Transforming from victim to survivor—Part 2: Fixing the systems that enable disruptive intraoperative behaviour

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Abstract

Disruptive intraoperative behaviour is prevalent and consequential. It undermines patient care, sets a poor example for medical students, and erodes clinician wellbeing. Part 1 of this article series emphasized the importance of micro-level solutions, including proper appraisals and behavioural responses by victims and witnesses. However, focusing exclusively on clinician-level strategies puts undue responsibility on those individuals already affected. Part 2 focuses on the broader systems that allow disruptive behaviour to persist and, more importantly, how they can be changed. Specifically, this article explores how systems of hiring, education, mentorship, and cultural reinforcement shape the clinical environment and can either enable or prevent unprofessional conduct. Hiring practices should include candid discussions about professional expectations and anticipated challenges, while selecting candidates aligned with organizational values. Educational programs should explicitly teach clinicians the values and soft skills needed to avoid and mitigate disruptive behaviour and then engrain these skills using simulation. Mentorship systems should match new clinicians with good models of professionalism and should leverage advancements in professionalism education to hasten cultural change. Finally, organizations should create clear policies, enforce behavioural expectations consistently and fairly, create confidential reporting mechanisms, adjust working conditions to reduce stress and burnout, and supply supports to clinicians in need. Complex social issues like disruptive behaviour require both individual action and systems reform. Ultimately, combining these micro and macro-level solutions can mitigate the negative impacts of disruptive behaviour and shift organizational culture toward professionalism and safety.

Keywords: teamwork, incivility, bullying, professionalism, mentorship, simulation

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Introduction

Multiple studies confirm the ubiquity of disruptive behaviours in the operating room (Cochran & Elder, 2014; Villafranca, Hamlin, Enns et al., 2017), including acts of physical and psychological abuse (Villafranca et al., 2019; Villafranca, Hamlin, Jacobsohn et al., 2017). This behaviour undermines patient care, sets a poor example for medical students, and has deleterious physical and psychological consequences for healthcare professionals (Goh et al., 2022; Pogue et al., 2022; Rehder et al., 2020). At the system level, disruptive behaviour jeopardizes how efficient institutions function, by increasing the risk of adverse events, employee grievances, absenteeism, and subsequent staff turnover (Villafranca, Hamlin, Enns et al., 2017). Although research identifying the problem is widely available and referenced, disruptive behaviour remains a current and pressing issue that is underreported to management (Fast et al., 2020). This article series presents practical actions both individual clinicians and managers can use to prevent and mitigate the issue. Part 1 of this article series focused on micro-level solutions to disruptive behaviour—actions that individual clinicians can take in response to disruptive behaviour (Villafranca et al., 2025). These responses can mitigate or exacerbate consequences, and current responses are suboptimal (Villafranca et al., 2024). Micro-level solutions are critical to helping clinicians manage their current work environment and empowering them to affect outcomes. However, overemphasizing these solutions risks placing undue burden on individual clinicians to

control the damage caused by unprofessional colleagues. It also rests on the hope that cumulative individual action will generate broader cultural change. Equal responsibility must be placed on management and leadership, since they can produce widespread and lasting cultural change by modifying systems. Management includes individuals in formal leadership roles who oversee unit operations, while leadership includes a broader range of influential people who span formal roles, such as educators or clinical coordinators, and informal roles, such as unit staff who volunteer to help develop strategies or projects (Jibreal, 2021). Ideally, management works with both formal and informal leaders to develop and improve perioperative systems.

It is these systems, as they currently function, that have allowed disruptive behaviour to thrive (Campos et al., 2022; Peisah et al., 2023; Rogers et al., 2013). Integrating individual interventions with systemic reforms creates a more sustainable culture of civility and safety. This article, Part 2, shifts the conversation toward system change by reviewing systems of hiring, systems of education, systems of mentorship and socialization, and systems of culture reinforcement and maintenance.

Systems of hiring

Hiring is a time-consuming and stressful duty borne by healthcare managers. This responsibility is complicated by staffing shortages, resource constraints, and frequent staff turnover; all of which are exacerbated by disruptive behaviour (Hastie et al., 2020; Higgins et al., 2013; Potts et al., 2020). Moreover, many managers report lacking the confidence and skills necessary to make good hiring decisions, and this challenge does not reliably lessen with experience (Kester et al., 2022). Nevertheless, this responsibility remains an essential gatekeeping action that shapes organizational culture. Hiring practices that fail to assess candidates for professionalism, or do not establish cultural expectations up front, can introduce individuals who are predisposed to bring disruptive behaviour into the organization. Whereas hiring practices that succeed in this regard, support safety culture, which is a system of shared values, behavioural expectations and professional attitudes that aim to overcome inherent problems within the operative environment (Hedsköld et al., 2021).

Commonly, hiring decisions are guided by mission statements and initiatives developed at the regional and societal level (Alberta Health Services, 2025; Ontario Health, 2025; Reese et al., 2021; Shubeck et al., 2020). New hires should share the vision and philosophy of the organization (Rosenstein, 2015) and be the candidates best positioned to contribute to its short-term goals and broader mission. Additionally, hires should fill the specific needs of individual units. For instance, if a unit is experiencing high levels of disruptive behaviour, interviews should incorporate questions that probe the candidate's views and skills related to professionalism. Broaching the topic of disruptive behaviour provides the hiring team valuable insights into whether the candidate could immediately make a positive contribution to the unit's culture or would need additional support to take on that role. Furthermore, the interview acts as a key initial conversation allowing interviewers to state behavioural expectations at the outset, and outline the aspirational vision they have for the culture of the unit. Too often, new hires face a "hidden curriculum" characterized by a disconnect between what is taught during formal education and what is observed in practice (D'Eon et al., 2007; Gofton & Regehr, 2006; Ludwig et al., 2018). This can, ultimately, lead them to abandon the standards established in training and, instead, copy the disruptive behaviour modeled by senior staff, or at least tolerate and enable it (Alshareef & Flemban, 2025; Doherty et al., 2025). By discussing current initiatives during the interview process, organizations can ensure that new hires realize efforts to change the culture are in process. This can prepare hires to encounter disruptive behaviour from the odd recalcitrant clinician without abandoning all hope. Establishing expectations at this early stage can be equally important when hiring occurs in a union-based environment, where clinicians may be hired based on seniority and may have already adopted dysfunctional behaviours that were tolerated in their previous roles. In addition to being a vetting process, interviews should be seen as an initial contact, setting the tone for relationships between new hires and various parties, including other team members, patients, and management.

Systems of education

While clinical education starts with professional entrance-to-practice programs at the post-secondary level, it continues throughout the clinician's career (Healthcare Quality Council of Alberta, 2013; Nes et al., 2022). Hospitals offer mandatory annual education, as well as specific programming, to advance various knowledge and skills. This represents an opportunity for managers and leadership to provide clinical cohorts with education that will enable them to handle disruptive behaviour. To that end, topics, such as conflict resolution and interpersonal skills, must be prioritized. Programs that do not ingrain the importance of civility and teamwork within the interdisciplinary context can produce clinicians who do not recognize the harm caused by disruptive behaviour (Moreira et al., 2019; Moreno-Leal et al., 2021). Ideally, educational opportunities address knowledge gaps, increase skills, and establish or strengthen values needed within the operative environment. Clinicians should be educated to identify disruptive behaviour and appreciate its antecedents and consequences.

As with other forms of hospital-based education, this content could be delivered using various modalities. Simulation-based training, however, is particularly well-suited to educating clinicians about disruptive behaviour, due to its many advantages. It aligns well with best practices in adult education and offers experiential opportunities for individuals or teams to practise

communication and conflict-resolution skills in true-to-life scenarios (Elendu et al., 2024; Farina et al., 2024; Saleem & Khan, 2023). While simulation is often associated with refining "hard" (i.e., technical) skills, it is equally suited for developing the "soft" skills needed to address disruptive behaviour. These include practising assertive communication, navigating team hierarchies, and responding to incivility during team-based scenarios that may involve role-play and guided observation exercises (Aggarwal et al., 2010; Lynch, 2020). Simulation has also been well studied, to the degree that best practices have been established for its use in healthcare environments (Lame & Dixon-Woods, 2020; Watts et al., 2021). Furthermore, simulation is flexible, allowing leaders to tailor learning goals to interpersonal challenges they are seeing on the unit and, subsequently, to adapt scenarios as requirements change. The use of simulation is also becoming more accepted in clinical training. As simulation becomes increasingly commonplace in professional education, new professionals arrive to the workplace well-versed in simulation protocol and procedures. At the same time, experienced staff increasingly recognize the benefits of simulation, leading to greater and more enthusiastic participation in simulation-based educational offerings (Abas & Juma, 2016; Okuda et al., 2009; Shandiz et al., 2021). In fact, simulation represents a learning experience that many clinicians find exciting. It presents challenging and engaging problems within an environment that poses no risk to patients. Because of this, students can be actively encouraged to experiment with different responses to disruptive behaviour. When paired with structured debriefing models, such as Plus-Delta, in which participants reflect on what went well before suggesting what might be done differently, simulation can make the learning process reflective and concrete, thereby increasing the likelihood of lasting culture change (Cheng et al., 2021; International Nursing Association for Clinical Simulation and Learning [INACSL] et al., 2025; Lateef, 2010; Oh et al., 2021).

Having extoled the benefits of simulation for teaching soft skills to clinicians, we must stress that its effectiveness depends on its proper implementation. Unit leadership must follow best practices for designing, facilitating, and evaluating simulations. Ideally, this would include having facilitators complete formal simulation training, such as that provided by the Canadian Association of Schools of Nursing. Minimally, simulations should be developed using guidelines produced by reputable organizations, such as the INACSL (Canadian Nurse Educators Institute, 2025; INACSL, 2021). While it is beyond the scope of this article to review all best practices and describe the range of available simulation types, readers are encouraged to consult the references provided herein as a starting point. Knowing and adhering to simulation best practices ensure students learn the intended content, and that the time and cost of the simulation is justified (Diaz-Navarro et al., 2024; Experiential Learning Hub, 2021; INACSL, 2021). For instance, it is essential to ensure that the simulation occurs in a psychologically safe learning environment that normalizes vulnerability and avoids assigning blame (Somerville et al., 2023; Turner et al., 2023; Vaughn et al., 2024). Care must be taken to safeguard all participants, regardless of the roles they have played in conflicts involving disruptive behaviour outside of the simulation. Interpersonal dynamics must be considered ahead of time, to minimize the risk of triggering or retraumatizing clinicians who have experienced or witnessed disruptive behaviour. Precautions would include ensuring that scenarios are not overly similar to conflicts experienced by the group in real life, setting behavioural expectations for participants in advance, allowing participants to step away from a scenario without judgment if they become overwhelmed, and ensuring that all components, including a pre-brief (outlining procedures and behavioural expectations), the simulation scenario itself, and the structured debrief, remain confidential. It would also be wise to identify pathways for distressed participants to seek emotional support, if needed.

For leaders new to simulation, its implementation may seem daunting. Fortunately, helpful resources exist. First, there is a growing library of virtual simulations available online. These offer learners repeat access, flexible scheduling, and the ability to be completed individually or in groups (Verkuyl et al., 2024). We have not linked to specific simulations here, as the content of these libraries is continually changing. Nevertheless, we recommend searching for already developed simulations related to disruptive behaviour before designing your own, to save time and effort. These alternatively could be used as templates or sources of ideas if more tailored scenarios are required. Second, educators and affiliates who are well versed in simulation development and facilitation are an invaluable resource. In settings with fewer institutional educators or limited resources, leadership instead can rely on best practice standards (INACSL, 2021) and other published resources, to help design and implement simulations (Canadian Nurse Educators Institute, 2025; Experiential Learning Hub, 2021; Harrington & Simon, 2022; Tapia & Waseem, 2023). Critically, managers and leaders must understand and take seriously the complexities of simulation, its associated risks, and how those risks are best minimized, prior to attempting its implementation.

Systems of mentorship and cultural socialization

Once a clinician is hired, they must be integrated properly into the unit with the goal of making them competent team members who display high levels of professionalism. The goal of integration into a unit with an appropriately professional culture, however, can be undermined by the new clinician's fears of inadequacy, generalized anxiety, lack of confidence in their skills, and newfound awareness of their knowledge gaps, as well as difficulties in navigating their assigned workload or the health system more generally (Alharbi et al., 2023; Malau-Aduli et al., 2020; Piccuito & De Santis Santiago, 2023). These

factors can make new clinicians feel like outsiders, make the task of integration seem insurmountable, and can encourage poorer behaviour by increasing stress. Even clinicians transitioning to the operating room from other clinical areas can experience the same challenges.

In situations where the unit culture does not reflect a high level of professionalism, new clinicians should be introduced to management's vision for the unit culture. This goal should be framed as realistic and broadly shared by the clinical staff. Their initial experiences in the workplace can either support or undermine confidence in this vision. Exposure to negative role models is influential, and both students and new hires are at risk of becoming disillusioned when experiencing or witnessing disruptive behaviour, to the degree that they begin adopting these behaviours over time.

This range of concerns, including how students navigate the transition to clinical practice and how they react to negative role modelling, can be addressed through mentorship, in which an experienced clinician is formally assigned to support, guide, and constructively role-model for a novice within the operative area. (Burgess et al., 2018; Dirks, 2021; Gularte-Rinaldo et al., 2023; Venkatesa Perumal & Singh, 2022). Mentorship is of benefit when it occurs early in the clinician's career and extending the mentorship period to at least one year seems to offer additional benefits (Gularte-Rinaldo et al., 2023; Vázquez-Calatayud & Eseverrii-Ascoiti, 2023; Venkatesa Perumal & Singh, 2022). Mentorship has proved to be a remarkably flexible tool, given the range of positive outcomes it can produce. This includes making clinicians better versed in evidence-based practice, as well as increasing their capability of providing more compassionate care for patients and better support for peers (Hookmani et al., 2021; Melnyk et al., 2021; Murry et al., 2022). Given its flexibility, the focus of mentorship can be tailored to the needs of the unit, thereby easing the new clinician's transition to that specific setting (Vázquez-Calatayud & Eseverrii-Ascoiti, 2023). Beyond easing transitions, mentorship offers additional benefits for both mentors and mentees, including increased confidence, higher job satisfaction, stronger team cohesion, and a renewed passion for the profession (Burgess et al., 2018; Venkatesa Perumal & Singh, 2022).

However, selecting the right mentors is crucial; just as with hiring, mentors should be chosen based on merit. Mentorship that is inadequate or led by clinicians who act disruptively will transmit the behaviour to the new generation of clinicians, reinforcing the hidden curriculum and perpetuating the harms associated with disruptive behaviour. Recruiting qualified mentors remains a challenge, as busy clinicians can be reticent to take on the role, due to competing time pressures in the clinical environment. This is understandable and management should ideally frame mentorship as an honour and privilege, rather than a burdensome duty (Abi-Rafeh & Nahai, 2025). Consequently, clinicians displaying exceptional levels of professionalism should be not only encouraged but, potentially, incentivized to serve as mentors. New hires should also be preferentially partnered with these clinicians. Leaders at all levels must model professionalism (The Royal College of Surgeons of England, 2021), and mentors should be routinely assessed to ensure they are transmitting the values of the organization. Framing mentorship as a privilege rather than a right also sets the expectation that access to the role of mentor must be earned and maintained through good performance. An appropriate mentor can help individual clinicians stay aligned with professional standards by modelling good behaviour and counteracting the new hire's incidental exposure to unprofessional behaviour from other clinicians. Over the long term, a well-run mentorship program can actively promote a culture of civility by shaping the shared professional norms of the next generation of clinicians.

Systems of culture reinforcement and maintenance

Organizational systems that reinforce and maintain a culture of professionalism should be considered. Using systems that do not hold clinicians to account or do not provide adequate supports will allow even the most civil and collaborative culture to drift toward unprofessionalism. While we have reviewed the management of disruptive behaviour previously, several key strategies are essential to mention (Villafranca et al., 2018; Villafranca, Hamlin, Enns et al., 2017).

Decades of commentary recommend that organizations should develop and rigorously enforce policies that define behavioural expectations, and outline consequences for disruptive actions of different severity and frequency (Barnsteiner et al., 2001; Hickson et al., 2007; Pfifferling, 1997, 1999; Piper, 2003; Swiggart et al., 2009; Ward, 2002). The document also should define the term "disruptive behaviour" explicitly to avoid confusion (Harolds, 2021). These policies should ideally be accompanied by a dedicated code of conduct outlining concrete examples of professional and unprofessional behaviour (Hastie et al., 2020; The Royal College of Surgeons of England, 2021). These policies and guiding documents must apply to all staff, including leadership, to ensure that everyone contributes to a culture of professionalism (Schwartz & Sullivan, 1993). For these policies to be effective, they must be consistently applied and properly enforced (Rosenstein, 2011).

Continuous monitoring is vital to detect when these policies must be enforced (The Royal College of Surgeons of England, 2021). This includes routine performance reviews using established metrics and various feedback channels. The goal of this monitoring would be to provide clinicians with ongoing feedback about their performance as an individual and as a team member. Regular monitoring helps identify any drift toward unprofessional conduct, enabling timely corrective action

before minor issues become systemic problems. This process should not be solely punitive or even remedial. It also should identify individuals displaying high levels of professionalism for recognition and rewards (be they positional, financial, or opportunity-based). In addition to routine monitoring, targeted monitoring of clinicians who have undergone corrective action for disruptive behaviour should occur, to confirm that the issue is resolved (Harolds, 2021).

Establishing reliable reporting mechanisms is critical (Tso et al., 2023). These channels should be confidential and easily accessible to encourage staff to report disruptive behaviour promptly and without fear of retaliation (Tso et al., 2023). Whistleblowers must be protected by establishing clear anti-retaliation policies and perhaps using reporting systems that are strictly anonymous, or at least confidential (Harolds, 2021). At the same time, the rights of accused clinicians should be protected by giving them opportunities to respond and access an appeals process (Harolds, 2021). Ideally, reporting systems could be supplemented by regularly surveying staff about their exposure to disruptive behaviour, using established tools that are freely available (Villafranca et al., 2021). These actions help ensure that management can promptly identify and address issues as they arise.

Leadership should recognize that organizational factors, including working conditions, can increase the risk that clinicians will act disruptively (Aunger et al., 2023; Chinene et al., 2022; Villafranca et al., 2018), primarily by increasing their stress, burnout, and depression (Brown et al., 2009; Houck, & Colbert, 2017; Wright, 2021). Clinicians in these states are less able to regulate their emotions and make sound judgements, thereby increasing the risk of unprofessional behaviour. If institutions do not make efforts to set up work environments that prevent disruptive behaviour, even the most well-intentioned clinicians may find themselves slipping into incivility. Workplace factors believed to increase the risk of disruptive behaviour include excessive workloads, poor scheduling practices, inadequate breaks and recovery time between stressful events, lack of supplies, role conflict, patient safety concerns, and insufficient psychological support for clinicians (Aunger et al., 2023; Campos et al., 2022; Houck & Colbert, 2017; Keller et al., 2020;).

Leaders should counter this risk actively by incorporating clinician well-being into their quality improvement evaluations (Houck & Colbert, 2017). Useful sources of information that can provide early warning signs would be climate survey results, burnout screening tools, and data that tracks mandatory overtime and missed breaks. Leaders can also do daily rounds to gain firsthand information about practitioner concerns and affect, which can help them to assess the risk for, and presence of, disruptive behaviour (Alberta Health Services, 2012). Working conditions should be adjusted, as possible, to mitigate issues before they begin.

It is equally important that managers provide supports for clinicians who are at risk of burnout, especially when they are exposed to disruptive behaviour (The Royal College of Surgeons of England, 2021). This would include Employee Assistance Programs and accessible counselling services for offenders, victims, and also witnesses. These resources enable clinicians to address personal and professional stressors before they contribute to disruptive behaviour and can help them resolve issues stemming from their exposure to the behaviour. Additional supports and guidance should be provided so there is a clear and safe path for disruptive clinicians to be reintegrated into the team, where possible (The Royal College of Surgeons of England, 2021).

Conclusion

Over the course of this two-article series, we have examined a dual approach to addressing disruptive behaviour, which combines individual-level strategies with system reforms. On the micro level, clinicians need to manage their cognitive appraisals, avoid detrimental self-labeling, use adaptive coping strategies, and act as an upstander who responds assertively to disruptive behaviour, to protect their well-being and enhance patient safety. Concurrently, leadership should drive initiatives that reform hiring practices, educational curricula, mentorship programs, and organizational policies, to promote widespread and lasting cultural change. By integrating these immediate, micro-level responses with longer-duration, macro-level interventions, healthcare teams can create a culture of professionalism and safety. Ultimately, this dual strategy mitigates the negative impacts of disruptive behaviour and paves the way for more widespread improvements to OR culture.

Author notes

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Conflicts of Interest

None declared.

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Contribution and CRediT Statement

Alison Forest: *Conceptualized and designed the review, located relevant academic literature, reviewed and organized most of the source material, drafted the manuscript, helped address reviewer comments, reviewed and approved the final manuscript.*

Brett Adams: *Located relevant academic literature, reviewed and organized some of the source material, helped to develop the bibliography, critically edited the manuscript, reviewed and approved the final manuscript.*

Owen Krestow: *Located relevant academic literature, reviewed and organized some of the source material, helped to develop the bibliography, critically edited the manuscript, 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.*

Alexander Villafranca: *Created the idea for the review, developed the literature search strategy, provided supervision, reviewed and organized some of the source material, drafted one section of the paper, critically edited the manuscript for intellectual content and style, coordinated the timeline and submission process, helped address reviewer comments, and reviewed and approved the final manuscript.*

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