RESEARCH ARTICLE

Rumeysa Ekinci[1]
Ezgi Agadayi[2]
Roumina Yousefzadehmoghaddam[1]
Bogdan-Adrian Musat[3]
Suleyman Cayir[1]

[1] Sivas Cumhuriyet University, Faculty of Medicine, Medical Student, Sivas, Türkiye.
[2] Sivas Cumhuriyet University, Faculty of Medicine, Department of Medical Education, Sivas, Türkiye.
[3] University of Medicine, Pharmacy, Science, and Technology of Târgu Mureș, Medical Student, Târgu Mureș, Romania

Corresponding Author:
Ezgi Agadayi
mail: drezgiagadayi@hotmail.com

Received: 10.01.2025
Acceptance: 02.05.2025
DOI: 10.18521/ktd.1596098

Our study was presented as a Poster Presentation in 02-26 May 2023 at the 21st Family Medicine Research Days (21. AHAG).

Konuralp Medical Journal
e-ISSN1309–3878
konuralptipdergi@duzce.edu.tr
konuralptipdergisi@gmail.com
www.konuralptipdergi.duzce.edu.tr

Violence in Healthcare in Two Different Countries: A Study on Turkiye and Romania

ABSTRACT

Objective: The aim of this study is to assess the issue of violence in healthcare from the perspective of physicians in Sivas, Turkiye, and Sibiu, Romania.

Method: This research was conducted as a descriptive study. The study population comprised 500 participants from Turkiye and 200 from Romania. A 23-item data collection form, developed by the researchers, was used. The form was divided into sections covering sociodemographic characteristics, history of exposure to violence, and perspectives on violence. The form was initially created in Turkish, translated into Romanian, and underwent content validity assessment. Data were analyzed using the SPSS 22.0 software, applying descriptive statistical analysis, chi-square tests, and independent samples T-tests.

Results: Of the participants, 44% were from Turkiye and 56% from Romania. The rate of exposure to violence in healthcare was found to be 76% in Turkiye and 44% in Romania. In Romania, the most frequent setting for violence was the emergency department (53.7%), while in Turkiye, violence occurred equally in emergency departments and outpatient clinics (46.5%). The proportion of physicians considering working abroad due to healthcare-related violence was 33% in Turkiye and 5% in Romania. Physicians in both countries recommended legal reforms and stricter penalties, enhancing security in healthcare facilities, raising public awareness, and improving communication as key measures to prevent violence in healthcare.

Conclusions: Violence in healthcare was identified as a significant issue in both countries. The locations and causes of violence were similar. Turkish physicians expressed a higher desire to emigrate due to violence in healthcare. It is essential for policymakers in both countries to urgently address the prevention of violence in healthcare.

Keywords: Violence, Exposure To Violence, Physicians, Turkiye, Romania.

İki Farklı Ülkede Sağlıkta Şiddet: Türkiye ve Romanya Üzerine Bir Araştırma

ÖZET

Amaç: Bu çalışmada Türkiye Sivas'ta ve Romanya Sibiu'da sağlıkta şiddeti doktorların gözünden değerlendirmek amaçlanmıştır.

Yöntem: Araştırmamız tanımlayıcı bir çalışmadır. Araştırma evreni Türkiye'den 500, Romanya'dan 200 kişiden oluşmaktaydı. Araştırmacılar tarafından oluşturulan 23 soruluk veri toplama formu kullanıldı. Formun bölümleri; sosyodemografik özellikler, şiddet öyküsü ve şiddete bakış açısı şeklindeydi. Form Türkçe olarak oluşturuldu, sonrasında Romence'ye çevrilip kapsam geçerliliği yapıldı. Veriler SPSS 22.0 paket programı ile analiz edildi. Tanımlayıcı analizler, ki-kare testi, bağımsız örneklem T testi kullanıldı.

Bulgular: Katılımcıların %44'ü Türkiye'den %56'sı Romanya'dandı. Sağlıkta şiddete maruz kalma oranı Türkiye'de %76, Romanya'da %44 olarak bulundu. Şiddetin yeri ise Romanya'da en sık acil servisler (%53,7) iken, Türkiye'de acil servis ve poliklinik eşit (%46,5) olarak bulundu. Sağlıkta şiddet nedeniyle yurt dışında çalışmayı düşünen hekimlerin oranı Türkiye'de %33, Romanya'da ise %5'di. Sağlıkta şiddeti önlemek için her iki ülkedeki hekimlerin de önerileri; yasaların düzenlenmesi ve cezai yaptırımların artırılması, sağlık kuruluşlarında güvenliğin artırılması, halkı bilinçlendirme ve iletişimin iyileştirilmesiydi.

Sonuç: Sağlıkta şiddetin her iki ülkede de sorun olduğu tespit edildi. Şiddetin yaşandığı birimler ve sebepleri benzerdi. Türk hekimlerin sağlıkta şiddet nedeniyle beyin göçü gerçekleştirme isteği daha fazlaydı. Her iki ülke için de politika yapıcıların sağlıkta şiddeti önlemek konusunu acil olarak gündeme alması gerekmektedir.

Anahtar Kelimeler: Şiddet, Şiddete Maruz Kalma, Doktorlar, Türkiye, Romanya.

INTRODUCTION

Violence, one of the most significant problems faced by societies and seen in various sectors, is also prevalent in the healthcare field (1). According to the World Health Organization (WHO), violence is defined as physical assault, murder, verbal assault, emotional, sexual, or racial harassment. When considering workplaces, violence is observed to occur most frequently in the healthcare sector. A study highlighted that working in healthcare poses a sixteen times greater risk of experiencing violence compared to other industries (2). In this study, we adopt the following working definition of violence in healthcare institutions: "a situation involving threats, physical, or sexual assault coming from patients, their relatives, or any individual that poses a risk to healthcare workers." Where violence exists, there are undoubtedly underlying causes, and these must be carefully addressed (3).

The causes of violence in healthcare include a lack of communication, the influence of media, inadequate healthcare infrastructure, patient-related sociocultural factors, excessive patient load, insufficient number of doctors, shortcomings in legal regulations, and security vulnerabilities. Health communication, one of the essential aspects of communication, is "the form of communication carried out by individuals or groups on health-related issues, directed towards target audiences." The communication between healthcare workers and patients or their relatives cannot be evaluated independently of factors such as age, gender, education, socioeconomic, societal, and institutional factors. A lack of communication, one of the main causes of violence in healthcare, was identified as the most significant issue in a study (40.4%) (1). This communication gap can lead to legal disputes between doctors and patients. To minimize these issues, patients and their relatives should be thoroughly informed about medical interventions, clear communication should be established, and robust legal frameworks should be implemented in healthcare institutions. Media also plays a critical role in shaping public perception of violence in healthcare. The way incidents of violence against healthcare workers are reported, the frequent portrayal of such events, and the framing of medical malpractice cases contribute to the normalization of violence in society. Sensationalized reporting and the depiction of violence as a problem-solving method in movies and TV shows further reinforce this issue. Therefore, media ethics should be a guiding principle when deciding whether and how to report such incidents (1,4).

Another contributing factor is the reluctance of healthcare workers to file complaints after experiencing violence. Due to the low number of reports, driven by insufficient legal frameworks, the true extent of violence in healthcare remains unknown. Violence not only harms healthcare workers but also negatively affects the institution and other patients awaiting treatment. For healthcare workers to perform their duties effectively, they first and foremost need a safe working environment. Violence is not merely an attack that causes physical harm; it also leads to mental and emotional damage in individuals (1). According to the WHO, 8% to 38% of healthcare workers experience physical violence at some point in their careers. Healthcare workers are affected both psychologically and physically by such incidents, leading to a loss of job motivation. Consequently, violence against healthcare workers endangers the quality of care and disrupts the provision of healthcare services. It also results in significant financial losses for the healthcare sector (5).

The violence experienced by healthcare workers in Turkiye is also seen in other countries (1). In our study, we aimed to evaluate healthcare violence from the perspective of doctors in Sivas, Turkiye, and Sibiu, Romania.

MATERIAL AND METHODS

Study Type: This was a descriptive study.

Design: This study was conducted face-to-face in various departments of Sivas Cumhuriyet University (SCU) Hospital in Turkiye between February 2023, and May 2023, and Lucian Blaga University of Sibiu (LBUS) Hospital in Romania between February 2023, and March 2023. The study population consisted of a total of 700 individuals, with 500 participants from SCU and 200 from LBUS. No sample size calculation was performed in this study, as the aim was to include the entire population. All physicians were contacted and informed. The response rates were 17.2% for the center in Turkiye and 54% for Romania.

In this completed study, a post-hoc G-power analysis was conducted to determine the statistical power for a known population with an unknown prevalence. Based on this analysis, for a total population of 700, with an acceptable margin of error of 5%, and a sample size of 194, the confidence interval was determined to be 90%.

The research design and processes are shown in Figure 1 with a flow diagram.

Data Collection Tool: Participation in the study was based on voluntary consent. The exclusion criteria for the study were refusal to participate and incomplete completion of the questionnaire. The data collection tool used in the study consisted of 23 questions, which were developed by the researchers through a literature review. The first section of the questionnaire, composed of 8 questions, addressed sociodemographic characteristics; the second section, with 7 questions, explored participants' history of exposure to violence; and the third section, with 8 questions, examined their

perspectives on violence. One of the questions was open-ended, and thematic analysis was conducted for its evaluation.

The questionnaire was initially prepared in Turkish, then translated into English, and reviewed by three experts. After receiving approval from the experts, it was translated into Romanian by a Romanian researcher. This Romanian version was subsequently sent to three native Romanian-speaking experts for review and approval. The Turkish version of the form was used in Turkiye, and the Romanian version was applied in Romania.

Bias Reduction Strategies

Handling of Missing Data: Everyone who agreed to participate in the research completed the questionnaire completely.

Selection Bias: Since the study aimed to include all physicians in the selected hospitals, every eligible physician was contacted and informed about the study to encourage participation. However, participation was voluntary, which may have influenced response rates.

Reporting Bias: The questionnaire was designed based on a literature review to ensure comprehensiveness and neutrality. Participants were informed that their responses would remain anonymous, encouraging them to provide honest answers. Additionally, a mix of closed-ended and open-ended questions allowed for a more nuanced understanding of their experiences.

Translation Accuracy: To minimize any bias arising from language differences, the questionnaire underwent a rigorous translation and back-translation process, reviewed by multiple experts in both languages.

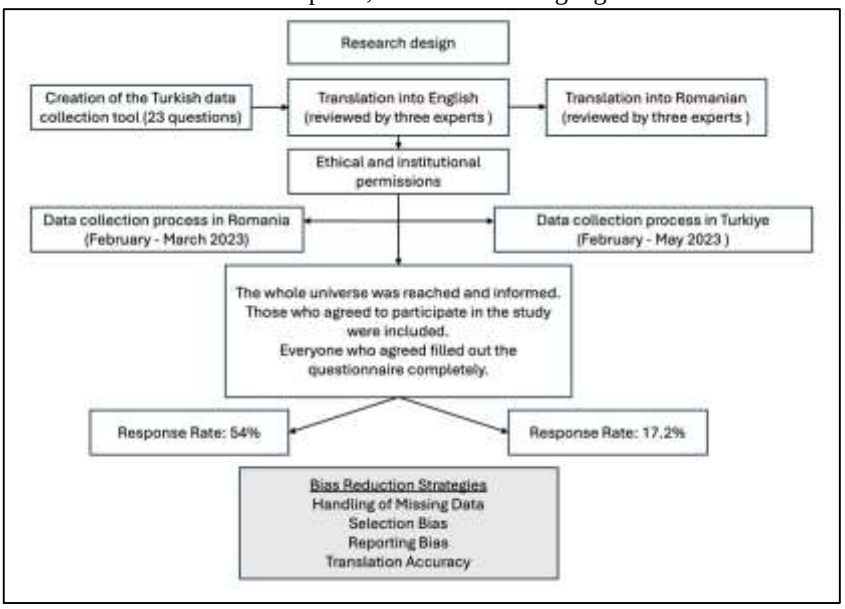

Figure 1. A flow diagram the research design and processes

Statistical Analysis: The data collected were analyzed using SPSS (Statistical Package for Social Sciences) package program for Windows version 22. The analysis of the skewness and kurtosis coefficients was used to determine whether the numerical data was adequate for a normal distribution. Most researchers (6, 7, 8) suggest that skewness and kurtosis values should be between -1 and +1 for normality, while some others propose a wider range (e.g., ±2) depending on the sample size. Considering the sample size in our study, we primarily followed Huck's (6) suggested criterion of -1 to +1; however, we acknowledge that alternative threshold values also exist. First, the data were evaluated by a descriptive statistical analysis. For numerical data, measures of central distribution (mean ± standard deviation) were determined, whereas frequencies were computed for categorical data. To compare categorical data, a chi-square test has been used. The T-test for independent samples was used to assess numerical data with normally distributed means that differed significantly between the two groups. With a 95% confidence interval, a p-value of less than 0.05 was accepted as statistically significant. For the evaluation of the open-ended question, two researchers developed codes and themes for the responses in Turkish, and a Romanian researcher did the same for the responses in Romanian. In a subsequent meeting involving all researchers, the final version of the themes was established, and decisions were made regarding which quotations would be included in the text.

Ethics Approval and Permissions: The study was approved by Sivas Cumhuriyet University Scientific Research and Publication Ethics Committee for Social and Human Sciences (approval date/number: 23.02.2023/E-99711239-050.04-268583). Approval to conduct the survey at LBUS was obtained from the dean of LBUS while approval for implementation at SCU was granted by the dean's office and hospital administration. Informed consent was obtained from all individual participants included in the study.

RESULTS

The average age of the 194 physicians participating in the study was 33.6 ± 8.2 years. Of the participants, 44.3% (n=86) were from Turkiye, and 55.7% (n=108) were from Romania. Regarding gender, 65.4% (n=125) of the physicians were female, and 34.6% (n=66) were male. Of the participants, 9.3% (n=18) were academics, 24.7% (n=48) were specialist doctors, and 66% (n=128) were resident doctors. In terms of specialties, 3.2% (n=6) were from basic sciences, 68.1% (n=128) from internal sciences, and 28.7% (n=54) from surgical sciences. The distribution of participants' demographic characteristics by country is shown in Table 1.

Table 1. The distribution of participants' demographic characteristics by country

	Turkiye		Romania		p
	n (%)	Mean ± SD	n (%)	Mean ± SD	
Age	-	32.6±7.7	-	34.3±8.6	0.142
Gender					
Female	45 (36.0)	-	80 (64.0)	-	**0.001**
Male	41 (62.1)	-	25 (37.9)	-	
Title					
Academician	18 (100)	-	0 (0)	-	
Specialist	5 (10.4)	-	43 (89.6)	-	**<0.001**
Resident	63 (49.2)	-	65 (50.8)	-	
Field of Specialization					
Basic Science	1 (16.7)	-	5 (83.3)	-	
Internal Science	65 (50.8)	-	63 (49.2)	-	**0.036**
Surgical Science	18 (33.3)	-	36 (66.7)	-	
Units*					
Emergency	28 (49.1)	-	29 (50.9)		0.431
Polyclinic	74 (54.8)		51 (45.2)		**<0.001**
Operation Room	19 (52.8)		17 (47.2)		0.180
Laboratory	1 (11.1)		8 (88.9)		**0.037**
Intensive Care	22 (71)		9 (29)		**0.001**
Primary Care	6 (54.5)		5 (45.5)		0.544
Inpatient care	29 (65.9)		15 (34.1)		**0.002**

* A person can work in more than one unit.

In Romania, 64.8% of participants (n=70) were satisfied with their specialty, while 32.4% (n=35) were partially satisfied. In Turkiye, the satisfaction rate with the specialty was 64.0% (n=55), and the rate of those who were partially satisfied was 31.4% (n=27). Satisfaction with the specialty was similar in both countries (p=0.784). Among the participants, 32.6% (n=28) in Turkiye and 13.0% (n=14) in Romania reported that they would change their specialty if given the opportunity (p=0.001).

The rate of participants in Romania who experienced violence in healthcare was 44.4% (n=48), whereas it was 75.6% (n=65) among participants in Turkiye. There was a significant difference in the experience of violence in healthcare between participants from the two countries (p<0.001). The frequency of experiencing violence from colleagues was 37.0% (n=40) in Romania and 80.2% (n=69) in Turkiye (p<0.001). When asked which gender of colleagues the violence they witness at work affects the most, Turkish physicians said they thought that female (36.2%) and male (31.9%) physicians were exposed to violence almost equally. In contrast, most physicians in Romania preferred not to specify gender (p=0.001). The incidence of violence in healthcare institutions in the past year was 52.8% (n=57) in Romania and 74.4% (n=64) in Turkiye (p=0.002). The frequency of verbal violence experienced by physicians in Turkiye was higher than that of physicians in Romania (p<0.001). There was no significant difference in the frequency of physical violence experienced (p=0.274). The units where violence was witnessed were more common in clinics and primary care settings in Turkiye compared to Romania, while in Romania, it was more frequent in operating rooms than in Turkiye. The data are presented in detail in Table 2.

The frequencies of hearing about violence in healthcare in the media were found to be 47.8% (n=32) daily, 35.8% (n=24) weekly, 11.9% (n=8) monthly, and 4.5% (n=3) very rarely in Turkiye. In Romania, these figures were 10.4% (n=11) daily, 17% (n=18) weekly, 31.1% (n=33) monthly, and 41.5% (n=44) very rarely. There was a significant difference between the two countries regarding the frequency of hearing about violence in healthcare in the media (p<0.001).

Table 2. The rates of exposure to violence in healthcare by country

	Turkiye		Romania		
	n (%)	Mean ± SD	n (%)	Mean ± SD	p
Personal exposure to violence		-		-	
Yes	65 (75.6)		48 (44.4)		<0.001
No	21 (24.4)		60 (55.6)		
Violence incidents in the institution in the last year		-		-	
Yes	64 (74.4)		57 (52.8)		0.003
No	22 (25.6)		51 (47.2)		
Violence exposure of colleagues		-		-	
Yes	69 (80.2)		40 (37.0)		<0.001
No	17 (19.8)		68 (63.0)		
Gender of colleague exposed to violence					
Female	25 (36.2)	-	7 (18.9)	-	
Male	22 (31.9)	-	7 (18.9)	-	0.001
Both	7 (10.1)	-	1 (2.7)	-	
Not specified	15 (21.7)	-	22 (59.5)	-	
Profession of colleague exposed to violence					
Medical doctor	50 (72.5)	-	19 (47.5)	-	
Other healthcare personnel	4 (5.8)	-	0 (0)	-	0.007
Other personnel	1 (1.4)	-	2 (5.0)	-	
Not specified	14 (20.3)	-	19 (47.5)	-	
The rate of personal exposure to violence					
Verbal					
None	16 (19.3)		64 (59.3)		<0.001
Five or less than five	41 (49.4)		23 (21.3)		
More than five	26 (31.3)		21 (19.4)		
Physical	17 (19.8)	1.7 ±1.4	10 (9.3)	2.9 ±3.7	0.274
The rate of witnessed healthcare violence					
Verbal					
None	29 (34.9)		63 (58.3)		0.003
Five or less than five	23 (27.7)		20 (18.5)		
More than five	31 (37.3)		25 (23.1)		
Physical		2.7±2.4		1.5±0.8	0.030
The units where witnessed violence in healthcare*					
Emergency	40 (46.5)		58 (53.7)		0.197
Polyclinic	40 (46.5)		11 (10.2)		<0.001
Operation Room	0 (0)		9 (8.3)		0.004
Laboratory	0 (0)		2 (1.9)		0.504
Intensive Care	6 (7.0)		4 (3.7)		0.343
Primary Care	9 (10.5)		3 (2.8)		0.036
Inpatient care	10 (11.6)		5 (4.6)		0.062
Other	1 (1.2)		1 (0.9)		0.871

* A person can work in more than one unit.

Physicians were asked to assess the extent to which violence in healthcare was a problem in their countries using a 10 cm visual analog scale (VAS). The VAS score for physicians in Turkiye was 9.25±1.6, while for those in Romania, it was 4.29±2.4 (p<0.001). Their concerns about experiencing violence while providing healthcare services were also assessed using the VAS. The average score for physicians in Turkiye was found to be 7.53±0.3, whereas the average for physicians in Romania was 3.69±2.7 (p<0.001).

The proportion of those considering practicing medicine abroad due to violence in healthcare was 32.6% (n=28) in Turkiye and 4.6% (n=5) in Romania (p<0.001). Among Turkish physicians who expressed a desire to go abroad, 37.5% (n=9) indicated a preference for Scandinavian countries, 25.0% (n=6) for Germany, 12.5% (n=3) for the United Kingdom, 4.2% (n=1) for the United States, and 16.7% (n=4) for other countries. In Romania, among those wishing to go abroad for this reason, 20% (n=1) preferred the United States, and another 20% (n=1) preferred other countries.

In Turkiye, 87.2% (n=75) of physicians believed that violence in healthcare had increased over the years, while 12.8% (n=11) thought it had not changed. In Romania, 36.1% (n=39) of physicians believed it had increased, 46.3% (n=50) thought it had not changed, and 17.6% (n=19) believed it had decreased (p<0.001). Regarding the causes of violence in healthcare in Turkiye, physicians attributed responsibility in order of frequency: inadequacy of legal regulations, security deficiencies, sociocultural factors, excessive patient load, insufficient healthcare infrastructure, lack of communication, insufficient quantity of physicians, and insufficient quantity of healthcare personnel. In Romania, the causes were attributed in order of frequency: sociocultural factors, insufficient quantity of healthcare personnel, insufficient quantity of physicians, insufficient healthcare infrastructure, lack of communication, inadequacy of legal regulations, security deficiencies, and excessive patient load. The physicians' opinions on the causes of violence in healthcare in their countries are presented in Table 3.

Table 3. The physicians' opinions on the causes of violence in healthcare in their countries

Reasons	Turkiye n (%)	Romania n (%)	p
Insufficient healthcare infrastructure			
Yes	61 (70.9)	61 (56.4)	0.070
Partially	17 (19.7)	33 (30.5)	
No	8 (9.3)	14 (12.9)	
Sociocultural factors			
Yes	79 (91.8)	89 (82.4)	0.040
Partially	7 (8.1)	17 (15.7)	
No	0 (0)	2 (1.8)	
Lack of communication			
Yes	55 (63.9)	59 (54.6)	0.347
Partially	27 (31.3)	40 (37)	
No	4 (4.6)	9 (8.3)	
Excessive patient load			
Yes	76 (88.3)	17 (15.7)	<0.001
Partially	10 (11.6)	49 (45.3)	
No	0 (0)	42 (38.8)	
Insufficient quantity of healthcare personnel			
Yes	53 (61.6)	66 (61.2)	0.369
Partially	22 (25.5)	34 (31.4)	
No	11 (12.7)	8 (7.4)	
Insufficient quantity of physicians			
Yes	53 (62.3)	66 (61.2)	0.880
Partially	21 (24.7)	31 (28.7)	
No	11 (12.9)	11 (10.1)	
Inadequacy of legal regulations			
Yes	81 (94.1)	54 (50)	<0.001
Partially	4 (4.6)	41 (37.9)	
No	1 (1.1)	13 (12.1)	
Security deficiencies			
Yes	80 (93)	54 (50)	<0.001
Partially	5 (5.8)	36 (33.3)	
No	1 (1.1)	18 (16.7)	

"16.3% (n=14) of physicians in Turkiye and 3.7% (n=4) of physicians in Romania identified other factors as causes of violence in healthcare. In Turkiye, the additional factors included the media targeting healthcare professionals, the free healthcare system, and the absence of a referral system. In Romania, the additional factors were the media targeting healthcare professionals, psychiatric patients, and unnecessary visits to emergency departments.

Responses to the open-ended question 'What regulations and changes can be made to prevent violence?' were classified according to countries, and codes and themes were developed. The themes that emerged for each country are shown in Table 4.

Table 4. The themes that emerged for each country

Turkiye	**Romania**
Legal regulations and punitive measures	Legal regulations and punitive measures
Security-enhancing regulations in healthcare institutions	Security-enhancing regulations in healthcare institutions
Awareness and communication	Awareness and communication
Factors affecting examination time and referral system	Factors affecting examination time and efficient triage implementation
Professional prestige	Professional prestige
	The presence of an on-call psychiatrist in emergency departments

When the codes under the themes in Turkiye were examined:

1.Legal regulations and punitive measures: Physicians recommended that the laws be clear, strict, and enforceable. They suggested that European laws on violence in healthcare should serve as a model and that all penalties should be applied without suspension. As punitive measures, they proposed prison sentences, financial penalties, restricting the perpetrator's right to receive healthcare in that institution or city, or completely barring access to healthcare, and removing them from social security coverage. They also mentioned that news about the penalties given to perpetrators of violence could be published in the media as a deterrent.

2.Security-enhancing regulations in healthcare institutions: Turkish physicians recommended the assignment of police officers to work in hospitals and increasing the effectiveness of hospital security personnel. They suggested increasing security measures such as placing x-ray machines at hospital entrances to prevent sharp and piercing objects from entering healthcare facilities. They also proposed limiting the number of companions allowed with patients and prohibiting individuals without an appointment from entering the hospital.

3.Awareness and communication: They suggested teaching topics such as communication, hospital procedures, empathy, and health literacy to the public, starting in elementary school, and developing projects for this purpose. They noted that the use of appropriate language by politicians could have a positive impact on society. Additionally, they recommended adding courses during the pre-graduation period to improve communication skills for healthcare professionals.

4.Factors affecting examination time: Physicians emphasized that examination times are too short, and patient loads are too high. To address this, they suggested adjusting working hours, extending examination times, and increasing the number of healthcare staff. They also mentioned that limiting the number of daily patients could help reduce waste in healthcare. Furthermore, they suggested introducing a referral system and strengthening primary care to prevent unnecessary patient referrals to secondary and tertiary care levels.

5.Professional prestige: They recommended preventing derogatory portrayals of doctors in the media and urged that politicians and other influential individuals refrain from using language that undermines respect for healthcare professionals.

When the codes under the themes in Romania were examined:

1.Legal regulations and punitive measures: They recommended tightening legal regulations and ensuring their strict enforcement. They also suggested banning violent behavior and removing perpetrators from healthcare institutions.

2.Security-enhancing regulations in healthcare institutions: They recommended placing security cameras in hospitals and regularly monitoring them. They noted that the presence of police officers and security personnel in healthcare institutions could help prevent violence. Additionally, they proposed installing panic buttons in clinic rooms to facilitate effective intervention in case of an attack. They suggested limiting the number of companions allowed with patients and adding a warning note to the medical records of patients who had previously displayed aggressive behavior in healthcare settings.

3.Awareness and communication: They proposed educating patients about their responsibilities, behavioral rules, and the importance of communication in hospitals and conducting awareness sessions on these topics.

4.Factors affecting examination time: They recommended preventing overcrowding in healthcare institutions, limiting the number of appointments, increasing the number of healthcare staff, creating suitable work schedules for healthcare personnel, and implementing effective triage to reduce patient waiting times.
5.Professional prestige: They recommended ending the negative portrayal of healthcare professionals in the media to boost ratings and avoiding approaches that undermine respect for healthcare professionals.
6.On-call psychiatrist in emergency departments: They suggested creating a separate psychiatry unit in emergency departments and employing psychiatrists on a shift basis.

DISCUSSION

As noted by the WHO, violence in healthcare is a global issue (5). According to the data, between 8% and 38% of healthcare workers experience physical violence, and even higher rates experience threats and verbal abuse (9). Studies conducted in different countries have confirmed the high prevalence of workplace violence in healthcare. For example, in Australia, 72% of healthcare workers reported experiencing workplace violence (10), while another study found that 65% of nurses, 42% of occupational therapists, and 27% of physiotherapists were exposed to violence annually (11). Similar patterns have been observed in Italy, China, and Romania, where significant proportions of healthcare workers report exposure to violence (12–14).

In our study, 75.6% of doctors in Turkiye and 44.4% in Romania reported experiencing violence, highlighting that violence in healthcare is a widespread and pressing issue (1). Comparisons with other countries indicate that healthcare violence is not limited to specific regions. In the U.S., the rate of physical violence against physicians is four times higher than in any other profession (15), and in Germany, 94.1% of healthcare workers reported verbal abuse, with 33.3% experiencing psychological distress as a result (16).

Among Iranian nurses, the prevalence of verbal, physical, sexist, and racist violence, as well as threats, was found to be 81%, 25%, 7%, 15%, and 44%, respectively (17). Ayrancı's study (18) found that 69.5% of doctors had experienced verbal violence, while Hostiuc et al. reported that 93.4% of intern doctors had experienced psychological violence and 19.6% had experienced physical violence (14).

Our study found that 19.8% of doctors in Turkiye and 9.3% in Romania reported experiencing physical violence, whereas the rates of verbal violence were significantly higher, at 80.7% in Turkiye and 40.7% in Romania. Current literature indicates that female healthcare workers are disproportionately harmed by violence (19,20), even though both Turkish and Romanian physicians stated that violence affects male and female physicians equally. The higher incidence of verbal violence against female healthcare workers may be attributed to the perception that women are more vulnerable, their responses are less assertive compared to men, and their reactions are often met with sensitivity due to the patriarchal nature of society (21).

The emergency department was identified as the most frequent site where violence occurred in both Turkiye (46.5%) and Romania (53.7%). Previous studies have consistently highlighted emergency departments as high-risk settings for violence (18,20,22). Additionally, Turkish physicians in our study reported experiencing more frequent violence in outpatient clinics and primary care compared to their Romanian counterparts. This aligns with findings from previous research in Turkiye, where the lifetime prevalence of violence among family physicians in primary care was reported as 82% (23).

Factors contributing to violence in healthcare settings include high patient loads, staff shortages, long waiting times, demanding patient behavior, and communication issues (1,22). In our study, Turkish physicians most frequently cited insufficient legal regulations and security deficiencies as the primary causes of violence. In contrast, Romanian physicians emphasized sociocultural factors and the shortage of healthcare personnel as the main contributing factors. These findings are consistent with previous research, which has highlighted the role of weak legal enforcement and systemic healthcare challenges in exacerbating workplace violence (20).

It is also acknowledged that the media has a significant impact on how the general public views healthcare violence. In this study, Turkish physicians reported significantly higher exposure to media coverage of healthcare violence compared to their Romanian counterparts. Sensationalized media report coverage of violence may contribute to normalizing it and lessen the perceived seriousness of assaults on medical personnel (1). Responsible journalism should aim to frame such incidents to discourage violence rather than reinforce it.

In this study, Turkish physicians most frequently cited insufficient legal regulations and security deficiencies as the primary causes of violence. In contrast, Romanian physicians most frequently pointed to sociocultural factors and the shortage of healthcare personnel and doctors. Physicians in both countries recommended strengthening legal regulations, increasing punitive measures, enhancing security in healthcare facilities, raising public awareness, and improving communication between healthcare professionals and patients. While similar suggestions were made in Romania, they also proposed the presence of on-call psychiatrists in emergency departments. Data on violence against physicians in Romania was

limited in the literature. Carra attributes this to the fact that, prior to the 1989 Romanian Revolution, authorities considered presenting statistics that could damage the country's image as "inappropriate," and studies on this issue increased after the 2006 Health Reform Law was enacted (24).

The migration of physicians due to workplace violence has emerged as a growing concern, particularly in Turkiye. Factors such as high patient volume, excessive workloads, long working hours, wage disparities, limited opportunities for education, research, and career development, and most notably, the increasing incidents of violence against physicians are cited as the main reasons driving doctors to emigrate (25). In Ünlü's study, 63% of medical students expressed their intention to work abroad in the future (26). In our study, the percentage of physicians considering leaving their country due to healthcare violence was 33% in Turkiye and 5% in Romania, demonstrating a statistically significant difference between the two countries.

Family physicians play a crucial role in providing holistic, continuous care. Gökdemir (27) emphasized that the increasing violence in healthcare could be mitigated through policies that align with the "holistic model" and "comprehensive approach" fundamental principles of family medicine. Family physicians deal with all health-related physical, mental and social conditions of the patient within the scope of holistic care. The family physician is in the best position to ensure continuity of care because he/she knows the patient's past life, problems, illnesses, past and current medications, and the patient's lifestyle thanks to the opportunity provided by the long-term patient-physician relationship and is ready to cooperate with secondary and tertiary healthcare institutions if requested. One of the pillars of this problem can be solved by increasing the respected position of family physicians in society and strengthening their opportunities rather than restricting them.

CONCLUSION

Violence in healthcare is a global issue. In our study, the views of physicians from Turkiye and Romania were collected. The rate of exposure to violence was found to be significantly different between the two countries: 44% in Romania and 76% in Turkiye. Verbal violence was more frequently observed in Turkiye. In terms of the locations of violence, emergency departments were the most common setting in Romania, while in Turkiye, violence was equally common in emergency departments and outpatient clinics. Turkish physicians felt that media coverage of healthcare violence was more frequent. The percentage of physicians considering working abroad due to violence was 33% in Turkiye and 5% in Romania. Turkish physicians attributed the high frequency of violence to inadequate legal regulations and security shortcomings, whereas Romanian physicians most often pointed to sociocultural factors and the insufficient number of healthcare personnel and doctors. To prevent healthcare violence, physicians in both countries proposed strengthening legal regulations and punitive measures, enhancing security in healthcare facilities, raising public awareness, and improving communication.

Limitation

A single center was included in the study from each country; therefore, the results cannot be generalized to the entire population of either country. Another limitation is the low participation rate of Turkish physicians, which may be attributed to their heavy workload, leaving them unwilling to allocate time for the study. Additionally, some physicians may have been reluctant to discuss violence due to the negative experiences they have encountered. This low participation rate may have affected the study results.

Our study aimed to compare the perception of violence in healthcare among physicians in two different countries and provides important results. However, further investigation of the underlying causes could deepen the analysis. Focus group interviews with qualitative methods are recommended for future studies.

Funding: This study did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

Conflict of Interest: The authors declare no conflicts of interest related to this study.

REFERENCES

1. Solmaz B, Duğan Ö. Sağlık çalışanı ile hasta ve yakınları arasında yaşanan şiddetin nedenlerinden "iletişim" üzerine bir inceleme. Bolu Abant İzzet Baysal Üniversitesi Sosyal Bilimler Enstitüsü Dergisi. 2018;18(2):185-206.
2. Erten R, Öztora S, Dağdeviren HN. Sağlık kuruluşlarında doktorlara yönelik şiddet maruziyetinin değerlendirilmesi. Türkiye Aile Hekimliği Dergisi. 2019;23(2):52–63.
3. Aslan Ş, Yağcı Özen M, Güzel Ş. Sağlıkta şiddet: retrospektif bir inceleme. International Journal of Social and Humanities Sciences Research. 2019;6(44):3636–43.
4. Kaya K, Köken Tok Ö. Sağlıkta şiddetin bir başka yüzü: medya etkisi. Harran Üniversitesi Tıp Fakültesi Dergisi. 2021;18(2):217-20.
5. World Health Organization. Preventing violence against health workers [Internet]. Available: https://www.who.int/activities/preventing-violence-against-health-workers
6. Huck SW. Reading statistics and research, 6th ed. Boston: Pearson, 2012.

7. George D, Mallery P. SPSS for Windows step by step: A simple guide and reference. 4th ed. Boston: Allyn & Bacon; 2003.
8. Tabachnick BG, Fidell LS. Using multivariate statistics. 6th ed. Boston: Allyn and Bacon; 2013.
9. Hoşgör H, Türkmen İ. Bitmeyen çile: Sağlıkta şiddet (Medimagazin haber portalı üzerinden bir araştırma). Izmir Democracy University Health Sciences Journal, 2021;4(2):192-211.
10. Alexander C, Fraser J. Occupational violence in an Australian healthcare setting: implications for managers. J Healthc Manag. 2004;49(6):377-92.
11. Mullan B, Badger F. Aggression and violence towards staff working with older patients. Nursing standard. 2007;21(27):35–38.
12. Magnavita N, Heponiemi T. Violence towards health care workers in a Public Health Care Facility in Italy: a repeated cross-sectional study. BMC Health Serv Res. 2012;12:108.
13. Xing K, Jiao M, Ma H, Qiao H, Hao Y, Li Y et al. Physical Violence against general practitioners and nurses in Chinese Township Hospitals: a cross-sectional survey. PLoS One. 2015;10(11):e0142954.
14. Hostiuc S, Dermengiu D, Hostiuc M. Violence against physicians in training. A Romanian perspective. J Forensic Leg Med. 2014;27:55-61.
15. National Institute for Occupational Safety and Health (NIOSH). Violence: Occupational hazards in hospitals [Internet]. 2002. Available: https://stacks.cdc.gov/view/cdc/11401
16. Schablon A, Wendeler D, Kozak A, Nienhaus A, Steinke S. Prevalence and consequences of aggression and violence towards nursing and care staff in Germany-A survey. Int J Environ Res Public Health. 2018;15(6):1274.
17. Azami M, Moslemirad M, YektaKooshali MH, Rahmati S, Soleymani A, Shamloo MBB et al. Workplace violence against Iranian nurses: a systematic review and meta-analysis. Violence Vict. 2018;33(6):1148-75.
18. Ayranci U. Violence toward health care workers in emergency departments in west Turkey. J Emerg Med. 2005;28(3):361-5.
19. Jackson M, Ashley D. Physical and psychological violence in Jamaica's health sector. Rev Panam Salud Publica. 2005;18(2):114-21.
20. İlhan MN, Çakır M, Tunca MZ, Avcı E, Çetin E, Aydemir Ö, et al. Toplum gözüyle sağlık çalışanlarına şiddet: nedenler, tutumlar, davranışlar. Gazi Medical Journal, 2013; 24(1):5–10.
21. Sahebi A, Jahangiri K, Sohrabizadeh S, Golitaleb M. Prevalence of workplace violence types against personnel of emergency medical services in Iran: A systematic review and meta-Analysis. Iran J Psychiatry. 2019;14(4):325-34.
22. Türkmenoğlu B, Sümer EH. Sivas il merkezi sağlık çalışanlarında şiddete maruziyet sıklığı. 2017;17(4):216-25.
23. Uğraş Tiryaki E, Şimşek E. Aile sağlığı merkezinde sağlık çalışanlarına şiddet. MEYAD Akademi. 2024;5(1):37-49.
24. Carra C, Burlacu S, Faggianelli D. Violence within organizations in the health and medico-social sectors, comparative analysis France-Romania. Administratie si Management Public. 2016;27:123–42.
25. Aydan S. Hekim göçü açısından Türkiye'nin çalışma koşullarının değerlendirilmesi. Hacettepe Sağlık İdaresi Derg. 2023;26(3):895–920.
26. Ünlü HY, Daşlı Y. Sağlık eğitimi alan öğrencilerin beyin göçüne yönelik tutumları. Sosyal, Beşerî ve İdari Bilimler Dergisi. 2024;7(8):606-21.
27. Gökdemir Ö, Bhattacharya S. Violence at healthcare. Turkish Journal of Family Medicine and Primary Care. 2020;14 (2):323-8.