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Violence Against Healthcare Workers in Türkiye and Globally: A Narrative Review

Ali Ağar[1*], Soner Berşe[2]

[1]Artvin Çoruh University, Department of Occupational Health and Safety, Artvin, Türkiye.

[2]Gaziantep University, Department of Nursing, Faculty of Health Sciences, Gaziantep, Türkiye.

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ABSTRACT

Purpose: Violence against healthcare workers (HCWs) represents a major global public health concern with significant individual, organizational, and systemic consequences. Although workplace violence in healthcare has been widely documented, comparative analyses addressing structural determinants and healthcare systems providing universal access remain limited. This narrative review aims to examine the types, risk factors, consequences, and prevention strategies related to violence against HCWs, with particular attention to Türkiye's White Code system and international practices.

Materials and Methods: A narrative review methodology was adopted. Peer-reviewed journal articles, policy documents and institutional reports addressing workplace violence against HCWs were identified through an iterative search process, with priority given to sources reporting prevalence, risk factors, consequences, prevention strategies and policy responses, and to literature relevant to the Turkish context. Reports issued by the World Health Organization and the Turkish Ministry of Health were also examined. Evidence was synthesized narratively and organized according to the Social Ecological Model.

Results: Reported prevalence of workplace violence among HCWs ranged from 9.5% to 100% across studies and countries, with verbal abuse emerging as the most frequently reported form of violence. Cross-country comparisons revealed substantial variation related to healthcare system structures, reporting mechanisms, and methodological differences. In Türkiye, the White Code system represents an important institutional response; however, underreporting, organizational distrust, and limited evidence regarding long-term effectiveness remain significant challenges. Sexual harassment was identified as a major concern for nurses, with substantial implications for workforce retention. Findings also demonstrated that violence is shaped by interacting factors across multiple levels, including communication problems, staffing shortages, cultural norms, and policy-level healthcare pressures.

Conclusion: Violence against HCWs should be understood as a multi-level systemic issue rather than an isolated occupational hazard. This review contributes by integrating international evidence through the Social Ecological Model, highlighting structural differences across healthcare systems, and identifying gaps in evaluating institutional interventions. Effective prevention requires coordinated strategies at individual, organizational, community, and policy levels.

Keywords: Workplace violence, Health personnel, Nurses, Occupational health, Türkiye

***Corresponding author:** Ali Ağar, E-mail: aliagar@artvin.edu.tr ORCID: 0000-0003-2771-9587 (A. Ağar); 0000-0001-9108-3216 (S. Berşe)

Introduction

Violence against healthcare workers (HCWs) has emerged as a critical global public health concern that demands urgent attention from researchers, policymakers, and healthcare administrators. According to World Health Organization reports and multinational survey data, healthcare workers are among the occupational groups most frequently exposed to workplace violence (1, 2). This high level of occupational exposure underscores the unique vulnerabilities inherent in healthcare settings and highlights the urgent need for comprehensive prevention strategies.

The consequences of violence against HCWs extend far beyond individual harm. At the organizational level, violence threatens healthcare service quality, patient safety, and health system sustainability (3, 4). At the individual level, violent incidents diminish professional motivation, trigger burnout syndrome, and contribute to high turnover rates (5). Perhaps most concerning for the future of healthcare, evidence suggests that violence may be contributing to declining interest in healthcare careers among medical students (6).

Similar patterns of healthcare violence have been documented across diverse healthcare systems; however, the structural determinants of violence vary considerably across countries. Factors such as healthcare financing models, patient-provider ratios, service accessibility, cultural attitudes toward healthcare professionals, and institutional reporting mechanisms may shape both the frequency and nature of violent incidents. Compared with many OECD countries, Türkiye's healthcare system is characterized by high outpatient demand, heavy physician workloads, and a rapidly expanding universal healthcare model, which may intensify tensions between patients and healthcare professionals (7).

Türkiye presents a particularly instructive case for examining workplace violence in healthcare. As a country providing universal free healthcare through public hospitals, Türkiye experiences distinctive challenges including high patient volumes, extended waiting times, and communication difficulties that elevate violence risk (8). In response, the Turkish Ministry of Health implemented the White Code (Beyaz Kod) Emergency Call System in 2012, making it mandatory across all healthcare institutions (9, 10). Despite this significant policy intervention, implementation challenges persist, and violence continues to be a major concern for Turkish HCWs.

Previous studies have predominantly focused on prevalence estimates, descriptive characteristics of violent incidents, and legal dimensions of workplace violence in healthcare settings. Although these studies have substantially contributed to understanding the scope of the problem, relatively limited attention has been given to cross-national comparisons and broader system-level determinants of violence, particularly in healthcare systems characterized by high patient demand and universal service provision. In particular, limited evidence exists regarding how high patient volumes influence violence patterns, how cultural factors shape reporting behaviors, and how effective institutional mechanisms are in preventing workplace violence (11, 12, 13). Therefore, this narrative review aims to examine the scope, causes, and consequences of violence against healthcare workers from a multidimensional perspective, compare Turkish practices with international examples, and provide evidence-based recommendations for policymakers, healthcare administrators, and nursing leaders.

Materials and Methods

Theoretical Framework

This review is guided by the Social Ecological Model (SEM), which originates in Bronfenbrenner's ecological systems theory (14) and was reformulated for health promotion and prevention research by McLeroy et al. as the five-level individual, interpersonal, organizational, community and policy framework applied here (15). Recent empirical studies also emphasize that violent incidents are shaped not only by individual behaviors but also by organizational climate and systemic workload pressures (16, 17).

This framework is particularly suitable for analyzing violence against HCWs because it acknowledges the multifaceted nature of this phenomenon and guides the identification of intervention points at various levels.

As illustrated in Figure 1, the SEM framework identifies five interconnected levels of influence on violence against HCWs:

1. **Individual level:** Characteristics of perpetrators (patients, visitors) including mental health status, substance use, unrealistic expectations, and prior history of violence; and characteristics of HCWs including communication skills, experience, and resilience.
2. **Interpersonal level:** Quality of patient-provider communication, family dynamics, and relationships between healthcare team members that may influence violence occurrence and reporting behaviors.
3. **Organizational level:** Institutional factors including staffing levels, security measures, reporting systems (e.g., White Code), training programs, and organizational culture regarding violence prevention and response.
4. **Community level:** Cultural norms regarding acceptable behavior toward HCWs, media portrayal of healthcare professionals, and community expectations of healthcare services.
5. **Policy level:** Legislation protecting HCWs, healthcare system design (e.g., universal free care), resource allocation, and enforcement mechanisms. In the Turkish context, healthcare reforms aimed at expanding universal healthcare access have increased service utilization, which may indirectly contribute to overcrowding and heightened workplace tensions (7).

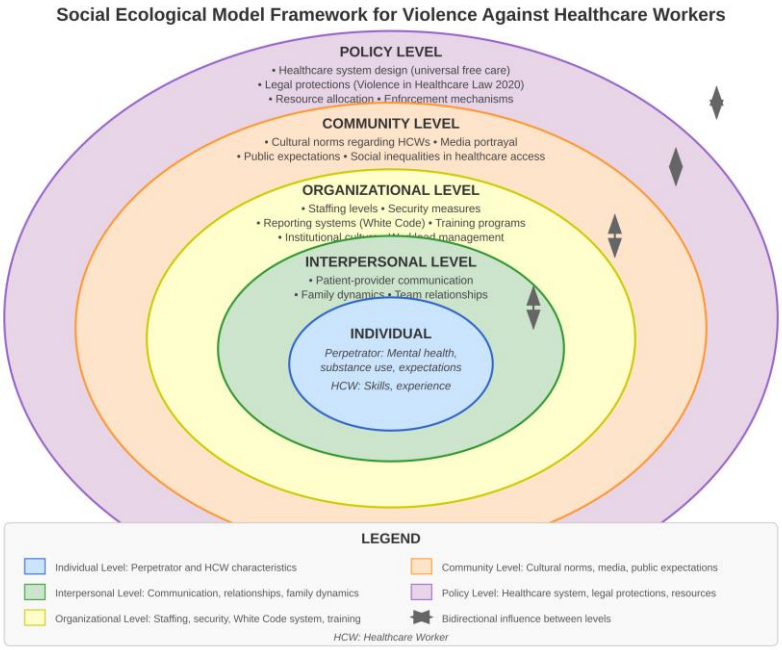

Figure 1. Social Ecological Model framework for understanding violence against healthcare workers. The model illustrates five interconnected levels of influence: individual factors (perpetrator and healthcare worker characteristics), interpersonal factors (patient-provider communication, family dynamics), organizational factors (staffing, security, reporting systems), community factors (cultural norms, public expectations), and policy factors (healthcare system design, legal protections). Bidirectional arrows indicate mutual influence between levels. Developed by the authors based on the Social Ecological Model (14, 15). HCW: Healthcare worker

In the Results section, the identified findings are interpreted through these SEM dimensions. For example, communication-related conflicts are discussed at the interpersonal level, staffing shortages and White Code implementation challenges at the organizational level, and structural healthcare policies at the policy level.

Study design
This study employed a narrative review methodology to provide a broad conceptual overview of violence against healthcare workers. Narrative reviews are particularly useful for synthesizing diverse evidence on complex public health issues where the aim is to integrate findings from different types of literature rather than conduct a formal systematic synthesis (18). Reporting was guided by the Scale for the Assessment of Narrative Review Articles (SANRA) quality criteria (19).

Literature selection
Relevant literature published in English or Turkish between 2010 and 2025 was identified through iterative searches, supplemented by hand-searching the reference lists of eligible publications. Peer-reviewed journal articles, policy documents and institutional reports related to workplace violence against healthcare workers were considered. Priority was given to studies addressing prevalence, risk factors, consequences, prevention strategies, and policy responses, particularly those relevant to the Turkish healthcare context. Seminal conceptual and framework sources published before 2010 were retained irrespective of the date restriction.

In addition, reports published by organizations such as the World Health Organization and Turkish Ministry of Health were reviewed to contextualize policy-level findings.

Data synthesis
The selected literature was analyzed using a narrative synthesis approach and findings were organized according to the Social Ecological Model. Key themes included types of violence, prevalence patterns, risk factors, consequences, institutional responses such as the White Code system, and policy implications.

Results

Definition and classification of violence
According to the joint framework developed by the International Labour Organization (ILO), International Council of Nurses (ICN), World Health Organization (WHO), and Public Services International (PSI), workplace violence encompasses "incidents where staff are abused, threatened or assaulted in circumstances related to their work" (20). Violence is classified into physical violence (hitting, pushing, kicking, sexual assault) and psychological violence (verbal abuse, threats, bullying/mobbing, sexual harassment) (20, 21). Table 1 presents prevalence ranges of different violence types. These findings primarily reflect individual- and interpersonal-level determinants of workplace violence within the Social Ecological Model framework, particularly communication-related and patient–provider interaction factors.

Table 1. Prevalence of violence types against healthcare workers

Type of Violence	Prevalence (%)	Source
Verbal abuse	42.1–94.3	(21, 22)
Threats	14.0–57.4	(21, 23)
Physical assault	0.5–15.9	(21, 24)
Sexual harassment	12.6–53.4	(25, 26)
Bullying/Mobbing	2.5–5.7	(21)
Overall (any type)	9.5–74.6	(21, 27)

Note: Ranges are drawn from different primary studies and reviews and are not directly comparable. Type-specific and overall estimates originate from different study sets with different denominators and recall periods (12-month versus career prevalence); a type-specific range may therefore exceed the overall range. Differences in study populations, definitions of violence, healthcare settings and data collection methods further contribute to heterogeneity.

Global epidemiology

Violence in the healthcare sector transcends geographical boundaries, representing a truly global problem. However, reported prevalence varies substantially across countries due to differences in healthcare system structures, reporting mechanisms, and study methodologies (11, 24). At the community and policy levels, these variations additionally reflect differences in cultural tolerance of violence toward healthcare professionals, as presented in Table 2.

Table 2. International comparison of violence against healthcare workers

Country	Prevalence	Main Type	Reporting System	Source
Türkiye	44.7%	Combined	White Code (mandatory)	(28)
China	65.8%	Verbal	Hospital-based	(29)
Saudi Arabia	57%	Psychological	Ministry reporting	(30)
Morocco	76%	Verbal	Limited	(31)
Italy	10%	Physical	Regional systems	(32)
Pakistan	25–100%	Verbal	Limited	(33)

Note: Prevalence estimates are not fully standardized across countries and may reflect differences in study design, definitions of workplace violence, and healthcare system reporting practices. Therefore, values should be interpreted as indicative rather than directly comparable.

Türkiye's White Code System

The White Code (Beyaz Kod) Emergency Call System represents Türkiye's primary institutional response to violence against HCWs. Established under the Ministry of Health's employee safety regulations and applied across all healthcare institutions, the system can be activated through the in-hospital extension "1111," which triggers an immediate security response, and through the nationwide "113" White Code call center or the Ministry's online notification form, both of which initiate the administrative and legal process (9, 10). Strengths include standardized documentation and integration with legal processes. However, reporting rates remain low, primarily because of reluctance to become involved in subsequent legal proceedings and perceptions that deferred sentences weaken deterrence; difficulty in reaching a telephone during an assault has also been reported, although the availability of the 113 line and online notification suggests that this accounts for only part of the shortfall (10, 34). Law No. 7243 of 2020, which amended Additional Article 12 of Law No. 3359 on Fundamental Health Services, increased by one half the sentences imposed for intentional injury, threat, insult and resisting an officer when these offences are committed against healthcare personnel because of their duties, and excluded such sentences from suspension (35). Within the Social Ecological Model framework, the White Code system represents an organizational and policy-level intervention aimed at improving reporting and response mechanisms. However, existing evidence suggests that its effectiveness is influenced by organizational culture and perceived trust in legal processes.

Sexual Harassment in Healthcare

Sexual harassment represents a particularly serious concern for female workers, who constitute approximately 70% of the global health and social care workforce (36). In a meta-analysis of 43 studies covering 52,345 nurses, pooled prevalence was 12.6% (95% CI: 10.9–14.4) for the preceding 12 months and 53.4% (95% CI: 23.1–83.7) across the nursing career, demonstrating that estimates depend heavily on the recall window applied (25). In an earlier Turkish study, 71.7% of nurses reported having experienced sexual harassment from patients, most commonly inappropriate staring (61.4%) and intrusive questions (34.8%) (37). Critically, sexual harassment has been associated with nurses' intention to leave their jobs and the profession, threatening workforce retention (38). These findings primarily reflect individual,

interpersonal, and organizational level risk factors, including gender imbalance in the healthcare workforce, communication dynamics, and institutional protection mechanisms.

Consequences of Violence

Violence produces both immediate and long-term consequences. Individual-level effects include physical injuries, anxiety, depression, post-traumatic stress disorder, and burnout syndrome (22, 24, 39). Organizational consequences include reduced healthcare quality, compromised patient safety, and high turnover rates (3, 4). System-level effects include healthcare workforce shortages and substantial economic costs from recruitment, training, absenteeism, and reduced productivity (40). These consequences thus span the individual, organizational, and system levels of the SEM framework.

Risk Factors

Risk factors operate at multiple levels: Individual factors include perpetrator mental illness, substance use, and unrealistic expectations (8, 41). Interpersonal factors include poor communication and language barriers (8). Organizational factors include inadequate staffing, long waiting times, insufficient security, and weak institutional policies (41, 42). Community factors include cultural norms tolerating violence and negative media portrayal (35). Policy factors include healthcare system design (universal free care creating high volumes) and inadequate legal enforcement (35, 43). These risk factors demonstrate the multi-layered nature of violence against healthcare workers within the Social Ecological Model framework, highlighting the interaction between individual behaviors and structural determinants.

Overall, the findings of this review are interpreted through the Social Ecological Model, demonstrating that violence against healthcare workers is not the result of a single-level determinant but rather the interaction of individual, interpersonal, organizational, community, and policy-level factors.

Discussion

This narrative review synthesizes evidence on violence against HCWs with particular attention to the Turkish context and implications for nursing. Several key findings warrant discussion. The wide prevalence range (9.5%–100%; Tables 1 and 2) reflects methodological heterogeneity including varying definitions, measurement instruments, denominators and recall periods. Future research would benefit from standardized approaches.

These findings are broadly consistent with international literature indicating that verbal abuse remains the most frequently reported form of violence in healthcare settings, while physical violence is reported less consistently across countries (11, 24). Similar to previous global studies, nurses appear to be disproportionately affected due to prolonged patient interaction, high emotional labor demands, and frontline exposure to patient dissatisfaction (26). However, substantial cross-country variation suggests that healthcare system structures, staffing models, and reporting cultures may significantly influence reported prevalence rates.

From a Social Ecological Model perspective, workplace violence should not be interpreted solely as a consequence of individual patient behavior. Rather, violent incidents emerge through interactions between interpersonal communication problems, organizational staffing shortages, community-level normalization of aggression toward healthcare professionals, and policy-level pressures such as overcrowding within universal healthcare systems. In the Turkish context, increased healthcare accessibility may have unintentionally intensified service demand, longer waiting times, and workplace tensions (34).

Türkiye's White Code system provides valuable lessons for institutional violence prevention. However, limited empirical evidence exists regarding its long-term effectiveness in reducing repeat incidents of workplace violence. Standardized documentation and legal integration offer a useful template for violence monitoring, while low reporting rates highlight the critical challenge that healthcare workers may distrust systems designed to protect them (10, 34). Addressing this requires complementary interventions including staff training and broader cultural change.

The sexual harassment findings are particularly concerning for nursing workforce sustainability. Given the documented association between sexual harassment and nurses' intention to leave,

this represents not only individual harm but a systemic threat requiring nurse-specific interventions. Beyond patient- and visitor-perpetrated violence, which is the focus of this review, recent Turkish evidence indicates that violence originating from colleagues shows modest associations with nursing students' perceptions of the profession and their career decisions, suggesting that intraprofessional violence warrants attention alongside external aggression (44).

Implications for nursing practice

Nurses should receive comprehensive training in violence recognition, de-escalation, and self-protection. Nurse managers should foster unit cultures where violence is neither tolerated nor normalized. Clinical protocols should address violence risk assessment in high-risk settings. Peer support systems should assist colleagues affected by violence.

Implications for policy

Policy implications include strengthened legal protections with effective enforcement; adequate resource allocation for security; modernization of reporting systems (e.g., mobile applications); mandatory violence prevention training in nursing curricula; and integration of violence prevention into healthcare accreditation standards.

Limitations

As a narrative rather than a systematic review, this study did not employ a formal quality assessment or meta-analysis. The focus on English and Turkish literature may have excluded relevant studies, and publication bias may have affected the findings. Additionally, although the primary evidence base covered the 2010–2025 period, with earlier conceptual and framework sources retained, the COVID-19 pandemic was not examined as a separate analytical category, which may have limited a more detailed understanding of pandemic-specific violence dynamics affecting healthcare workers. Despite these limitations, the review provides a comprehensive synthesis of current knowledge.

Conclusions

Violence against healthcare workers represents a complex, multifactorial phenomenon requiring multi-level intervention strategies. Guided by the Social Ecological Model, this narrative review synthesized evidence on the scope, determinants, and consequences of workplace violence in healthcare settings across multiple countries.

The findings indicate that violence prevalence remains highly variable across settings (9.5%–100%), with nurses being particularly vulnerable to verbal abuse and sexual harassment. At the system level, institutional responses such as Türkiye's White Code system illustrate efforts to address workplace violence, although implementation barriers limit their effectiveness.

This review contributes to the literature in three key ways:
(1) it integrates evidence using a Social Ecological Model framework to move beyond descriptive reporting toward multi-level analysis;
(2) it provides a comparative synthesis of healthcare violence patterns across countries, highlighting structural differences in reporting and healthcare system organization;
(3) it identifies gaps in evidence regarding the effectiveness of institutional interventions such as reporting systems and legal reforms.
Overall, violence against healthcare workers should be understood not only as an occupational hazard but as a systemic issue embedded within healthcare delivery structures. Protecting healthcare workers is essential for ensuring sustainable, safe, and high-quality healthcare systems.

Declarations

Ethical Approval Statement

Approval from an ethics committee was not required.

Author Contribution Statement

AA conceptualized the study and conducted the literature review.
SB contributed to the study design, critical revision, and academic supervision. Both authors read and approved the final manuscript.

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Conflict of Interest Statement

The authors certify that they have no affiliations with or involvement in any organization or entity with any financial (such as honoraria; educational grants; participation in speakers' bureaus; membership, employment, consultancies, stock ownership, or other equity interest; and expert testimony or patent-licensing arrangements) interest, or non-financial (such as personal or professional relationships, affiliations, knowledge or beliefs) interest in the subject matter or materials discussed in this manuscript.

Declaration on the Use of AI

In preparing this study, artificial intelligence tools were used solely for language support and spelling and grammar correction. The authors are solely responsible for all scientific content, interpretations and conclusions in this study.

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