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Behavioural Precursors of Violence Potential and Physician Responses in Public Healthcare: A Qualitative Inquiry

Kamu Sağlık Hizmetlerinde Şiddet Potansiyelinin Davranışsal İşaretleri ve Hekim Tepkileri: Nitel Bir İnceleme

Bilal GÜNAY [1] **Elif GENÇ TETİK** [2] **Ali Osman ÖZTÜRK** [3]

[1] *Nurse / MSc., Amasya Sabuncuoğlu Şerefeddin Training and Research Hospital, Health Institution Assessment and Development Unit, Amasya, Türkiye*

[2] *Assoc. Prof., Hitit University, Faculty of Economics and Administrative Sciences, Çorum, Türkiye*

[3] *Prof. Dr., Bandırma Onyedi Eylül University, Health Science Faculty & Rector of Hitit University, Çorum, Türkiye*

Sorumlu yazar / Corresponding author

Elif GENÇ TETİK
elifgenc@hitit.edu.tr

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ABSTRACT

Aim: *This study aims to examine conflict processes in patient–physician interactions in public hospitals; to identify emotional, verbal and behavioural precursors of violence shown by patients and their relatives; and to analyse how physicians perceive these warning signals and the emotional responses they experience after conflict.*

Material and Method: *The study was conducted using a qualitative design. Data were collected through semi-structured interviews with physicians working in emergency and outpatient units of a public hospital in Türkiye and through direct observations and interviews conducted in the Patient Rights Unit. Initially, behaviours of patients and relatives applying to this unit were observed, followed by interviews with patients/patients' relatives and physicians involved in conflict situations.*

Results: *Patients were observed to display early warning signs such as anger, impatience, threatening body language, raised voice, accusatory statements and increased stress reflecting a conflict environment with the potential for violence. Physicians reported fear of losing control, helplessness, anger and emotional exhaustion. It was found that signs of violent tendencies often appear before open aggression through communication problems and misunderstandings between the parties.*

Conclusion: *Even in the absence of overt violence, the potential for violence and the barriers on communication weaken healthcare delivery. Institutional recognition and management of early warning signals are essential for preventing violence in public hospitals.*

Keywords: *Conflict, Early warning indicators, Patient–physician interaction, Public hospitals, Violence in healthcare policy*

ÖZET

Amaç: *Bu araştırmanın amacı, kamu hastanelerinde hasta–hekim etkileşimlerinde ortaya çıkan çatışma süreçlerini incelemek; hastalar ve hasta yakınları tarafından sergilenen sözel, davranışsal ve duygusal şiddet öncüllerini tespit etmek; hekimlerin bu uyarı sinyallerini nasıl algıladıklarını ve çatışma sonrasında yaşadıkları duygusal tepkileri analiz etmektir.*

Gereç ve Yöntem: *Araştırma nitel tasarımda yürütülmüştür. Veriler, Türkiye'de bir kamu hastanesinin acil servis ve poliklinik birimlerinde çalışan hekimlerle yapılan yarı yapılandırılmış görüşmeler ve Hasta Hakları Biriminde gerçekleştirilen doğrudan gözlemler ve mülakatlar yoluyla toplanmıştır. İlk aşamada bu birime başvuran 30 hasta ve hasta yakınlarının davranışları gözlemlenmiş; ardından çatışma süreçlerine taraf olan 30 hasta/hasta yakını ve hekimle mülakatlar gerçekleştirilmiştir.*

Bulgular: *Hastaların şiddet potansiyeli barındıran bir çatışma ortamına işaret eden öfke, sabırsızlık, tehditkar beden dili, yüksek sesle konuşma, suçlayıcı söylemler ve artan stres gibi erken uyarı işaretleri sergiledikleri görülmüştür. Hekimler ise kontrol kaybı korkusu, çaresizlik, öfke ve duygusal tükenmişlik yaşadıklarını belirtmiştir. Ayrıca, şiddet eğilimine ilişkin işaretlerin çoğu zaman açık saldırıdan önce iletişim sorunları ve taraflar arasındaki yanlış anlamalar yoluyla ortaya çıktığı saptanmıştır.*

Sonuç: *Fiziksel veya sözel şiddet gerçekleşmese dahi, şiddet potansiyeli ve iletişim kırılmaları sağlık hizmeti sunumunu zayıflatmaktadır. Erken uyarı işaretlerinin kurumsal düzeyde tanınması ve yönetilmesi şiddetin önlenmesinde temel stratejidir.*

Anahtar Kelimeler: *Çatışma, Erken uyarı işaretleri, Hasta–hekim etkileşimi, Kamu hastanesi, Sağlıkta şiddet politikası*

INTRODUCTION

Violence in healthcare is a multidimensional phenomenon that extends beyond physical attacks to include verbal, psychological and symbolic forms of aggression. Patient–physician communication in public hospitals typically occurs under significant stress, time pressure and emotional tension, increasing the likelihood of conflict. In Türkiye, physicians face heavy workloads and bureaucratic processes intensively; these conditions might affect their capacity for calm and constructive communication during patient consultations. As a result, both parties become more vulnerable to conflict. While many disagreements could be resolved through empathy and effective communication, minor experiences of anger, frustration and helplessness can escalate into violent incidents. Although violence is often perceived as an unpredictable event, growing evidence suggests that it is mostly preceded by identifiable warning signals. Therefore, identifying the signals systematically and empowering physicians' ability to recognize and effectively respond to them is essential for preventing conflict and reducing emotional exhaustion (Ayrancı, Yenilmez, Balcı & Kaptanoğlu, 2006).

Violence in healthcare is an escalating problem worldwide and in Türkiye, with studies indicating that more than half of healthcare workers have experienced at least one form of violence, predominantly verbal aggression (Al et al., 2012). Media-based analyses done by the Association for the Prevention and Rehabilitation of Violence (2023) reveal an 85.7% increase in violent incidents in the past years, mostly affecting nurses and physicians. These findings indicate that violence, in its various forms, affects all healthcare professionals in our country.

The distribution of violence differs by health workers depending on the frequency of their interactions with patients and their relatives. Nurses experience the highest rates of violence, followed by physicians, while administrative staff are affected to a lesser extent (Terkeş, İlter & Zorlu, 2022). Emergency departments and outpatient clinics, that are characterized by dense and stressful workplaces, are the settings where conflict and violence occur most commonly (Güven & Kurt, 2023). Underlying violent incidents against healthcare workers also lies the perception that violence may be useful as a tool for problem-solving (Oğan, 2012). When patients or their relatives believe that their goals to utilize healthcare services are obstructed, they might resort to violence to solve the problem they perceive. Sometimes, the source of the conflict may also stem not only from patient expectations but also from deficiencies in service delivery or communication gaps between healthcare staff and citizens (O'Brien, van Zundert & Barach, 2024; Yin et al., 2024).

In workplace characterized by intense interaction, such as hospitals, the processual nature of violence becomes more visible. According to the model developed by Tobin (2001), workplace violence unfolds through sequential stages, frustration, conflict, aggression and ultimately violence. Examining all these stages in detail allows for the early identification of violent behaviours and the development of preventive intervention strategies. The progression of violence can be conceptualized through a series of emotional and behavioural phases: the crisis stage, in which emotional stability and control begin to deteriorate; the anger stage, where frustration transforms into anger and behavioural regulation decreases; the aggression stage, in which anger becomes visible through actions: and finally the violence stage, when the person resorts to violence because they perceive it as justified. These phases are shaped by changes in emotions during decision-making and by organizational or environmental factors. Seeing violence as a dynamic process influenced by psychological, social and institutional factors shows the need for prevention strategies at each stage, especially in healthcare settings (Kaplan & Wheeler, 1983).

One of the leading process-based approaches in the literature is also Pondy's (1967) conflict model, which aligns with the findings of this study. Pondy conceptualises conflict through five sequential stages: latent conflict, perceived conflict, felt conflict, manifest conflict and conflict aftermath. Latent conflict refers to underlying tensions that exist even in the absence of explicit disagreement, often resulting from long waiting times, the high numbers of patients and different organisational or structural deficiencies commonly seen in public sector hospitals. Perceived conflict emerges when patient–provider interaction begins and early behavioural or communicative precursors become visible. At this stage, a problem has not been emotionally internalised yet, but its potential becomes cognitively recognisable. The phase

where emotional reactions become mutually experienced and the conflict becomes psychologically concrete is referred to as felt conflict. Here, both parties might experience fear, anxiety, stress that set the stage for escalation. The fourth stage, manifest conflict, represents the point at which the tension and responses become externally observable including behaviours such as verbal aggression, shouting, insults, threatening gestures or physical assaults. The final stage, conflict aftermath, includes the emotional, relational, psychological and organisational effects that stay after the conflict. Regardless of how many of the first four stages have occurred, some degree of aftermath tends to continue for one or both parties (Parvaresh-Masoud, Cheraghi & Imanipour, 2021).

Overall, Pondy's conflict model provides a strong theoretical framework that captures how potential violence develops step by step, multi-stage process, extending from the initial conditions of latent conflict to the enduring effects observed in the aftermath. This makes the model useful for explaining how a persistent atmosphere of potential violence can form in healthcare settings even before open aggression occurs.

This study focuses on early indicators of violent tendencies occurring during patient-physician interactions in a public hospital setting. Specifically, it analyses the verbal, emotional and behavioural expressions of patients and their relatives while examining how physicians perceive these signals and what they experience emotionally during and after conflict.

Research Questions

1. What verbal, emotional and behavioural signs and conflict-related accounts do patients and their relatives present in the Patient Rights Unit (PRU)?

2. According to physicians, what verbal, emotional and behavioural signs do patients and their relatives show in emergency and outpatient clinics?

3. What emotional reactions do physicians experience in this conflict environment and how do these reactions affect their professional attitudes and their communication with later patients?

MATERIALS AND METHODS

Research Type

This study employed a qualitative research framework. An exploratory case study design was adopted, enabling an in-depth examination of a specific social phenomenon, namely, conflict and the potential for violence in healthcare delivery, within its real-life context (Yin, 2014). While the hospital environment constitutes the setting of the study, the research phenomenon is defined as conflict processes in patient–physician interactions that carry the potential for violence. In this research, the unit of analysis consists of the verbal, emotional and behavioural indicators emerging within healthcare interactions. This methodological structure views violence in healthcare as a complex conflict process and offers a broad analytical framework that includes both behavioural and emotional risk signs (Ferron, Kosny & Tonima, 2022). Through this approach, the study examines not only individual interactions in healthcare setting but also emphasises the need for preventive policies at the institutional level in public hospitals.

Study Population and Sample

The research was conducted in the emergency and outpatient units of a public training and research hospital in Türkiye in May 2025. These units were selected through purposive sampling due to their high patient volume and the increased likelihood of violent incidents occurring in such settings. Participants were also purposively selected from individuals with direct experience of patient-physician conflict. Accordingly, patients and their relatives (n=30) who experienced conflict and applied to the Patient Rights Unit and specialist and resident physicians (n=30) working in the emergency and outpatient departments who had experienced conflict with patients or their relatives constituted the two main participant groups of the study.

Data Collection Tools

Data were collected through semi-structured interviews and direct observation since usage of these two methods concurrently in the literature is a common way to follow. Data of this study were collected through two separate semi-structured interview forms developed for patients and their relatives and physicians as well as through direct observations. The observation protocol is discussed below together with the semi-structured interviews conducted with patients, their relatives and physicians as both were carried out concurrently.

Interview form: The interview forms consisted of

open-ended questions addressing the emergence of conflict processes, behavioural precursors, communication barriers, emotional reactions and post-conflict evaluations. Interviews were conducted face to face and all questions posed to the participants consisted of open-ended questions. Demographic profile questions were asked first, followed by questions regarding the participants' perspectives on the behavioural precursors of violence in healthcare settings, explored from the viewpoints of different parties within the hospital. After the interview questions were prepared, they were shared with the chief physician. With the support of the hospital's senior management, both emergency and outpatient clinic physicians and patients and their relatives attending the Patient Rights Unit were contacted.

Both patients and their relatives and physicians were asked a series of open-ended questions. Examples of questions directed at physicians include: "How do you feel when faced with a conflict situation arising from problems with patients or their relatives?", "Has this situation changed your perspective on your profession and on patients?" and "What are the physical, verbal and psychological indicators of violent tendencies?" Examples of questions directed at patients and their relatives include: "What kind of feedback did you receive in response to the problem you encountered?", "Was it positive or negative?" and "If it was negative, how did you feel at that moment?"

Observations covered interactions occurring during applications to the Patient Rights Unit on the basis of the data gathered in the physician interviews. Since this approach is widely applied in research (e.g., Handley, Bunn, Lynch & Goodman, 2019; De Pryck, 2023), the researcher conducted the field study by both carrying out interviews and undertaking observations as a non-participant observer, while maintaining limited interaction throughout the study. Observation protocol was developed step by step during the data collection and data analysis process. Based on the interviews with the physicians, the themes are determined reflecting the behaviours of the patients and patients' relatives. These themes were later used to guide the observation process. This helped keep the observations consistent with the analysis and improved the overall coherence of the study (Miles, Huberman & Saldana, 2020). Although observation naturally involves some subjectivity (Creswell, 2013, p. 20), this was reduced by using physicians' responses as a guide, which increased the rigor of the analytical process.

Data Collection

The data collection process was conducted in two stages. In the first stage, face-to-face semi-structured interviews were conducted with physicians who had experienced conflict situations. In the second stage, patients and their relatives applying to the Patient Rights Unit were observed and interviewed and field notes were taken. All interviews, which were audio-recorded and observations lasted approximately 10-30 minutes and written transcripts were subsequently prepared.

Data collection is usually stopped when similar patterns start to repeat in qualitative research (Small, 2009). In this study, the fieldwork was completed once sufficient data saturation was reached, which was observed with a total of 60 participants.

Ethical Consideration

Prior to the study, ethical approval was obtained (Date: 30.04.2025; Approval Number: 2025-0226). Institutional permission was also secured from the relevant hospital administration and informed voluntary consent was obtained from all participants. Participants' identities were kept confidential and the data were anonymized during the analysis process.

Data Analysis

In this study, an exploratory case study design was adopted as the main research framework, allowing for an in-depth examination of conflict situations in public healthcare settings. Within this framework, thematic analysis commonly used in qualitative research (Braun & Clarke, 2006) was used as the analytical method to examine the collected data in a systematic way.

Data analysis followed a structured process. Initially, observation notes and interview transcript were read several times to gain familiarity with the data. Subsequently, initial open codes were generated directly from the data. These codes were grouped into categories based on their conceptual similarities. Finally, related categories were brought together to develop broader themes.

This iterative process involved continuous comparison between data, codes and themes to keep the analysis consistent. As a result of the

analysis, speech style and tone, body language, emotional expressions and behavioural responses were identified as the main themes showing signs of conflict. In addition, physician-related themes were examined under three areas: effects on attitudes toward the profession, effects on attitudes toward patients and individual-level impacts. The analytical process was structured to demonstrate that violence in healthcare develops as a multilayered conflict dynamic prior to overt physical aggression.

RESULTS

Based on the researcher's field observations, verbal and nonverbal behavioural cues exhibited by individuals who applied to the Patient Rights Unit will be identified and presented alongside comparable cues described by physicians. Finally, the emotional and psychological effects of these conflict situations on physicians will be analysed from their own perspectives. The data will be examined using a process-based approach, in which each stage of the conflict, especially those that may lead to violence, is analysed systematically.

Indicators of Violence Potential in Patients and Relatives: Observations and Interviews

Affect refers to short-term emotions shown through facial expressions, gestures and tone of voice, reflecting a person's inner emotional state (Schnall, 2011). In this context, the emotional and behavioural reactions of patients and their relatives when they faced service-related problems were systematically observed in the PRU while the researcher was present as a non-participant observer. The findings obtained through these observations are presented in Table 1, where the identified themes and their corresponding codes are shown alongside the number of occurrences of each code and their relative percentages within the relevant dataset.

Table 1. Early Indicators of Violence Potential Based on Observation

Themes	Codes	Number of Codes (n)	Relative Percentage of Codes (%)
Speech Style & Tone	Loud or raised voice	22	13.30
	Fast/excited speech	16	9.69
	Accusatory statements	12	7.30
	Insistent tone	12	7.30
	Tense, pressuring tone	7	4.24
Hand & Body Movements	Standing instead of sitting	14	8.48
	Trembling hands/feet	10	6.06
General Appearance	Restless, tense demeanor	19	11.50
	Introverted appearance	10	6.06
	Depressive mood	8	4.84
Behaviors	Refusal to accept issue	18	10.90
	Resistance to cooperation	12	7.30
	Lack of persuasion	5	3.03
	Total	165	100

Based on the researcher's observations, the most often observed signs were categorized into four thematic groups. The willingness of patients and relatives to approach the Patient Rights Unit suggests that they were aware of their reactive anger and preferred to express complaints through formal and institutional channels. During the initial moments of application, most individuals perceived the situation as a crisis and displayed anger as the dominant emotional response; however, their emotional tension tended to decrease throughout the interview process as they remained open to communication. This observation shows that when communication channels are utilized properly, the tendency toward conflict may be effectively regulated.

The study has some findings that align with the latent conflict phase that is the first stage of Pondy's Model. Barriers to getting appointments, procedural problems and system limitations may create tension during interactions. For example: "I have been waiting for months, but someone else was given an appointment within a few days." "They kept sending me from one place to another and no one clearly explained what I should do." These examples show that there are underlying factors that feed conflict even before it becomes visible.

Within the "Speech Style and Tone of Voice" theme, signs of loud, insistent, accusatory, rapid, emotional speech and physical signs such as being

restless, tension and shaking within the "Hand and Body Movements" and "General Appearance" themes show high emotional intensity during patient-physician interactions. These patterns suggest that the conflict is not only recognized but also emotionally experienced, matching to the felt stage of conflict in Pondy's model.

At the initial stage, participants described their experiences as unfair, inappropriate showing that they already saw it as a problem. Many patients recognized the situation as a personal or procedural unfairness.

For example, one participant stated:

"The doctor said there's nothing wrong with me… But I've been experiencing this pain for years..."

These statements indicate that the interaction went beyond a routine service encounter and had entered the stage of perceived conflict, where a problem is explicitly recognized and linked to the actions of healthcare staff.

Beyond this, the data also show strong emotional reactions such as anger, frustration, stress and helplessness. These reactions suggest that the conflict was not only perceived but also felt by the participants. Participants often described that the tension increased during the interaction: "I didn't think of fighting but I got really angry… especially because I felt helpless." "It is impossible not to feel stressed… at the moment, I could have even killed him."

These expressions reflect the felt conflict stage, where emotional intensity becomes central to the interaction and increases the potential for escalation.

On a behavioural level, codes such as "refusal to accept the problem" and "lack of persuasion" reflect resistant attitudes toward the care process. One patient described a manifest confrontation:

"He told me to leave the room. I said, 'I'm not leaving…' Then I told him, 'Who do you think you are? I'm asking for my right."

Statements of one of the patients such as "the physician acted arbitrarily; they could have fixed the issue if they wanted" also indicate that there are significant gaps in patient knowledge regarding clinical and administrative healthcare procedures.

At this stage, patients and their relatives arrive at the Patient Rights Unit precisely because they have experienced a problem and therefore clear indications of perceived and felt conflict as conceptualized in Pondy's (1967) process-based framework, become observable. Changes in hand and body movements, shifts in general demeanour, alterations in behaviour and variations in speaking style and tone constitute explicit manifestations of these conflict stages. Yet still, patients and relatives approaching the PRU demonstrate a preference for constructive conflict resolution.

For example: "I was about to attack the doctor… but then I saw the Patient Rights Unit."

"If I hadn't seen this office, I might have beaten the doctor."

The tendency of individuals to express anger through communication rather than aggression is considered a significant protective factor against violence (Soykan, 2003).

Indicators of Violence Potential Based on Physician Interviews

Physicians' observations during encounters with patients and relatives, both at the moment of conflict and at the onset of tension, offer valuable insights into potential early warning signs of violence. To explore this, physicians were asked: "Are there any signs that indicate the likelihood of violent behaviour from patients or their relatives? If so, what are these signs?" The findings are presented in Table 2.

Based on physician reports, indicators of violence potential primarily involved communication patterns and body language. Early indicators such as aggressive tone, facial tension, loud voice and continuous movement rather than sitting reflect both physical and cognitive readiness for conflict. As Kling, Yassi, Smailes, Lovato & Koehoorn (2011) and Schneier, Rodebaugh, Blanco, Lewin & Liebowitz (2011) note, facial constriction, avoidance of eye contact and restless body language are frequently observed in individuals prone to aggression and should be recognized early by healthcare providers to prevent escalation.

Physicians emphasized that signs of tension and conflict can often be seen from the very beginning of the interaction:

"You can understand from their posture, eye contact and tone of voice. Some patients enter already tense and ready to react."

Table 2. Early Indicators of Violence Potential Based on Physician Reports

Themes	Codes	Number of Codes (n)	Relative Percentage of Codes (%)
Speech Style & Tone	Tense/aggressive tone	13	15.12
	Loud voice	9	10.46
	Sarcastic questioning	4	4.65
	Interruptive speech	4	4.65
	Imperative language	4	4.65
	Lack of greeting	3	3.49
	Insistent repetition	3	3.49
	Aggressive replies	1	1.16
Hand & Body Movements	Constant movement	7	8.14
	Clenched fists/teeth	2	2.33
	Impatience	1	1.16
General Appearance	Facial tension	9	10.46
	Restlessness	5	5.81
	Hypervigilance	2	2.33
	Posture changes	2	2.33
	Widened eyes	2	2.33
	Appearance disorder	1	1.16
Behaviours	Avoiding or intense eye contact	4	4.65
	Inappropriate entry/knocking	3	3.49
	Muttering	3	3.49
	Objecting to suggestions	2	2.33
	Disrespect to others	1	1.16
	Blocking passage	1	1.16
	Total	86	100

"They may come in without greeting, speak in an imperative tone and insist on certain treatments."

These signs are consistent with the perceived and felt stages of conflict as they indicate that the dissatisfaction is both recognized and felt more strongly.

In some cases, physicians said that the situation almost turned into open conflict: "They say things like 'You have to treat me' or 'Why are you not doing your job?'" Also, "Even when we explain the system, they continue to insist and become more aggressive."

Rather than interpreting these behaviours as direct aggression, the findings suggest that they are early warning signs. If not managed, they may develop into more serious conflict situations.

In this regard, it can be argued that nearly all stages of Pondy's (1967) process-based conflict framework are clearly reflected in this context. More specifically, the signs observed indicate a conflict environment that is felt and expressed by patients and their relatives and perceived by physicians during clinical encounters. While these indicators point to a manifest conflict environment, the absence of actual violent incidents within the examined cases demonstrates that full manifestation of conflict has not occurred. Instead of enacting violence or escalating the situation, all participants chose to pursue their claims by approaching the Patient Rights Unit. Therefore, recognising and interpreting perceived and felt conflict at an early stage may play a critical preventive role, contributing significantly to the mitigation of potential future incidents.

Impact of the Conflict Environment on Physicians

Treating violence in healthcare as an ongoing, multidimensional process, rather than a single event, constitutes a main contribution of this study. Physicians were asked to describe the effects of conflict experiences on their professional practice and emotional well-being reflecting the conflict aftermath stage in Pondy's process framework. The responses are summarized in Table 3.

The findings demonstrate that conflict experiences have significant psychological, occupational and relational consequences. The theme "Psychological Effects" appeared most frequently, including indicators such as increased irritability, reduced tolerance, heightened conflict reactivity and decreased morale and motivation.

These symptoms reflect emotional exhaustion. One physician said that "Our tolerance level has decreased. Another one also stated that "We work more tense and become irritated more easily." These statements suggest that conflict should be evaluated beyond the immediate interaction and points to an aftermath phase.

Table 3. Effects of Conflicts on Physicians

Themes	Codes	Number of Codes (n)	Relative Percentage of Codes (%)
Effects on Attitude Toward the Profession	Regret about choosing the profession or specialty	3	5.66
	Decreased concentration, reduced attention to patients and cognitive ability	3	5.66
	Professional burnout	2	3.77
	Considering leaving the profession	1	1.89
	Detachment from the medical profession	1	1.89
Effects on Attitude Toward Patients	Maintaining professional distance	4	7.55
	Communication difficulties with the next patient	1	1.89
	Patient-led approach	1	1.89
Individual Effects	Increased irritability, reduced tolerance, tendency to conflict	8	15.09
	Decreased morale and motivation	6	11.32
	More tense emotional state	2	3.77
	Emotional exhaustion and burnout	5	9.43
	Total	53	100

The theme "Effects on Professional Orientation" includes disillusionment with the profession, reduced motivation, professional burnout and thoughts of leaving the medical field. Two physicians explicitly stated, "... I even started questioning how long I can continue in this profession." And "I started thinking, did I choose the wrong profession?" Such responses indicate longer-term effects on professional identity and commitment.

The theme "Effects on Approaches to Patients" revealed that conflict contributes to shifts in patient-physician communication. While some physicians respond to conflict by becoming more distant, more rule-focused and stricter in their interactions, others reported that their communication with the next patients worsened. While professionalism may mitigate emotional reactivity, it can also weaken empathy and trust (Caruso et al., 2022), potentially eroding the therapeutic relationship. One physician said that "Sometimes I try to keep the interaction shorter if I feel a serious risk." Other one also stated "We try not to reflect it, but it affects our communication. You may not smile as much or spend enough time." These findings suggest that repeated conflict experiences gradually undermine trust in the care environment.

DISCUSSION

Violence is a process that should be analysed not only at the time it happens but also through the behavioural and emotional signs noticeable earlier. The literature points out that the most useful form of violence prevention comes from identifying early warning signs of conflict and putting proactive measures in place (Güner, 2022). The results of the current research support this processual understanding by showing that early warning signs, such as a raised voice, restlessness and confrontational behaviour, emerge before any overt violence occurs.

Pondy's conflict model offers a conceptual framework that fits well with the findings of this study. According to Pondy (1967), conflict progresses through a series of stages, latent conflict, perceived conflict, felt conflict, manifest conflict and conflict aftermath. The findings show that patient-physician interactions often stay within the felt and perceived conflict stages, creating a constant atmosphere of fear and sense of threat in the hospital environment, even when no physical violence actually occurs. Although the manifest stage of open conflict or violence did not materialize in many of the observed cases, the after-effects linked to the conflict process, such as emotional stress, fear and mental exhaustion among physicians were still clearly present. This may indicate that conflict can lead to serious

negative outcomes for healthcare workers even in the absence of direct violent incidents.

Instead of treating violence process as a single and sudden event, this study propounds that the conflict process can be managed by recognising the signs before the conflict is intensified. Increasing awareness of these signals also requires institutional training policies and behavioural monitoring guidelines (Arbury, Zankowski, Lipscomb & Hodgson, 2017). In this direction, communication plays a key role not merely an act of information exchange but an important component of patient safety, satisfaction and conflict management in healthcare settings. Communication occurs on two levels: institutional communication, including physical facilities, service procedures and work procedures; and therapeutic communication based on empathy and trust between the patient and the healthcare provider. Failures in either area may lead to emotional responses such as uncertainty, impatience, misinformation and institutional distrust, all of which raise the risk of conflict and violence (Özdemir-Takak, 2017; Özdemir-Takak & Baydar-Artantaş, 2018; Türkoğlu & Kantaş-Yılmaz, 2022).

The therapeutic communication process consists of orientation, identification, working and termination phases, with the orientation phase being particularly critical for identifying early indicators of violent behaviour (Seki Öz, 2020). In this study, most physicians stated that they recognised the first signs of violence during their initial interactions with patients. This ability varied according to working conditions, professional experience (Usluoğulları & Yurtsever, 2023). Some physicians stated that they could recognise only some of these signs, attributing this to factors beyond individual perception such as workload, patient characteristics and unmet expectations. Duğan and Arslan (2015) emphasise that these factors adversely affect communication between patients and providers.

One of the primary findings of this study concerns institutional mechanisms. All participants preferred to apply to the Patient Rights Unit rather than directing their reactions towards violence. This indicates that conflict situations can be managed more effectively when institutional channels are accessible and functional. Hochschild's emotional labour theory (1983) is relevant to the findings of this study. Suppressing or holding back real emotions such as anger or fear may appear to reduce conflict in the short term; however, this approach may increase emotional exhaustion and reduce job satisfaction in the long run. When institutional support mechanisms are insufficient, this burden becomes even heavier, under such conditions, even therapeutic communication may lose its effectiveness, negatively affecting both the mental strength of healthcare workers and the overall quality of care.

If perceived conflict, felt conflict and escalation signs can be identified early, institutions may intervene before interactions become more destructive. Literature indicates that the use of tools designed to predict the risk of violence in emergency departments such as brief scales incorporating risk indicators, triage-based violence risk screening, event-based coding systems and content analysis of incident reports, has increased substantially in recent years. Emerging evidence demonstrates that detecting pre-incident signals within the emergency care pathway enables more proactive and timely interventions (Kim et al., 2022; Quinn & Koopman, 2023).

Limitations of the Research

This study has several limitations. The analysis focused predominantly on individual-level parameters such as emotions, behaviours and interpersonal interactions. However, it is well known that organizational problems within healthcare institutions, deficiencies in service delivery and infrastructural limitations also play a substantial role in triggering violence. Also, the physical conditions of the interview setting and time constraints faced by participants during the data collection process may have influenced the depth and variety of the data obtained.

CONCLUSION

Conflict is a fundamental component of healthcare service delivery since it arises from interactions among actors with differing needs, expectations and demands. In this context, the findings of this study suggest that violence is not a sudden consequence of these conflicts, but rather the outcome of a gradual escalation shaped by interactional and institutional dynamics.

The findings of this study also show that the roots of violence in healthcare lie primarily in individual emotional and behavioural dynamics

focusing on the attitudes and behaviours exhibited by patients, relatives and physicians during the interaction as well as physicians' emotional reactions following conflict. The results indicate that violent behaviours are largely associated with problems encountered during access to healthcare and with communication failures. In emergency departments and outpatient clinics in particular, factors such as overcrowding, long waiting times, delays in service and unmet expectations intensify perceptions of victimization and contribute to the accumulation of anger among patients and their relatives.

Moreover, system-related factors such as high patient volumes and limited time per consultation increase communication deficiencies. Perceptions of indifference, lack of empathy, together with misunderstandings caused by incomplete or incorrect information, function as important triggers of violent related incidents. These findings emphasize that patients' and relatives' experiences within the healthcare process have a significant impact on their attitudes and behaviours toward healthcare professionals. As a result, one of the most effective ways to prevent violence is to manage patient and relative expectations more effectively throughout the service delivery process and to strengthen communication channels that allow complaints to be heard and resolved.

The physicians who participated in this study identified themselves as the primary targets of violent incidents. The findings show that healthcare workers are exposed primarily to verbal violence, though physical assaults and threats also occur. This situation decreases job satisfaction, increases exhaustion and negatively affects care standards in healthcare (Maslach & Jackson, 1981). Many healthcare workers stated that current policies and institutional practices are not sufficient to support them after violent incidents. Long legal processes and sanctions perceived as insufficiently deterrent reinforce feelings of helplessness among staff. The repetitive nature of violent incidents reduces professional motivation and may result in workforce loss in the health sector. Participants' experiences show that violence is not only a physical incident but also a concept that harms healthcare workers' occupational role, social status and respect. This loss of trust and respect negatively affects the effectiveness and reliability of the overall health system.

Both healthcare workers and patients/relatives have responsibilities in this regard. The study's findings indicate that a significant portion of violent incidents stems from communication gaps and misunderstandings. It is therefore essential that healthcare workers develop effective communication and conflict management skills. In-service training programs should be expanded to support staff in areas such as anger management, empathy and crisis intervention. Building a stronger institutional culture and a shared sense of responsibility may help healthcare organizations take a more united stand against violence.

Following institutional procedures and behavioural norms should be seen as essential. Informative brochures, visual materials and guidance services may be used to raise awareness among patients and relatives regarding institutional rules, processes and the appropriate channels for expressing dissatisfaction. In this study, the tendency of patients and their relatives to apply to the Patient Rights Unit reflects a search for institutional solutions and observational findings suggest that their anger tends to decrease during this process. This highlights the importance of institutional mechanisms. These units offer a structured channel where patients and relatives can raise their concerns formally and without resorting to violence. Improving these complaint and feedback systems may reduce the tendency to turn to aggression.

Future studies could take a broader approach by examining not only interactional factors (micro-level) but also organizational (meso-level) and systemic (macro-level) determinants of violence in healthcare. Further studies may address these limitations by designing research settings that allow for richer and more detailed data collection. Future research could also examine conflict at different levels of the health systems and produce evidence-based policy recommendations to prevent violence and better support both healthcare workers and patients.

Ethics Committee Approval

Ethics committee approval was received for this study from the Hitit University Non-Interventional Research Ethics Committee (Date: 30.04.2025 and Approval Number: 2025-0226).

Author Contributions

Idea/Concept: B.G.; Design: B.G., E.G.T.; Supervision/Consulting: E.G.T., A.O.Ö.; Analysis and/or Interpretation: B.G., E.G.T.; Literature Search:

B.G.; Writing the Article: E.G.T., A.O.Ö.; Critical Review: A.O.Ö.

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Conflict of Interest

The authors have no conflict of interest to declare.

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