

Transforming from victim to survivor—Part 1: Strategies for clinicians to safeguard themselves, colleagues, and patients from disruptive intraoperative behaviour

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Abstract

Disruptive intraoperative behaviour is pervasive and harms clinicians, patients, and institutions. Clinicians exposed to disruptive behaviour inadvertently become parties to an interpersonal conflict. While previous reviews focused on antecedents and consequences of disruptive behaviour, we adopt a conflict resolution perspective to (1) equip clinicians to maintain their well-being when faced with disruptive behaviour; and (2) outline how clinicians can respond to prevent escalation while not reinforcing the behaviour.

Clinician responses start with cognitive appraisals, which determine the psychological impact of disruptive behaviour. Clinicians can improve their appraisals using situational awareness, cognitive reappraisal, and grounding techniques. Over the long term, clinicians can use adaptive coping mechanisms, characterized by a “survivor” mindset, and avoid maladaptive strategies, characterized by a psychologically harmful “victim” mindset. Clinicians must be mindful of the roles they assume in conflicts. Manipulative and malicious responses turn clinicians into accomplices or retaliatory offenders, while overusing passive responses risks relegating them to being enabling bystanders. Instead, clinicians should respond assertively, which transforms them into upstanders. Successful assertive efforts involve refocusing attention, avoiding flash escalation, using structured communication tools, setting clear boundaries, and practising these skills via simulation. By adopting these micro-level interventions, clinicians can help cultivate a respectful OR culture and safeguard their well-being.

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Introduction

Shouting, throwing objects, bullying – these are examples of disruptive behaviour occurring in the operating room (OR). Ranging from mild incivility to outright abuse (Villafranca, Hamlin, & Jacobson, 2017), disruptive behaviour is formally defined as any interpersonal behaviour that makes victims and witnesses feel threatened and violates the way a reasonable person would want to be treated (Villafranca, Hamlin, Enns et al., 2017). Regrettably, this behaviour still occurs in healthcare, and most clinicians will observe it during their careers (Colaprico et al., 2023; Goh et al., 2022; Gupta et al., 2024; Hicks & Stavropoulou, 2022; Pogue et al., 2022; Rosenstein & O’Daniel, 2006; Trépanier et al., 2016; Villafranca et al., 2024). Recently, we found that 98% of healthcare workers report exposure to disruptive intraoperative behaviours (Villafranca et al., 2019).

These behaviours are not just passing inconveniences; they negatively affect various individuals within the OR. They diminish the psychological and physical well-being of victims and witnesses. Psychologically, clinicians can experience decreased confidence and motivation (Goh et al., 2022), and increased depression (Goh et al., 2022; Hawkins et al., 2019; Hutchinson & Jackson, 2013; Lever et al., 2019; Villafranca, Hamlin, Enns et al., 2017), anxiety (Goh et al., 2022; Hawkins et al., 2019; Hutchinson & Jackson, 2013; Villafranca, Hamlin, Enns et al., 2017), and burnout (Hawkins et al., 2019; Villafranca, Hamlin, Enns et al., 2017). Physically, clinicians may experience headaches, sleep disorders (Lever et al., 2019; Karatuna et al., 2020), fatigue, gastrointestinal issues, and increased risk of tachycardia

and hypertension (Goh, et al., 2022; Karatuna et al., 2020). Disruptive behaviour also can diminish clinicians' work quality, since it can undermine communication, teamwork, clinical decision making, and technical performance (Hicks & Stavropoulou, 2022; Johnson & Benham-Hutchins, 2020; Villafranca, Hamlin, Enns et al., 2017). Decreased work quality affects patient safety and care (Cochran & Elder, 2015; Moreno-Leal et al., 2022; Pogue et al., 2022; Shafran et al., 2023). Specific safety concerns reported include patient falls, medication errors, patient dissatisfaction, and even mortality (Goh et al., 2022; Houck & Colbert, 2017). Ultimately, disruptive behaviour can affect institutions by decreasing clinician work satisfaction and increasing the risk of staff turnover, thereby increasing recruitment and retention costs (Goh et al., 2022; Hawkins et al., 2019; Trépanier et al., 2016; Villafranca, Hamlin, Enns et al., 2017).

Previous literature often centred on the “disruptive clinician” (Dang et al., 2015; Walrath et al., 2013), sometimes specifically the “disruptive surgeon” (Cochran & Elder, 2014, 2015), and how to prevent and manage such individuals' poor behaviour (Hastie et al., 2020; Schaeffer, 1989). This perspective has merit, given that the disruptive clinicians are the minority (Hamlin et al., 2016; Panagioti et al., 2019), and some disruptive behaviours represent “never” events (e.g., sexual harassment, bigotry, etc.; Hicks & Stavropoulou, 2022).

Clinical conflict resolution models recognize clinicians inadvertently become part of a conflict when exposed to disruptive behaviour. Furthermore, interactions amongst clinicians can contribute to escalating conflict (Fiester, 2015; Hocker et al., 2017), partly due to clinicians shifting their role in the conflict from victim to retaliatory aggressor (Villafranca et al., 2024), or from bystander to accomplice (Dirican et al., 2022). Thus, clinicians must be made aware of their possible roles in the interaction and be equipped to respond to disruptive behaviour in a manner that both safeguards their psychological well-being and avoids the extremes of deferential passivity or reactive aggression.

Our review adopts a conflict resolution perspective and presents tools to deal with disruptive behaviour in real time. Our specific purposes were to 1) provide clinicians with strategies to maintain well-being when dealing with disruptive behaviour; and 2) outline responses to disruptive behaviour that avoid escalation without enabling the behaviour. By integrating these strategies, clinicians can reduce the incidence and impact of disruptive behaviour, making operating rooms safer for patients and staff.

Mind Over Mayhem: Cognitive appraisals and coping strategies to protect your wellbeing

When a clinician faces a stressful situation, such as a conflict, they make sense of it through the automatic process of cognitive appraisal, which determines how they respond to the

event—physiologically, emotionally, and behaviourally (Lavoie et al., 2021). Importantly, appraisals of the same situation vary among people, and can be modified to support mental health, since, over time, appraisals can affect an individual's health and well-being.

Cognitive appraisals are made in steps (Lavoie et al., 2021). Imagine a nurse overhears another clinician making an ambiguous comment about them. First, the overhearing clinician makes a primary appraisal to evaluate whether the event poses a threat to their well-being or goals (Spătaru & Maricuțoiu, 2024) and determines the size and immediacy of that threat. In this case, was the comment intentionally insulting? Could it threaten their reputation? Next, the clinician makes a secondary appraisal to assess what can be done (Lavoie et al., 2021), and whether they have the resources to deal with the present threat. In this case, the clinician considers which actions might resolve the problem and protect their psychological well-being. This informs their emotional response (Yeo & Ong, 2024), their level of stress (Fernandez De Henestrosa et al., 2023), and their behavioural response.

A cognitive appraisal of a stressful situation is positive when the clinician interprets the event as a manageable challenge or an opportunity for growth, thereby mitigating stress (Riepenhausen et al., 2022). A positive appraisal recognizes legitimate threats, while avoiding common cognitive biases, such as catastrophizing (i.e., exaggerating the probability or severity of negative outcomes) and filtering out the positive (i.e., focusing only on negative aspects of the situation). Such biases can cause ambiguous stimuli to be interpreted as threatening or make minor threats appear larger, contributing to burnout (Ayele & Barchard, 2024). Conversely, a negative appraisal is a biased interpretation of the situation, which amplifies stress and negative emotions (Krackow & Rudolph, 2008) and increases the risk of psychological sequelae after the event (Espejo et al., 2012; Nanney et al., 2015; Samuelson et al., 2021).

Improving cognitive appraisals

As a perioperative clinician, you can take practical, self-guided actions to improve your appraisals and safeguard your psychological wellbeing against such stressors as disruptive behaviour. You can improve your situational awareness, conduct in-the-moment cognitive reappraisals, and ground yourself when strong emotions arise. This involves three factors: perceiving key elements in the environment, recognizing their significance, and predicting future outcomes using that understanding. Most errors occur with the first factor (Jones & Endsley, 1996), due to inattention, failure to seek necessary information, ignoring useful information already available, or failing to update information when situations change. Flawed perceptions lead to flawed cognitive appraisals.

The simplest way for an OR clinician to improve their situational awareness is to regularly scan the OR, looking for environmental

stressors (e.g., time pressure, equipment issues, case complexity), changes in team communication, and other interpersonal dynamics. This helps clinicians promptly recognize disruptive behaviour and properly assess threats to patient care.

Cognitive reappraisal happens when a clinician intentionally reinterprets a distressing situation, such as exposure to disruptive behaviour, to try to improve its emotional impact (i.e., increasing positive emotion, while decreasing negative emotion). To do this, they reframe the event in a neutral or even positive light (National Health Service, n.d.). This does not require suppressing emotions, but rather changing the emotional reaction to the event before the full emotional response happens (Denson & Fabiansson, 2023; Gross & John, 2003).

There are numerous techniques to do this. One method involves challenging upsetting thoughts using cognitive behavioural therapy (CBT) techniques, such as the catch, check, change strategy: *catch*—identifying negative thoughts as they arise; *check*—reflecting on the thought's accuracy and usefulness; and *change*—changing to a more accurate and/or helpful one. Remember, thoughts are not facts and not all factual thoughts are useful; for example, cognitive distortions associated with poor appraisals are unhelpful thoughts.

Decentering, a related technique, is when you notice your thoughts, but don't identify with them immediately or uncritically (Pollard & Foreman, 2011) and adopt a more mindful and detached perspective, instead. A common mantra from this perspective is: "I am not my thoughts—I am observing them" (Pollard & Foreman, 2011). Such psychological distancing helps separate your thoughts from your identity, which decreases their emotional weight (Bennet et al., 2021).

If an overwhelming emotional reaction takes hold, grounding techniques can help shift your attention away from distressing thoughts and back to the present, typically by focusing on one or more of the five senses. For example, the 5-4-3-2-1 technique involves shifting your attention to the immediate environment, and identifying five things you can see, four things you can hear, three things you can touch, two things you can smell, and one thing you can taste. Such activities can reduce both anxiety and dissociation (Center for Substance Abuse Treatment, 2014).

Self-labeling and coping

While the above techniques help you manage appraisals and stress in the moment, repeated exposure to disruptive behaviour can lead to further issues, such as harmful self-labels and poor coping. Self-labels are identities individuals adopt after internalizing repeated events, such as ongoing personal exposure to disruptive behaviour. For example, a clinician might come to label themselves as a "victim" if they feel consistently powerless against disruptive behaviour, or as a "survivor" if they reframe the problem as an opportunity for growth.

While a clinician's perception of an event's magnitude can affect its impact on their health and wellbeing, their chosen self-label can affect these outcomes independently. Identifying as a victim or survivor shapes a clinician's resilience in both their professional and personal lives (Kets de Vries, 2012; Munroe et al., 2021). Identifying as a victim may be beneficial initially by motivating the clinician to seek help; however, it can become detrimental if adopted over the long term (Ben-David, 2020). For instance, if the "victim" label becomes part of the clinician's self concept, it can hinder recovery and prolong psychological distress (Ben-David, 2020). These individuals become what psychologist Sarah Ben-David calls "career victims", who experience persistent feelings of powerlessness and learned helplessness (Ben-David, 2020). Learned helplessness is feeling powerless to change negative situations (even if you can), which leads you to abandon efforts to change them (Ben-David, 2020). In addition, both negative cognitive appraisals (Bityutskaya & Korneev, 2021) and self-labelling as *victim*, can lead to poor coping strategies (Riepenhausen et al., 2022).

Coping is defined as thoughts and behaviours people adopt to manage stress (Folkman & Moskowitz, 2004). Adaptive coping strategies have positive physical, psychological, or social consequences (Algorani & Gupta, 2023; Holahan et al., 2021). This includes actions that successfully address the cause of the distress, such as problem-solving, information seeking (Algorani & Gupta, 2023; Holahan et al., 2021), and actions that successfully decrease the emotional distress associated with the situation, such as cognitive reframing, acceptance, and the use of humour (Algorani & Gupta, 2023). A survivor mindset is often associated with these adaptive coping strategies, especially those related to problem-solving (Munroe et al., 2021).

In contrast, maladaptive strategies can worsen mental health and increase the incidence of psychopathological symptoms (Algorani & Gupta, 2023; Stallman, 2020). Some strategies, including denial or wishful thinking, do not address the situation (Holahan et al., 2021). Others, including avoidance, escapism, and emotional suppression, do not reduce stress in a sustainably healthy way (Algorani & Gupta, 2023). A victim mindset is associated with these passive coping strategies (Kets de Vries, 2012). While occasional use of a maladaptive behaviour may be harmless, it becomes detrimental if established as a habit. Thus, clinicians should attempt to cope with disruptive behaviour adaptively and should adopt a survivor mindset to best recover from, and build resilience against future exposure to disruptive behaviour.

Improving coping

While acute techniques, such as cognitive reappraisal and grounding, are critical for managing immediate emotional responses to disruptive behaviour, long-term resilience depends on intentional use of adaptive coping strategies.

Clinicians can monitor and adjust their coping strategies, combining in-the-moment techniques with routines that promote good physical, emotional, and social well-being.

Consistent self-care is an essential component of long-term adaptive coping. This includes habits that promote health, well-being, and resilience (National Institute of Mental Health [NIMH], 2024), such as a nutritious diet, regular physical activity, adequate sleep, stress management, and keeping close connections with family and friends (International Self-Care Foundation [ISF], 2025). Also, clinicians can routinely reassess their coping strategies and seek professional support when needed. By combining these practices with the acute strategies discussed earlier, clinicians can encourage a survivor mindset that minimizes the impact of disruptive behaviour.

De-escalation without defeatism: Responding to disruptive behaviour in real time

Since clinicians exposed to disruptive behaviour inadvertently become part of the conflict, their reactions can make the situation worse or better. During conflicts in the OR, the key priorities should be safeguarding the patient, preventing harm to yourself and colleagues, and avoiding damaging relationships between team members. This involves de-escalating while not reinforcing the behaviour.

Response strategies and roles within a conflict

Looking at disruptive behaviour as a conflict, there are typical roles individuals adopt. The aggressor is the main clinician who is acting disruptively. The victim is the person to whom the disruptive behaviour is directed. Bystanders are clinicians who witness the behaviour but take no action. Accomplices are clinicians who see the event and elect to contribute to, or at least enable the behaviour. And finally, upstanders are people who witness the behaviour and “intervene on behalf of [the] person being attacked or bullied” (Oxford Languages Dictionary, n.d.), thereby standing up against injustice and mistreatment (Canadian Museum for Human Rights, 2019). Our previous research identified four common ways that clinicians respond to disruptive behaviour: assertively, passively, manipulatively, or maliciously (Villafranca et al., 2021). Each of these response strategies involves adopting a particular role and can be evaluated based on whether it would be a productive response to disruptive behaviour.

Passive responses involve acquiescing to the disruptive clinician's demands, ignoring and accepting the behaviour, or avoiding confrontation (Villafranca et al., 2021). This is the strategy of a bystander. Using this strategy is acceptable or even wise when the disruptive behaviour is inconsequential; the problem is that many clinicians use this strategy most of the time, or nearly exclusively (Villafranca et al., 2024). This normalizes and reinforces the disruptive behaviour (Canadian Medical Protective

Association [CMPA], 2023; Stone et al., 2023), thereby increasing both the number of disruptive events and the risk of cumulative psychological harm. It also could embolden the disruptive clinician, resulting in progressively more egregious behaviour. Passive responses pose an acute risk to patients, since common avoidant behaviours include decreased communication between team members, and acquiescent behaviours include unindicated alterations in care (representing undermined clinical decision-making; Villafranca et al., 2024). Individuals who adopt this strategy are more likely to never report disruptive behaviour (Fast et al., 2020), which jeopardizes management's ability to identify and address the issue promptly.

The opposite extreme is responding to the behaviour maliciously by adopting such destructive behaviours as victim blaming, threatening, or using physical force against the offender (Villafranca et al., 2021). When a clinician victim blames, or otherwise supports, enables, or justifies the disruptive behaviour, they become accomplices in the conflict. When they react threateningly or violently toward the aggressor, they become aggressors themselves through their retaliatory actions. Confrontations between two or more clinicians who are acting disruptively can lead to escalatory spirals, in which aggressive actions trigger increasingly hostile responses in a tit-for-tat exchange (Hocker & Wilmot, 2017). Only a minority of clinicians resort to these extreme actions, yet each incident risks the safety of everyone in the OR, and the integrity of professional relationships. This culminates in increased disciplinary risk to the responding clinician, as well as increased legal risk to the clinicians and healthcare organizations.

Similarly concerning are manipulative responses, involving mobbing (i.e., a clinician attempts to turn others against the aggressor), or attempting to either annoy or mislead the aggressor (Villafranca et al., 2021). A clinician adopting this response strategy may engage in covert actions that qualify as retaliatory disruptive behaviour, thereby turning themselves into offenders. If the manipulation is uncovered, it can escalate the conflict and severely undermine trust between clinicians (Bies, 2015). Furthermore, if the deception by the responding clinician poses a risk to the patient (e.g., misleading the offender about the clinical care provided), it could also pose an acute legal risk to the responding clinician and to their employing institution. Despite this, around 4% of clinicians report using this strategy recently (Villafranca et al., 2024).

The most desirable of the four response strategies is responding assertively by using a variety of actions to try to modify, replace, or prevent the disruptive behaviour (Villafranca et al., 2024). A clinician who adopts this response strategy is acting as an upstander, regardless of whether the behaviour is directed toward them or others, because in either instance they are intervening on behalf of the patient. When assertiveness techniques are chosen and implemented judiciously,

they can prevent escalation or even de-escalate the situation, set appropriate boundaries, and reduce the likelihood that the behaviour is repeated.

Techniques to respond more assertively

Specific strategies can be used to ensure responses are more consistently assertive, without becoming malicious or manipulative. These include using de-escalation techniques, setting clear boundaries, grading your response based on the magnitude of the issue, and practising all these techniques in pre-planned simulations.

It is critical to recognize that conflicts can become immediately and substantially worse, through what clinical conflict expert Autumn Fiester (2013, 2015) terms “flash escalation”. In such situations, tensions and emotions quickly increase (like adding dry tinder to a flame), making it more difficult to resolve the conflict (Fiester, 2013, 2015). This occurs as a result of a small action or off-hand statement, which could be made with neutral or even good intentions, yet includes statements that may dismiss or trivialize the concerns of the offender (e.g., “You need to calm down right now”), statements that offer either qualified or insincere acknowledgement (e.g., “I see what you mean, but...”, or “Ok, ok, we all understand that you need attention...”), statements that are insulting (e.g., “You are acting like a crazy person!”), and statements that amount to public finger-wagging toward an upset and potentially volatile person (e.g., “How dare you do that!”; Center for Bioethics, 2017, 2024). Such statements might help clinicians vent frustration, yet predictably they make the situation worse. Refocusing and using structured communication tools effectively avoids flash escalation and might even de-escalate, postpone, or stop the conflict.

Refocusing involves using different techniques to “disrupt the disruptive behaviour” by deliberately redirecting attention away from the conflict and back to the patient, thus supporting the primary goal—patient care and safety. This can be achieved by using direct verbal cues (e.g., “Keeping our focus on this task is critical, since it could really affect the patient”), non-verbal cues, such as a directing gesture toward the patient or passing an instrument, and even cautiously using humour to reduce tension (Hastie et al., 2020). To avoid appearing dismissive, these actions ideally should be preceded by an acknowledgement that a conflict is occurring and that the offending clinician is airing a grievance (Fiester, 2012, 2015). Fiester recommends including three components in this acknowledgement (Center for Bioethics, 2017):

1. A statement of assent: Validate the person’s perspective and emotions, even if the grievance itself isn’t valid. For example, “I understand what you are saying, and I see why you would be upset”.
2. A statement of consolation: Express sympathy and regret for the situation (especially its emotional impact), regardless of who is at fault. For example, “I am sorry that this situation has stressed you out and made you upset.”

3. A statement of culpability: Acknowledge how your actions/inactions (or those of others) could have contributed to the problem. For example, “I recognize that my speaking loudly probably added to your stress.”

This acknowledgement is meant to reduce tension and avoid escalation, so that the non-offending clinicians maintain control of the situation.

It is also useful to use structured communication tools, or at least preplanned phrases, to facilitate communicating during high stress situations (Healthcare Quality Council of Alberta, 2013; Tso et al., 2023). Such tools can standardize responses to disruptive behaviour, thereby reinforcing institutional expectations (The Joint Commission, 2019). They minimize the impact of personal biases and strong emotions, which can cause unwise and impulsive behaviour (The Joint Commission, 2019). They also allow the purposeful, advanced selection of words that are clear, precise, and non-judgemental, thereby reducing the risk of ill-chosen extemporaneous phrases (Healthcare Quality Council of Alberta, 2013). Further, using the team’s agreed upon phrases or gestures quickly flags the disruptive behaviour without making the conflict personal. Examples of structured communication tools meant to enhance clarity, assertiveness, and timeliness include CUS (Concerned, Uncomfortable, Safety; Agency for Healthcare Research and Quality, 2023), SBAR (Situation, Background, Assessment, Recommendation; Agency for Healthcare Research and Quality, 2019), DESC (Describe, Express, Specify, Consequences; The Government of South Australia, n.d.) and PACE (Probe, Alert, Challenge, Emergency; Psych Safety, 2024). Resource kits, including tips and tools to develop your own preplanned phrases, are also available (Healthcare Quality Council of Alberta, 2013).

When selecting a response, ensure you set appropriate boundaries that do not reinforce the behaviour or undermine patient safety. These can be physical boundaries (touch, space, and physical interactions), intellectual boundaries (topics of conversation and how your intellectual input is respected), emotional boundaries (emotional disclosure, labour, and closeness), and time boundaries (how and when others can use your time, and how you choose to spend your time; Tawwab, 2021).

Critically, clinicians can set boundaries about how they want to be treated and what they expect to happen after experiencing disruptive behaviour. For instance, a time boundary may involve delaying discussions related to the behaviour until after the situation has calmed down (Royal College of Surgeons of England, 2021; Tso et al., 2023). To set boundaries effectively, start by identifying personal and professional limits based on priorities and values (Herbst et al., 2023). Next, define what these limits entail, (i.e., responsibilities you are willing to undertake, and actions you are willing to accept; Herbst et al., 2023; Tso et al., 2023). Clearly communicate

these expectations to others to avoid confusion (Herbst et al., 2023; Tso et al., 2023), and when communicating, speak assertively and respectfully, keeping the message direct without over-explaining (Herbst et al., 2023). It is critical that, once set, boundaries are enforced with any violations acknowledged and addressed, while remaining professional (Herbst et al., 2023). Finally, clinicians are encouraged to reassess regularly and adjust their boundaries as needed, seeking support from mentors or peers when necessary (Herbst et al., 2023).

A graded response to disruptive behaviour is appropriate, given differences in severity (Royal College of Surgeons of England, 2021). By matching the response to the seriousness and time-sensitivity of the behaviour, the team can avoid underreacting or overreacting and, as possible, preserve professional relationships, while ensuring harmful behaviours are stopped and subsequently reported through official channels. We recommend the following approach. For minor issues, consider brief, private conversations that occur immediately after the event. By following up, you demonstrate that you take the issue seriously. By having this conversation in private, you avoid publicly embarrassing the individual while graciously not escalating the incident through formal reporting channels. For serious disruptions, or repeated events, the behaviour must be documented and then reported through proper channels. For egregious behaviour, immediate intervention is likely needed, using clear “stop the line” language, if patient safety is at risk. It also may be necessary to call security if there is a risk of physical harm due to violence or aggression, since that can facilitate removal of the offender and others from the interaction (Royal College of Surgeons of England, 2021). Many other graded models of both individual responses and disciplinary actions by management have been proposed (Hastie et al., 2020; Hickson et al., 2007; Royal College of Surgeons of England, 2021).

Simulation is underused to help clinicians improve their responses to disruptive behaviour (Lynch, 2020). It presents a safe and controlled environment where clinicians can practise a range of skills in realistic scenarios and respond without putting patients at risk. Group simulation is especially useful for improving how teams communicate, thereby enhancing team coordination. An immediate debriefing session should be included so participants receive constructive feedback on their responses and can make inquiries about their cognitive appraisals. Programs including TeamSTEPPS® and Crisis Resource Management have provided solid evidence that simulation training can improve decision-making and leadership, in turn promoting patient safety.

Conclusion

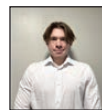
This review focuses on the often-overlooked importance of micro-level solutions to disruptive behaviour, and the value gained by adopting a conflict resolution perspective. By

managing their own cognitive appraisals, clinicians can actively protect their psychological wellbeing and build resilience against repeated exposure. This involves building situational awareness, reappraising stressful situations, grounding attention to the present moment, and using adaptive coping strategies that promote a survivor mindset. Moreover, by avoiding passive, malicious, and manipulative reactions and, instead, responding assertively, clinicians can de-escalate conflict, enforce boundaries, and act as upstanders. Simulation training and structured communication tools can help internalize these practices, making them accessible under pressure. With these actions, clinicians are better prepared to disrupt the cycle of disruption and, in doing so, protect both themselves and the patients they serve. Future research should refine these strategies and assess their long-term impact on clinical practice and OR culture.

Author Notes



Alexander Villafranca, PhD, is an Assistant Professor at the University of the Fraser Valley. He studies interpersonal dynamics and moral reasoning in high-stress healthcare contexts and holds a PhD in Empirical Bioethics. His work has been cited more than 1,200 times and has gained attention on social media, with articles reaching Altmetric scores in the 95th to 97th percentile of over 20 million ranked studies. His research has also been featured by media outlets, including the Canadian Broadcasting Corporation, CTV News, and the Winnipeg Free Press.



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She has worked as a perioperative clinical nurse, clinical resource nurse, perioperative nurse educator, and nurse manager, and is currently the Nursing Professional Lead for the Winnipeg Health Region. Previously, Lesia acted as an executive member of the Manitoba Operating Room Nursing Association. Lesia is passionate about perioperative nursing and the role we play in providing excellent patient care.

Conflicts of interest

None declared.

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Contribution and CRediT Statement

Alexander Villafranca: Created the idea for the review, developed the literature search strategy, provided supervision, reviewed and organized some of the source material, drafted sections of the paper, critically edited the manuscript for intellectual content, coordinated the timeline, submission process, or responses to reviewers, and reviewed and approved the final manuscript.

Brett Adams: located relevant academic literature, reviewed and organized some of the source material, drafted sections of the paper, helped address reviewer comments, reviewed and approved the final manuscript.

Owen Krestow: located relevant academic literature, reviewed and organized some of the source material, drafted one section of the paper, reviewed and approved the final manuscript.

Alison Forest: helped plan the review article, critically edited the manuscript for important intellectual content, reviewed and approved the final manuscript.

Lesia Yasinski: helped plan the review article, critically edited the manuscript for important intellectual content, reviewed and approved the final manuscript.

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