurses are spread too thin, dealing with high-acuity patients and worried families, patients' anger is often vented to their nurses. The anger can be generated by their feelings of vulnerability and powerlessness as they grapple with depersonalized institutional routines, intrusive procedures, and the receipt of bad news about diagnosis, disability, and prognosis. Additional precipitants of patients' anger include (a) unrealistic expectations that their nurse will be a saintly angel of mercy (Muff, 1982), (b) lack of attention to their physical or psychological needs (Shattell, 2002), and (c) failure of health care personnel to recognize their wholeness and uniqueness (Plaas, 2002). Of course, men and women bring with them into health care settings their habitual anger cognitions and styles of managing anger. Based on the above-cited research findings, it is logical to expect that men may become angered by loss of control, inefficiency of the system, and/or lack of staff professionalism, while women may feel both angry and hurt if they perceive staff as uncaring and/or unwilling to take time to listen to them and form a relationship.

Unfortunately, a nurse's response to a patient's anger is often a defensive one that actually fuels more anger. A patient who is in pain, waiting for an analgesic injection, does not want an explanation ("we're short of help; there are other people ahead of you waiting for a shot"); instead, the patient wants reassurance that something will be done ("I'm really sorry that you've had to wait; I will take care of it right now"). Of course there are patients whose demands seem endless, creating aversion in their caregivers. A classic article by Groves (1978) provides advice for dealing with several types of difficult patients, including those he calls the "dependent clingers" and the "entitled demanders." What nurses must understand is that underneath the angry demands are deep fears of abandonment. While negative feelings toward such patients are understandable, and limits should be set ("I will return to check on you in 15 minutes; please don't call again in the interim unless it is an emergency"), the ultimate solution is giving consistent care that alleviates their fear.

Smith and Hart (1994) conducted a study to examine how medical-surgical nurses managed angry patient situations. When patient anger was perceived as a personal attack, nurses tended to disconnect. They did not understand the patient's reality. As their own anger arose, they feared its power and they sought to hide it. They tried strategies such as taking a timeout, transferring blame, seeking peer support, and "returning to smooth," which meant repairing the relationship with the patient. The "smoothing" did not involve talking with the patient about the anger incident, simply acting as though nothing had happened -- a less-than-ideal resolution. A better outcome was achieved by three of Smith and Hart's study participants, who were able to remain connected with the patient, analyze the anger, and not take it

personally. According to the previously cited research of Thomas and colleagues, many people are ashamed after an anger outburst; it logically follows that they may welcome a nurse taking the initiative to clear the air and restore the patient-nurse relationship. Thomas (1998) offers a number of strategies for decreasing patient anger (see [Table 1](#)).

There is always a possibility that a patient's or family member's anger could escalate to violence. It is vitally important to be alert for clenched fists, pacing, and other signs that an individual is becoming increasingly agitated and potentially assaultive. Threats should be taken seriously and communicated to security personnel promptly. Nurses and other health care workers are at high risk for workplace violence because of their extended periods of direct contact with patients and families during very stressful circumstances and their vulnerability when working in small numbers or alone (for example, on night shifts) (Anderson, 2002). Particularly at risk for violence are younger, less-experienced staff and student nurses (Echternacht, 1999). Prior victimization is also a risk factor. In a recent study by Anderson (2002), nurses who had experienced childhood or adult abuse reported that they experienced more workplace violence events than nurses who had no history of abuse.

Roberts (1991) conducted a study of female nurses who had been assaulted by patients. All of the nurses reported long-term consequences for their job performance. Particularly distressing was management's blaming them for the assault. They found themselves labeled as "the nurse who got hit." Management seldom supported prosecution of the attacker, and nurses were reluctant to proceed with legal action on their own. Coping strategies of the nurses were mainly avoidant: minimizing, denying, and forgetting about the assault. The traumatic experiences of these nurses indicate that a great deal needs to be done not only to reduce the violence itself but also its damaging sequelae. All nurses need training in assessing angry individuals and in violence prevention tactics. Violence Prevention Guidelines have been issued by the Occupational Safety and Health Administration. At this writing, it is not known how many health care facilities are in compliance with these guidelines.

Physician Anger

Another manifestation of dysfunctional anger in health care settings is the oft-reported verbal abuse of nurses by physicians. Physician-perpetrated abuse was more common in Anderson's (2002) study than abusive acts by patients. In a study by Manderino and Berkey (1995), 90% of a sample of staff nurses said they experienced verbal abuse by physicians during the past year.

Participants in the author's studies of female and male RNs (Brooks et al., 1996; Smith et al., 1996) reported disrespectful treatment, criticism, attacks, tirades, and baseless accusations from physicians. Their own words powerfully depict what they experienced. Nurses said that they were "lambasted," "thrashed," "picked on," "belittled," and "lectured." Typical was the following report by a male nurse who had been accused by a physician of something he had not done:

"He thrashed me verbally in front of my peers...I thought, I just can't take this professional abuse...very frustrating to not be able to prove that I hadn't done it...feeling helpless and not being able to defend...not being able to resolve it" (Brooks, 1996, p. 13).

At the moment of such an angry attack by a physician, the nurse's feelings of helplessness are understandable. The attack is often unexpected as well as unfair. But nurses must learn to cope effectively with physician temper tantrums, not only to preserve their own self-esteem but also to prevent adverse consequences for patient care. Researchers found that when doctors acquire a reputation for tantrums, nurses hesitate to call them about a patient or make suggestions about the patient's care (Diaz & McMillin, 1991). Suggestions about how to deal with verbal abuse are listed in [Table 2](#).

Anger of Nurses at Each Other

One of the most disturbing aspects of the research data on nurses' anger was the vehemence of their

anger at each other. Words taken verbatim from the interview transcripts illustrate how nurses wound each other with words: "faultfinding," "bickering," "backbiting," "needling," "snapping," and "cutting" (Brooks et al., 1996; Smith et al., 1996). More subtle manifestations included damaging gossip, nonverbal signals, and chilly silence. These hurtful behaviors are manifestations of a phenomenon called *horizontal violence* or *horizontal hostility* (Muff, 1982). Horizontal hostility is a characteristic of oppressed groups who fight among each other because they cannot vent anger at those in power; in the case of nurses, those in power include physicians, supervisors, and administrators. Despite many notable advances in the nursing profession, the majority of nurses still work in hospitals or other facilities with a hierarchical system, where there are one or more levels of personnel above them. There are even hierarchies within nursing itself, based on degrees, certifications, or nursing specialty. For example, in the study by Smith et al. (1996), critical care nursing was viewed as a higher status specialty than maternal-child or psychiatric nursing. Study participants related this hierarchical ordering to the amount of technology employed in patient care.

Some believe that horizontal hostility occurs in nursing because nurses are predominantly women, "trained from birth to be passive-aggressive," as one nurse described it (Smith et al., 1996, p. 28). It is true that nursing traditionally has been viewed as "women's work," devalued in a patriarchal culture just as women themselves have been. It is also true that passive-aggressive behaviors are evident in other female-dominated occupations. But it became clear in the study of male RNs that they too made disparaging remarks about colleagues and experienced verbal attacks from supervisors and co-workers. Horizontal hostility does not occur just because most nurses are women; it occurs because all nurses -- male and female -- have been oppressed. While some authors exhort nurses to develop a positive professional identity (Roberts, 2000) or make a personal declaration "I elect not to be oppressed" (Kritek, 1999), these measures alone will not suffice because oppressive conditions continue to exist.

Nursing Anger

Oppressive conditions present nurses with justifiable reasons to feel anger and hostility. In their work environments they are often prevented from meeting their physical needs (breaks and meals), personal needs (scheduling), and professional needs (autonomy over practice and administrative support) (Carlson-Catalano, 1990). Forced cross-training and mandatory overtime contribute to a sense of oppression. There is a widespread perception that management is nonsupportive. A massive five-country study of 43,000 nurses found that fewer than half of the nurses reported that management in their hospitals was responsive to their concerns, provided opportunities for them to participate in decisions, and acknowledged their contributions to patient care (Aiken et al., 2001). Nurses in the author's studies, as well as those surveyed recently by Fletcher (2001), decried the lack of support from their immediate supervisors. Perhaps the most deeply distressing consequence of the unsupportive environment was the general feeling that they could not provide the kind of patient care they wanted to give because of insufficient time and resources (Brooks et al., 1996; Smith et al., 1996). One study participant said she felt like the character in the fairy tale Rumpelstiltskin who was put in a room full of straw every night and told to produce gold (Smith et al., 1996).

There is no question that nurses have legitimate cause to be angry, given these egregious violations of their workplace rights and professional values, but there is abundant evidence that much of their anger is mismanaged. Taking it out on each other is destructive and will never lead to problem solving. In fact, it is leading to exodus from the profession. A study of nurse burnout showed that nurses with the highest burnout scores reported the greatest amount of conflict with other nurses (Hillhouse & Adler, 1997). Conversely, group cohesion strongly influences job satisfaction (Lucas, Atwood, & Hagaman, 1993). The more a nurse perceives support from colleagues, the less he or she burns out (Duquette, Kerouac, Sandhu, & Beaudet, 1994).

In the concluding section of this article, general strategies for managing anger will be described. However, dealing with the horizontal hostility in nursing requires more than learning effective anger management. There must be healing of the emotional pain that has been inflicted by all of the sniping and

backbiting. Thomas (1998) recommends that nurses make a commitment to supportive collegiality, reach out to one another, share of themselves, listen to their colleagues as they disclose their real selves and honest opinions, and then respond with warmth and empathy -- especially in times of discouragement and distress. Nurses should refuse to get caught up in workplace negativism or destructive gossip. They should congratulate colleagues who obtain promotions, certifications, and advanced degrees. Nurses could institute "wellness days" for their workgroups (Extended Services Team, 1997), and socialize in hikes or picnics outside the workplace to build team camaraderie. If there is festering conflict about a specific issue, a psychiatric nurse specialist could lead a series of meetings with nurses on the unit. Brandman (1996) provides an excellent example of a conflictual situation in a neurologic intensive care unit that was ameliorated by a series of six 1-hour sessions every other week, in which anger and pain were processed with the guidance of the psychiatric nurse specialist.

Research-Based Anger Management Strategies

The cardinal principles of anger management are (a) taking constructive action on the precipitants of anger whenever possible, and (b) when no constructive action is possible, finding healthy ways to discharge the strong physiologic arousal of anger through exercise, laughter, or calming techniques such as meditation (Thomas, 2001). Habitual anger suppressors (often female) may need to learn that honest expression of feelings need not damage relationships. Habitual anger venters (often male) may need to learn that judicious use of assertive behavior gets better results than yelling or cursing. Research shows that there are notable health benefits of simply talking over an anger incident with a supportive listener, even if the individual cannot talk directly to the provocateur because of status differences (supervisory personnel) or because of situational constraints (inappropriate time and place). Individuals who regularly discuss anger episodes with a confidant have lower blood pressure and better general health status (Thomas, 1997). Anger discussion is correlated inversely with stress (Thomas & Donnellan, 1993) and depression (Droppleman & Wilt, 1993); in other words, less stress and depression are experienced when the individual discusses anger rather than harboring it and ruminating about it. Additionally, Ausbrooks, Thomas, and Williams (1995) found that anger discussion is positively correlated with a stronger sense of self-efficacy and optimism. Talking out anger incidents with a confidant yields other benefits as well. Insight into the dynamics of the interaction may be developed from a review of the incident, and after doing so, a plan may be generated to solve the problem (Thomas, 1998).

Increasing personal skill in conflict resolution is valuable both for an individual nurse and for the organization in which the nurse works. A critical analysis of research on nurses' conflict-management strategies revealed that the two predominant strategies were avoiding and compromising (Valentine, 2001), although the most effective strategy would be collaborating (Marriner-Tomey, 1995). Valentine attributed nurses' underuse of collaborating to (a) their perceived power differential with regard to physicians and administrators, and (b) their lack of self-confidence. She also speculated that nurses may doubt that conflict presents an opportunity to learn to resolve issues.

Many nurses could benefit from developing increased skills in assertiveness, bargaining, and negotiating. Classes at a community college in speech or debate techniques can be helpful in learning how to mount an argument and deliver it persuasively. Such classes frequently involve videotaping so the individual can learn to minimize distracting mannerisms that undercut personal effectiveness. As always, new skills must be practiced; professional organizations provide the perfect opportunity to do so. An added benefit is joining forces with other nurses who care about the same workplace issues, such as unsafe conditions and ill-conceived policies.

Counseling is recommended for individuals whose anger is intense and chronic. There is empirical evidence that cognitive-behavioral therapies are efficacious in reducing irrational thoughts and ineffective response patterns (Deffenbacher, 1995). Individuals whose gender role socialization inculcated dysfunctional anger management patterns may want to avail themselves of women's groups or men's groups that assist in exploring new conceptualizations of femininity and masculinity. When grievances are of long duration, as in the case of the nurses whose management did not support them when they

experienced a patient assault, it may be time to relinquish the resentful feelings through forgiveness. Forgiveness does not mean condoning the wrongful actions of another; it means liberation from carrying the heavy burden of old anger, bitterness, and sadness (Thomas, 1998). Significant reductions in long-held anger have been achieved by highly structured small-group forgiveness interventions (Thoreson, Luskin, & Harris, 1998). There are a number of healing rituals that individuals can undertake on their own as well (Thomas, 1998).

Conclusion

Once educated about anger and empowered to act appropriately on behalf of his or her rights as a human being, each nurse has a vital obligation to the profession. Each has a part to play in creating a more humane and satisfying workplace, and ultimately, a more powerful profession. Anger and conflict will always be present in the stressful health care delivery environment. However, intelligent management is possible -- and indeed, urgently needed.

Tables

Table 1. Decreasing Patient Anger

- While remaining calm and speaking softly, help the patient to discover why he or she is angry.
- Validate the patient's complaint ("I can see why you are upset") and then focus on what can be done to address it.
- Set limits on inappropriate anger expression (such as profanity) and teach the patient how to communicate concerns in a more effective, assertive manner.
- Use consultants in your facility, such as a psychiatric liaison nurse, social worker, psychologist, or chaplain if you are at your wit's end dealing with an angry, demanding patient.
- Consider rotating the nurses assigned to the patient or recruiting volunteers to spend time with him or her.

Table 2. Dealing with Verbal Abuse by Physicians

- Remember that you are not responsible for the abuse and need not defend yourself. It does not matter what alleged acts of omission or commission provoked the doctor, you do not deserve to be yelled at or insulted.
- Set firm limits on abusive behavior by forcefully saying, "Don't talk to me that way!"
- Ask colleagues to support you. In some institutions, nurses call a special "code" when a colleague is being verbally abused: All come to stand with the nurse in support.
- Be aware that you can leave an abusive situation. You do not have to remain and endure unacceptable behavior.
- Resolve never to allow a physician to verbally abuse you in front of a patient.
- Use the appropriate channels in your workplace to report incidents of harassment and intimidation (encouraged in the military).

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