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Review Article

Disruptive clinician behaviours in healthcare: prevalence, impact and strategies for cultural reform

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ABSTRACT

Disruptive clinician behavior (DCB)—ranging from incivility to overt aggression—undermines team dynamics, clinician well-being, and patient safety, particularly in community healthcare systems where resources and oversight may be limited. This narrative review synthesizes evidence from peer-reviewed and gray literature published between January 2013 and June 2024, focusing on the prevalence, typologies, drivers, and institutional responses to DCB, with special attention to its impact in community-based settings and broader public health implications. Using sources from PubMed, Scopus, and Google Scholar, and search terms such as "disruptive behavior," "workplace incivility," "medical bullying," and "patient safety," eligible studies included hospital and community healthcare workers, trainees, and medical students. Findings reveal DCB is highly prevalent and disproportionately affects junior staff and women, driven by factors such as hierarchical power imbalances, inadequate institutional oversight, cultural permissiveness, and reporting barriers. The consequences are far-reaching, ranging from increased burnout and reduced clinical performance to weakened team cohesion. Effective interventions include peer-support programs, simulation-based professionalism training, and leadership-led cultural reform. Addressing DCB demands systemic change grounded in psychological safety, policy clarity, and leadership accountability, with these principles integrated into medical education and community health governance to foster safer, more equitable healthcare environments.

Keywords: Disruptive behavior, Patient safety, Community medicine, Medical workforce, Healthcare culture, Workplace incivility

INTRODUCTION

Disruptive clinician behavior (DCB) refers to inappropriate interpersonal conduct occurring within healthcare environments, ranging from incivility and dismissive communication to intimidation, harassment, and physical aggression. In perioperative and hospital-based settings, such behaviors have been associated with impaired communication, reduced team cohesion, and threats to patient safety.[1,2]

Lower-intensity behaviors—including ignoring colleagues, failing to respond to communications, condescending remarks, and public criticism—are frequently reported across hospital systems. Multi-center survey data indicate that a substantial proportion of healthcare professionals experience unprofessional behaviors on at least a monthly basis, with variation across roles and departments.[3-5]

These behaviors are particularly concerning in high-acuity clinical environments such as operating rooms, where tense communication episodes have been directly observed and linked to workflow disruption.[6] Specialty-based differences in reported unprofessional conduct have also been documented. In a large national cohort study of physicians, procedural specialties were more frequently associated with coworker-reported unprofessional behaviors.[7] Persistent exposure to incivility and hostile communication has been linked to clinician distress and

diminished psychological safety.[8,2] In medical education, mistreatment during clerkships—particularly within obstetrics-gynecology rotations—has been documented, highlighting the vulnerability of trainees within hierarchical systems.[9,10]

Conceptual analyses emphasize the need for clearer typological frameworks and system-level approaches to address disruptive clinician behavior as both an organizational and patient safety concern.[8,11]

METHODS

This review adopted a narrative approach to synthesize empirical and theoretical literature on DCB and its implications for healthcare systems.

Search strategy

Literature was identified through systematic searches of PubMed, Scopus, and Google Scholar, supplemented by gray literature from institutional and governmental healthcare bodies. The search covered January 2013 to June 2024. Keywords included: "disruptive behavior," "workplace incivility," "medical bullying," "physician harassment," and "patient safety." Boolean operators were used to combine and refine search results.

Inclusion criteria

Inclusion criteria included peer-reviewed articles (original research, systematic reviews, and large cohort studies), studies focused on hospital-based clinical settings, including emergency departments, surgical units, and academic medical centers and research involving healthcare professionals (physicians, nurses, trainees, or medical students).

Exclusion criteria

Exclusion criteria included non-English language publications, commentaries, opinion pieces, and editorials and studies from non-healthcare or administrative workplace contexts.

Data extraction and analysis

A thematic synthesis approach was used to organize findings across five domains: behavioral typologies, prevalence, contributing factors, organizational responses, and public health consequences. Due to the narrative nature of this review, no formal risk-of-bias assessment was conducted.

NATURE AND TYPES OF DISRUPTIVE BEHAVIORS

DCB encompasses a heterogeneous group of interpersonal actions that interfere with professional functioning and collaborative care.[11,8]

Spectrum of interpersonal aggression

Explicit behaviors include verbal threats, intimidation, humiliation, discriminatory remarks, and physical aggression. Perioperative literature has documented instances of abusive conduct within operating rooms, including shouting and demeaning comments directed at staff.[1,12] Observational research in surgical teams demonstrates that tense communication episodes can disrupt coordination.[6]

Incivility and low-intensity disruptions

Subtle behaviors—including ignoring colleagues, excluding individuals from decision-making, and dismissive language—are commonly reported across hospital systems.[4,3] Large multi-hospital surveys confirm recurring exposure to rude communication and exclusion across professional groups.[4,5]

Bullying, harassment, and discrimination

Bullying and harassment represent persistent and targeted forms of DCB. A meta-analysis of medical trainees reported substantial prevalence of harassment and discrimination.[10] Gender-based mistreatment has been documented within obstetrics and gynecology training environments.[9,13]

Conceptual and classification challenges

Terminological variability complicates measurement and intervention. Reviews highlight inconsistent use of terms such as "incivility," "bullying," and "unprofessional behavior".[8,11] Some frameworks distinguish interpersonal aggression from structurally embedded coercive practices within organizations.[11]

PREVALENCE AND EPIDEMIOLOGICAL INSIGHTS

Large multi-center studies demonstrate widespread reporting of unprofessional behaviors. An evaluation across Australian tertiary hospitals found that most respondents reported experiencing at least one form of unprofessional behavior in the preceding year.[5] Common behaviors included rude communication and dismissal of opinions. Cross-hospital surveys similarly demonstrate frequent exposure to ignored communications, public criticism, and exclusion.[3,4]

Specialty differences

In a national cohort study involving over 35,000 physicians, a minority proportion were reported for unprofessional behaviors, with procedural specialties more frequently flagged.[7] Most physicians had no reports, suggesting concentration within a subset.[7] Observational data from operating rooms further illustrate tense communication episodes in surgical environments.[6]

Mistreatment in medical training

Meta-analytic data indicate substantial rates of harassment and discrimination among medical students and residents.[10] Clerkship-level differences have been observed in obstetrics and gynecology rotations.[9] Systematic review evidence confirms ongoing sexual harassment and discrimination within the specialty.[13]

Reporting and underreporting

Fear of professional consequences may discourage reporting, particularly among trainees and junior staff.[14,10] Qualitative evidence from emergency medicine highlights hesitancy to report harassment due to anticipated career repercussions.[14]

CONTRIBUTING FACTORS AND BARRIERS TO ADDRESSING DISRUPTIVE CLINICIAN BEHAVIOR

Hierarchical authority gradients may discourage reporting of inappropriate conduct.[10,14] National workforce reporting has identified concerns regarding bullying and institutional retaliation.[15] Organizational climate influences reporting behavior. Communication breakdowns and intimidation may inhibit speaking up about safety concerns.[2] Willingness to report workplace violence is associated with perceptions of fairness and institutional protection.[16] Fatigue and shift-related stress may exacerbate interpersonal tension in high-acuity settings.[17]

Operating room environments may amplify conflict under pressure.[1,6] Ambiguity in terminology and policy definitions complicates enforcement.[8,11] Inconsistent standards may permit normalization of inappropriate conduct.[9,10]

INSTITUTIONAL RESPONSES AND MITIGATION STRATEGIES

Structured early identification and feedback models emphasize confidential intervention and graduated response.18 Trainees are more likely to speak up when institutions provide clear reporting channels.[19] Peer-support and professionalism centers offer confidential guidance and mediation.[20] Broader "culture of respect" frameworks emphasize leadership accountability and clear behavioral expectations.[21] Conflict resolution tools, such as the U-TURN model, provide structured mechanisms for addressing interpersonal conflict.[22]

Hospital-wide culture change programs have demonstrated shifts in reported coworker behaviors over time.[5] Clear policy definitions and ethical framing of professionalism as integral to quality care are essential for consistent enforcement.[23] Sustainable reform requires integration of reporting systems, leadership modeling, and institutional accountability.[8,21]

CONCLUSION

Disruptive clinician behavior remains a measurable challenge within hospital and academic healthcare systems. Although most clinicians do not engage in recurrent misconduct, a subset contributes disproportionately to workplace disruption. Evidence indicates that hierarchical culture, policy ambiguity, occupational stressors, and limited reporting protections contribute to persistence of DCB. Institutional strategies that integrate early feedback, structured reporting, leadership engagement, and cultural reform appear more promising than isolated punitive responses. Framing professionalism as integral to patient safety and organizational quality may strengthen sustained reform efforts.

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