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Perceptions of unprofessional behavior in the clinical workplace among healthcare staff

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ABSTRACT

Background: Professionalism among healthcare providers is essential to fostering trust, ensuring patient safety, and maintaining effective communication within healthcare teams. Despite general professionalism among providers, unprofessional behavior—such as exclusion, blaming, and lack of responsiveness—persists, with negative impacts on clinical outcomes and provider well-being. This study investigates the prevalence and types of unprofessional behaviors within an academic medical center, analyzing how these behaviors vary by role, gender, and department.

Methods: This cross-sectional study surveyed attending physicians, residents, and advanced practice providers (APPs) at a tertiary academic medical center. Participants were surveyed on the frequency and types of unprofessional behaviors experienced or witnessed, using an adapted workplace behavior survey based on Joint Commission standards. Surveys were distributed during mandatory professionalism training sessions with results analyzed using ordinal and negative binomial regression to assess associations between role, gender, and behavior frequency.

Results: Among 388 respondents, 63% reported experiencing unprofessional behavior monthly or more frequently, with behaviors like non-responsiveness (44.3%) and exclusion from decision-making (43.0%) most commonly reported. Residents were more likely to encounter unprofessional behavior than attending physicians (OR 2.25, $p < 0.001$), and APPs frequently reported dismissive behavior (OR 2.44, $p < 0.05$). Female respondents faced higher rates of discrimination (OR 2.52, $p < 0.01$) than males. Cross-department interactions were a significant source of unprofessional behavior, with nurses, other residents, and attending physicians outside one's department identified as common sources.

Discussion: The findings highlight the need for targeted interventions to address unprofessional behaviors within specific roles and interdepartmental interactions. Frequent unprofessional conduct by and toward residents and APPs underscores the importance of tailored training programs and organizational support systems. Further research is warranted to explore interventions that foster professionalism and reduce the occurrence of disruptive behaviors across healthcare teams.

Keywords: health , staff professional , behavior

INTRODUCTION

Professionalism encompasses behaviors that build trust within both interpersonal and organizational contexts (1). When healthcare providers exhibit unprofessional conduct, it can compromise patient safety by hindering interprofessional communication, reducing psychological safety, and negatively impacting the clinical learning environment (2, 3). Such behaviors can lead to serious repercussions, including adverse events, errors, and even heightened patient mortality (4–6). Additionally, unprofessional conduct can affect healthcare providers' well-being, fostering self-doubt, lowering morale, and contributing to burnout (7, 8).

Research indicates that most healthcare providers generally demonstrate professionalism (9, 10), but the harmful impact of the few who do not act professionally is disproportionately high (11). A survey of 102 healthcare

facilities in the U.S. found that 77% of healthcare professionals had witnessed unprofessional behavior by physicians, with 65% seeing it at least five to six times annually (2). In the perioperative setting specifically, between 35% and 75% of healthcare staff reported observing unprofessional behaviors (9, 12). In response, accrediting organizations have increasingly held medical schools, hospitals, and other healthcare institutions accountable for improving professionalism and addressing the mistreatment of students and trainees (13–15). In 2008, the Joint Commission mandated the eradication of behaviors that "undermine a culture of safety" (13), though achieving these standards has proven difficult (14, 16, 17).

Alarmingly, bullying and harassment of medical students, residents, and other healthcare team members continue to be prevalent worldwide (18–20). Studies have examined specific unprofessional behaviors, such as harassment and discrimination toward medical students and residents (18, 19), bullying directed at residents (20), and yelling or bullying behaviors in the perioperative setting (12, 14). Other studies have focused on the sources and targets of unprofessional conduct (12, 21). Since unprofessional behavior is not a single issue, it is crucial to identify different types across various professional roles and departments to effectively address the challenge (16, 22). This study uniquely explores multiple forms of unprofessional behavior, identifying the sources and targets of each and distinguishing whether incidents are more common within a single department or across departments.

This study aims (i) to analyze the frequency and types of unprofessional behavior and (ii) to identify healthcare professionals most likely to exhibit or be the targets of these behaviors. The findings will inform the development of targeted training and remediation programs to address specific professionalism challenges across different roles.

Methods

Setting and Participation

This study was conducted in a large academic medical center with a tertiary care facility and a dedicated Center for Professionalism and Peer Support (CPPS) that promotes an environment of respect and trust. the CPPS developed a structured, fair, and confidential system for reporting, assessing, and managing both recurring and significant instances of unprofessional conduct (1). As part of its efforts to reduce unprofessional behaviors, the institution provided educational programs and training that incorporated simulation-based video scenarios representing various forms of unprofessional behavior. These sessions were mandatory for all credentialed personnel, including attending physicians, residents, and advanced practice providers (APPs) (23). APPs consisted of nurse practitioners, physician assistants, clinical nurse specialists, certified registered nurse anesthetists, and certified nurse midwives. These training sessions were utilized in the study as a convenience sampling method, distributing surveys at the beginning of each course to ensure a high response rate and representative sample, given the compulsory nature of the training. Participation was open to all APPs, residents, and attending physicians in the organization, with these groups chosen due to resource constraints.

Data Collection

All credentialed personnel received notifications via an online education system to attend one of the scheduled professionalism training sessions, for which they registered electronically. Each participant was randomly assigned to a session, where they received no prior information about the training specifics. Surveys were administered immediately before the session began to minimize information bias. The same trainer (JS) led each session. Attendees were given a brief description of the study and invited to complete an anonymous paper survey, which ensured no repeated responses. Measures were taken to protect privacy; the surveys were completed privately and anonymously, and neither the trainer nor the participants could link responses to individual attendees. At the conclusion of each session, the paper surveys were collected, and responses were entered into an Excel database for subsequent analysis in R software version 3.6.0. No incentives were provided to encourage participation, and the Institutional Review Board waived ethical approval for the study (…).

Survey Development

The survey was adapted from a prior workplace behavior survey createdbased on an extensive literature review of reported unprofessional behaviors in healthcare settings, as well as behaviors identified by The Joint Commission as detrimental to a safety culture (13). The senior author (JS), who directed the CPPS, also contributed insights based on direct experiences managing professionalism issues (1). To establish face validity, expert colleagues reviewed and provided feedback on the survey, after which items were modified for clarity. Subsequently, the survey underwent group discussions with trainees and attending physicians to further refine the wording. After six years of use, the survey was revised in 2017 to capture more detailed data on the frequency of specific unprofessional behavior subtypes identified in the literature (15, 22, 24, 25) and through the senior author's expertise (JS). A revised version was reviewed by an expert panel including specialists in patient safety, safety culture, and medical education, as well as two physicians. The panel's feedback was integrated, and the final version was validated for clarity and relevance. This updated survey included subtypes

such as exclusion from decision-making, lack of response to communications, blaming, dismissive behavior, displays of anger, sexual harassment, and discrimination based on various personal attributes.
In this study, "experiencing unprofessional behaviors" was defined as witnessing or being the target of such behaviors, with participants asked to reflect on experiences in their work environment. Respondents reported the frequency of each behavior on a scale from daily to annually, or never. Six survey items were designed with single or multiple closed answer options.

Data Analysis
The analysis first calculated the overall frequency of unprofessional behaviors reported by participants, along with the frequency of each behavior subtype. Regression models were then applied to assess associations between professional role, gender, and types of unprofessional behavior. Frequency (e.g., daily, weekly) was treated as an ordinal variable, with significance assessed via a Wald test following ordinal logistic regression. Gender-based analyses excluded respondents who preferred not to disclose their gender due to the small sample size of this group. Ordinal regression was used to determine the sources of unprofessional behaviors, while negative binomial regression estimated the rate of unprofessional behaviors exhibited by various roles. Significance was defined as $P < 0.05$ for all tests, and analyses were conducted using the R statistical software package 3.6.0. R markdown code is available on request for reproducibility.

RESULTS
In total, 388 surveys were analyzed, achieving an estimated response rate exceeding 95%, as noted by the trainer who compared completed surveys to participant numbers. Among respondents, 54.3% identified as female (211 participants), 42.5% as male (165 participants), and 3.0% (12 participants) preferred not to disclose gender. Professionally, the respondents included 118 attending physicians (30.4%), 169 residents (43.6%), and 101 advanced practice providers (APPs) (26.0%).
A majority, 63% (244 respondents), encountered unprofessional behavior monthly or more frequently, with 6.8% experiencing it daily, 25.5% weekly, and 30.7% monthly. Additionally, 10% reported facing such behaviors annually, while 27.0% had never encountered it. Detailed analysis revealed varied frequency across behavior subtypes, focusing on monthly incidents or more.
The most common type of unprofessional behavior was non-responsiveness to calls or pages, with 44.3% reporting this monthly or more frequently—6.2% daily, 16.2% weekly, and 21.9% monthly. This was followed by exclusion from decision-making, with 43.0% reporting it monthly or more—5.1% daily, 15.2% weekly, and 22.7% monthly. Notably, 39.4% reported instances of blaming at least once a month, including 2.8% daily, 16.7% weekly, and 19.9% monthly.
Other behaviors such as dismissiveness (48.5%), expressions of anger or yelling (42.4%), and public denigration (35.1%) were reported monthly or more often. Discrimination occurred monthly or more for 18.3% of respondents, while 4.6% faced sexual harassment. Female respondents were significantly more likely than males to experience discrimination, with an odds ratio (OR) of 2.52 (CI 1.337, 4.765, $p < 0.01$).
Residents reported encountering unprofessional behavior significantly more frequently than attending physicians, with an OR of 2.25 (CI 1.182, 2.698, $p < 0.001$). A high percentage of residents—69.5% of females and 68.3% of males—experienced these behaviors at least once per month. APPs were notably more likely to experience dismissive behavior than attending physicians, with an OR of 2.44 (CI 1.585, 3.291, $p < 0.05$). Furthermore, respondents with 1–5 years in the organization were twice as likely to report unprofessional behavior compared to those with less than a year's tenure (OR 2.0, CI 1.512, 2.479, $p < 0.1$), and this likelihood increased further for those with over five years (OR 2.74, CI 1.804, 3.670, $p < 0.05$).
Participants identified several roles as common sources of unprofessional behavior, totaling 375 responses. Among these, 31.7% cited nurses, 16.5% identified residents from other departments, and 15.5% named attending physicians from other departments. Cross-departmentally, behaviors were observed more frequently from residents or attending physicians outside one's own department (32%) than within (17.3%). Perceptions about sources of unprofessional behavior were consistent across roles. Patients were identified as the least likely source of unprofessional behavior, with an incidence rate ratio (IRR) of 0.059 (CI -1.367, 1.485, $p < 0.001$), followed by APPs (IRR 0.176, CI 0.691, 1.044, $p < 0.001$), and administrators (IRR 0.206, CI -0.608, 1.019, $p = 0.001$). Male respondents were significantly less likely than females to be targeted by unprofessional behavior (IRR 0.61, CI 0.318, 0.903, $p < 0.01$).

DISCUSSION
Our findings reveal that unprofessional behavior is frequently encountered by attending physicians, residents, and APPs, with most incidents arising from individuals outside of their own discipline or department. Notably, residents were over twice as likely to experience unprofessional conduct compared to attending physicians, and nurses were identified as the most common source of such behavior, followed by residents from other

departments. Women were also significantly more likely to encounter discrimination and unprofessional conduct overall.

Many observed trends relate to underlying tensions and conflicts among different professional roles, disciplines, and departments. Modern healthcare depends on multidisciplinary teams that require effective collaboration and communication to maintain patient safety and high-quality care (26). However, interdisciplinary teamwork is often hindered by limited understanding and respect for the roles and contributions of other professions (26, 27). Social identity theory suggests that members of a specific professional group, such as physicians, nurses, or allied health professionals, tend to view their group's attributes positively while perceiving other groups less favorably (28, 29). Our findings show that unprofessional behavior is more often directed toward team members from different departments, underscoring a strong "ingroup" versus "outgroup" mentality and a markedly tribal culture within healthcare (28).

Additionally, our results point to a potential role conflict among residents, who often act both as targets and sources of unprofessional behavior. This conflict may stem from the dual pressures residents face, balancing the expectations of their attending physicians for patient care with differing perspectives from professionals in other disciplines (30). Lacking sufficient conflict management skills further exacerbates their difficulty in managing these professional tensions (31). Furthermore, the vulnerability of residents due to their younger age, trainee status, and limited authority places them at a higher risk for being targeted. Negative role modeling by supervisors, coupled with residents' dependence on evaluations and the judgment of their performance by attending physicians, may also contribute to residents displaying unprofessional behaviors themselves (32).

Regarding gender differences, our results align with prior studies indicating that women are generally more susceptible to unprofessional behavior, particularly discrimination and sexual harassment (33). Such disparities, which emerge as early as medical school, remain significant challenges for female residents and attending physicians (14, 15). These experiences reinforce the male-dominated culture that persists within medicine and healthcare fields (34).

An additional significant finding is the perception among respondents that nurses were the most frequent source of unprofessional behavior. This aligns with past studies, which show that many healthcare professionals report encountering unprofessional conduct from nurses, with interns particularly identifying nurses as the primary source (21, 35). Contributing factors may include insufficient interdisciplinary training, variations in communication training across disciplines (30, 31, 36), historical imbalances, and established interprofessional hierarchies (37). Although nurses were not part of our study sample, previous research indicates that they also frequently experience unprofessional conduct (5, 35, 37).

This study makes a valuable contribution by detailing the types and frequencies of unprofessional behavior encountered by healthcare professionals across different roles, as well as identifying who is typically affected and who initiates such behaviors. The level of specificity provided offers a foundation for creating strategies aimed at preventing and managing unprofessional conduct within healthcare teams (refer to Implications).

A limitation is that this study used convenience sampling, which introduces potential selection bias. However, because data collection occurred within required training sessions, all eligible healthcare professionals were invited to participate. Furthermore, our findings regarding the common targets and types of unprofessional conduct align with previous studies using diverse samples in healthcare (19, 20, 38, 39). Another limitation is the study's focus on a single academic hospital, raising concerns about broader applicability. Nonetheless, national accreditation bodies like The Joint Commission, ACGME, and LCME recognize that professionalism issues are widely pervasive across healthcare organizations (13–15). Additionally, since data was gathered through self-reported surveys reflecting participants' perceptions rather than direct observation, this may affect objectivity. That said, the anonymous nature of the data collection and its independence from formal reporting channels supports the validity of the results. This study's intent was to measure the occurrence of certain behaviors across professional groups rather than delve into specific instances of unprofessional behavior, and it is worth noting that research in this area typically relies on personal accounts over observational data. Although our response rate was an estimate, small session sizes allowed for accurate counts of returned surveys by trainers. Another limitation is the exclusion of certain healthcare groups, whose perspectives on unprofessional behavior are relevant but outside the scope of this study (5, 35). Future studies would benefit from examining these perspectives. Additionally, it would have been advantageous to collect demographic data on race/ethnicity to analyze the frequency of unprofessional behavior across racial backgrounds, an area for further exploration.

Healthcare organizations need equitable, supportive processes for addressing professionalism concerns that allow for thoughtful assessment and response based on validation, specific behaviors, and affected individuals or groups (1). Standard online reporting systems may lack the nuance required for such a relational approach (40). Professionalism initiatives could also benefit from a focus on interdisciplinary dynamics, using proactive education to promote mutual understanding and respect among healthcare roles (27), and to dismantle disciplinary barriers, which could foster trust and improve communication (28, 41). Recognizing that heavy workloads and stress can intensify unprofessional behavior and contribute to burnout is also critical, given the current well-being crisis among healthcare professionals (42, 43). Physicians experiencing burnout are twice as

likely to show reduced professionalism and three times more likely to receive low patient satisfaction scores (7). As such, comprehensive interventions at both the behavioral and systemic levels are necessary to establish a healthy, supportive work environment (44–47). Ultimately, responsibility for workplace culture falls on both healthcare organizations and professionals, with initiatives driven from within the medical community likely to have a stronger impact (48).

CONCLUSIONS

This study reveals that unprofessional behavior is a common issue affecting attending physicians, residents, and APPs, with notable differences in the nature, sources, and targets of these behaviors. Residents are disproportionately targeted, and women experience unprofessional conduct more frequently than men. Nurses are the most common source, followed by residents from other departments. Findings suggest that healthcare teams would benefit from interdisciplinary training focused on communication and conflict resolution skills to foster mutual respect for each other's roles and provide constructive feedback on behavior. Given its multifaceted nature, unprofessional behavior requires a tailored approach to enhance patient safety, improve workplace culture, and support the well-being of healthcare providers.

REFERENCES

1. Shapiro J, Whittemore A, Tsen LC. Instituting a Culture of Professionalism: The Establishment of a Center for Professionalism and Peer Support. Jt Comm J Qual Patient Saf. 2014;40(4):168–AP1. doi: 10.1016/s1553-7250(14)40022-9
2. Rosenstein AH, O'Daniel M. A Survey of the Impact of Disruptive Behaviours and Communication Defects on Patient Safety. Jt Comm J Qual Patient Saf. 2008;34(8):464–471. doi: 10.1016/s1553-7250(08)34058-6
3. Wiegmann DA, ElBardissi AW, Dearani JA, Daly RC, Sundt TM. Disruptions in surgical flow and their relationship to surgical errors: An exploratory investigation. Surgery. 2007;142(5):658–665. doi: 10.1016/j.surg.2007.07.034
4. Cooper WO, Spain DA, Guillamondegui O, et al. Association of Coworker Reports About Unprofessional Behaviour by Surgeons with Surgical Complications in Their Patients. Jama Surg. 2019;154(9):828. doi: 10.1001/jamasurg.2019.1738
5. Saxton R, Hines T, Enriquez M. The Negative Impact of Nurse-Physician Disruptive Behaviour on Patient Safety: A Review of the Literature. J Patient Saf. 2009;5(3):180–183. doi: 10.1097/pts.0b013e3181b4c5d7
6. Cochran A, Elder WB. Effects of disruptive surgeon behaviour in the operating room. Am J Surg. 2015;209(1):65–70. doi: 10.1016/j.amjsurg.2014.09.017
7. Hodkinson A, Zhou A, Johnson J, Geraghty K, Riley R, Zhou A, et al. Associations of physician burnout with career engagement and quality of patient care: systematic review and meta-analysis. Bmj. 2022;378:e070442. doi: 10.1136/bmj-2022-070442
8. West CP, Dyrbye LN, Shanafelt TD. Physician burnout: contributors, consequences and solutions. J Intern Med. 2018;283(6):516–529. doi: 10.1111/joim.12752
9. Villafranca A, Hamlin C, Enns S, Jacobsohn E. Disruptive behaviour in the perioperative setting: a contemporary review. Can J Anaesth J Can D'anesthesie. 2016;64(2):128–140. doi: 10.1007/s12630-016-0784-x
10. Weenink JW, Westert GP, Schoonhoven L, Wollersheim H, Kool RB. Am I my brother's keeper? A survey of 10 healthcare professions in the Netherlands about experiences with impaired and incompetent colleagues. Bmj Qual Saf. 2014;24(1):56–64. doi: 10.1136/bmjqs-2014-003068
11. Hickson GB, Pichert JW, Webb LE, Gabbe SG. A Complementary Approach to Promoting Professionalism: Identifying, Measuring, and Addressing Unprofessional Behaviours. Acad Med. 2007;82(11):1040–1048. doi: 10.1097/acm.0b013e31815761ee
12. Rosenstein AH, O'Daniel M. Impact and Implications of Disruptive Behaviour in the Perioperative Arena. J Am Coll Surgeons. 2006;203(1):96–105. doi: 10.1016/j.jamcollsurg.2006.03.027
13. Behaviours that undermine a culture of safety. Sentinel Event Alert Jt Comm Accreditation Healthc Organizations. 2008;(40):1–3.
14. Pei KY, Hafler J, Alseidi A, Slade MD, Klingensmith M, Cochran A. National Assessment of Workplace Bullying Among Academic Surgeons in the US. Jama Surg. 2020;155(6). doi: 10.1001/jamasurg.2020.0263
15. Fairchild AL, Holyfield LJ, Byington CL. National Academies of Sciences, Engineering, and Medicine Report on Sexual Harassment: Making the Case for Fundamental Institutional Change. Jama. 2018;320(9):873–874. doi: 10.1001/jama.2018.10840
16. Weenink J-W, Kool RB, Bartels RH, Westert GP. Getting back on track: a systematic review of the outcomes of remediation and rehabilitation programmes for healthcare professionals with performance concerns. Bmj Qual Saf. 2017;26(12):1004–1014. doi: 10.1136/bmjqs-2017-006710

17. Rosenstein AH. Physician disruptive behaviours: Five-year progress report. World J Clin Cases. 2015;3(11):930–934. doi: 10.12998/wjcc.v3.i11.930
18. Freedman-Weiss MR, Chiu AS, Heller DR, et al. Understanding the Barriers to Reporting Sexual Harassment in Surgical Training. Ann Surg. 2019;Publish Ahead of Print(NA;):NA; doi: 10.1097/sla.0000000000003295
19. Hill KA, Samuels EA, Gross CP, et al. Assessment of the Prevalence of Medical Student Mistreatment by Sex, Race/Ethnicity, and Sexual Orientation. Jama Intern Med. 2020;180(5):653–665. doi: 10.1001/jamainternmed.2020.0030
20. Leisy HB, Ahmad M. Altering workplace attitudes for resident education (A.W.A.R.E.): discovering solutions for medical resident bullying through literature review. Bmc Med Educ. 2016;16(1):127. doi: 10.1186/s12909-016-0639-8
21. Mullan CP, Shapiro J, McMahon GT. Interns' experiences of disruptive behaviour in an academic medical center. J Graduate Medical Educ. 2013;5(1):25–30. doi: 10.4300/jgme-d-12-00025.1
22. Swiggart WH, Dewey CM, Hickson GB, Finlayson RAJ, Spickard WA. A Plan for Identification, Treatment, and Remediation of Disruptive Behaviours in Physicians. Frontiers Heal Serv Management. 2009;25(4):3–11. doi: 10.1097/01974520-200904000-00002
23. Shapiro J; Employment Learning Innovations (ELI). Professionalism for Clinicians and Scientists. Atlanta: ELI, 2011.
24. Fnais N, Soobiah C, Chen MH, et al. Harassment and Discrimination in Medical Training: A Systematic Review and Meta-Analysis. Acad Med. 2014;89(5):817–827. doi: 10.1097/ACM.0000000000000200
25. der Vossen MM, van Mook W, van der Burgt S, et al. Descriptors for unprofessional behaviours of medical students: a systematic review and categorisation. Bmc Med Educ. 2017;17(1):164. doi: 10.1186/s12909-017-0997-x
26. Brock D, Abu-Rish E, Chiu C-R, et al. Interprofessional education in team communication: working together to improve patient safety. Bmj Qual Saf. 2013;22(5):414–423. doi: 10.1136/bmjqs-2012-000952
27. Gittell JH, Godfrey M, Thistlethwaite J. Interprofessional collaborative practice and relational coordination: Improving healthcare through relationships. J Interprofessional. 2012;27(3):210–213. doi: 10.3109/13561820.2012.730564
28. Weller J, Boyd M, Cumin D. Teams, tribes and patient safety: overcoming barriers to effective teamwork in healthcare. Postgrad Med J. 2014;90(1061):149–154. doi: 10.1136/postgradmedj-2012-131168
29. Bochatay N, Bajwa NM, Blondon KS, et al. Exploring group boundaries and conflicts: a social identity theory perspective. Med Educ 2019;53:799–807. doi: 10.1111/medu.13881
30. Muller-Juge V, Cullati S, Blondon KS, et al. Interprofessional collaboration on an internal medicine ward: role perceptions and expectations among nurses and residents. Plos One. 2013;8(2):e57570. doi: 10.1371/journal.pone.0057570
31. Foronda C, MacWilliams B, McArthur E. Interprofessional communication in healthcare: An integrative review. Nurse Educ Pract. 2016;19:36–40. doi: 10.1016/j.nepr.2016.04.005
32. Sternszus R, Macdonald ME, Steinert Y. Resident Role Modeling. Acad Med 2016;91:427–32. doi: 10.1097/acm.0000000000000996
33. Schlick CJR, Ellis RJ, Etkin CD, et al. Experiences of Gender Discrimination and Sexual Harassment Among Residents in General Surgery Programs Across the US. JAMA Surg. 2021;156(10):942–952. doi: 10.1001/jamasurg.2021.3195
34. Lombarts KMJ, Verghese A. Medicine Is Not Gender-Neutral–She Is Male. New Engl J Med. 2022;386: 1284–1287. doi: 10.1056/NEJMms2116556
35. Rosenstein AH, Naylor B. Incidence and impact of physician and nurse disruptive behaviours in the emergency department. J Emerg Medicine. 2011;43(1):139–148. doi: 10.1016/j.jemermed.2011.01.019
36. Rice K, Zwarenstein M, Conn LG, Kenaszchuk C, Russell A, Reeves S. An intervention to improve interprofessional collaboration and communications: A comparative qualitative study. J Interprofessional. 2010;24(4):350–361. doi: 10.3109/13561820903550713
37. Blackwood K, Bentley T, Catley B, Edwards M. Managing workplace bullying experiences in nursing: the impact of the work environment. Public Money Manage. 2017;37(5):349–356. doi: 10.1080/09540962.2017.1328205
38. Hu YY, Ellis RJ, Hewitt DB, Yang AD, Cheung EO, Moskowitz JT, et al. Discrimination, abuse, harassment, and burnout in surgical residency training. New England Journal of Medicine. 2019. Oct 31;381(18):1741–52. doi: 10.1056/NEJMsa1903759
39. Villafranca A., Hiebert B., Hamlin C. et al. Prevalence and predictors of exposure to disruptive behaviour in the operating room. Can J Anesth/J Can Anesth 66, 781–794 (2019). doi: 10.1007/s12630-019-01333-8
40. Myers JS, Shapiro J, Rosen IM. Gotcha! Using Patient Safety Event Reports to Report People Rather Than Problems. J Graduate Medical Educ 2020:12:525–8. doi: 10.4300/JGME-D-20-00165.1

41. Martinez W, Lehmann LS, Thomas EJ, et al. Speaking up about traditional and professionalism-related patient safety threats: a national survey of interns and residents. Bmj Qual Saf. 2017;26(11):869–880. doi: 10.1136/bmjqs-2016-006284
42. Wallace JE, Lemaire JB, Ghali WA. Physician wellness: a missing quality indicator. Lancet Lond Engl. 2009;374(9702):1714–1721. doi: 10.1016/S0140-6736(09)61424-0
43. Dewa CS, Loong D, Bonato S, Trojanowski L. The relationship between physician burnout and quality of healthcare in terms of safety and acceptability: a systematic review. Bmj Open. 2017;7(6):e015141. doi: 10.1136/bmjopen-2016-015141
44. Panagioti M, Panagopoulou E, Bower P, et al. Controlled Interventions to Reduce Burnout in Physicians: A Systematic Review and Meta-analysis. Jama Intern Med. 2017;177(2):195. doi: 10.1001/jamainternmed.2016.7674
45. Webb LE, Dmochowski RR, Moore IN, et al. Using Coworker Observations to Promote Accountability for Disrespectful and Unsafe Behaviours by Physicians and Advanced Practice Professionals. Jt Comm J Qual Patient Saf. 2016;42(4):149–AP3. doi: 10.1016/s1553-7250(16)42019-2
46. Hopkins J, Hedlin H, Weinacker A, Desai M. Patterns of Disrespectful Physician Behaviour at an Academic Medical Center: Implications for Training, Prevention, and Remediation. Acad Medicine J Assoc Am Medical Coll. 2018;93(11):1679–1685. doi: 10.1097/acm.0000000000002126
47. Katz MG, Rockne WY, Braga R, McKellar S, Cochran A. An improved patient safety reporting system increases reports of disruptive behaviour in the perioperative setting. Am J Surg. 2019;219(1):21–26. doi: 10.1016/j.amjsurg.2019.05.012
48. Jo Shapiro. Confronting unprofessional behaviour in medicine. BMJ 2018;360:k1025. doi: 10.1136/bmj.k1025