

Chapter 05



Workplace Violence Against Medical Personnel. Medico-Legal Analysis, Occupational Risks, and Institutional Response

ISBN: 978-9915-9869-9-9

DOI: 10.62486/978-9915-9869-9-9 .Ch05

Pages: 28-34

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Study results

Demographic characteristics of the sample

The composition of the sample reflected a heterogeneous distribution in terms of gender. There was a predominance of professionals who identified as female, constituting the most represented group within the analyzed set. Male physicians participated in smaller proportions, whereas a small fraction corresponded to other gender identities.

This distribution suggests a greater presence of women within the group of professionals who responded to the study. Although it does not allow for population inferences to be made, the pattern observed is consistent with trends reported in various healthcare contexts, where the progressive feminization of certain medical areas has been documented in recent decades.

From an analytical perspective, the gender variable becomes relevant when considering that the experience of workplace violence may be mediated by cultural, hierarchical, and relational factors that affect professionals differently.

Table 5.1. Distribution of physicians by age range		
Gender	No.	%
Female	14	58,3
Male	8	33,3
Other	2	8,3
Total	24	100

Distribution by age group

Analysis of the age variable revealed a predominant concentration of professionals in the middle range of working life. Most of the physicians surveyed were between 35 and 55 years of age, constituting the most represented age group.

The groups corresponding to younger and older professionals had considerably lower participation rates. This configuration can be interpreted as a reflection of the usual structure of active medical staff, where the middle range tends to bear the greatest burden of care and clinical responsibility.

From an interpretive standpoint, age is a relevant factor in the study of workplace violence. The accumulation of professional experience, exposure to high-demand contexts, hierarchical position, and sustained interaction with patients and family members can modulate both the perception and frequency of aggressive events.

Table 5.2. Distribution of physicians by age range		
Ages	No.	%
Under 35	2	8,3
35 to 55 years old	18	75
Over 55	4	16,7
Total	24	100

Similarly, the lower representation of young professionals could be associated with early

career stages, whereas the reduced participation of older physicians may be linked to transitions to less exposed roles or different work schedules.

Professional field

The distribution of participants according to their work setting revealed a predominance of physicians working in public sector institutions. More than half of the professionals surveyed worked in public hospitals, which was the most represented healthcare setting in the sample.

A smaller proportion of doctors were affiliated with private clinics or sanatoriums, while the group corresponding to private practices had the lowest relative frequency.

This pattern reflects a greater representation of professionals working in public hospital structures, which could be associated with both the composition of the sample and the availability and accessibility of participants during the study period.

From an analytical perspective, the workplace is particularly relevant in the study of occupational violence. Public hospitals tend to have a high demand for care, diverse clinical profiles, emergency situations, and contexts marked by organizational and social tensions. These conditions can influence the frequency and nature of the episodes of aggression experienced by professionals.

The presence of physicians from the private sector and independent practice also allows for the incorporation of comparative perspectives on different institutional dynamics.

Table 5.3. Distribution of physicians according to work setting		
Work setting	No.	%
Public hospital	14	58,3
Private Clinic or Sanatorium	6	25
Private Practice	4	16,7
Total	24	100

History of aggression in the workplace

A large majority of the physicians surveyed reported having experienced at least one episode of aggression in their work environment. The frequency of affirmative responses indicates that exposure to situations of violence or aggressive behavior is a common experience within the group analyzed.

The small number of professionals who reported not having experienced this type of event highlights the magnitude of the phenomenon within the context studied. This finding suggests that situations of aggression are not exceptional events but rather part of the work reality perceived by a significant proportion of physicians.

The identification of a history of aggression is particularly relevant when considering the possible associated psychological, professional, and institutional implications. The repetition or normalization of these episodes can affect the work environment, perceptions of safety, professional satisfaction, and dynamics of the doctor-patient relationship.

Similarly, this result establishes an empirical basis for further analysis of variables related

to the type of aggression, the actors involved, the responses adopted, and the resulting consequences.

Table 5.4. Distribution of physicians according to their history of aggression in their work environment		
History of aggression in their work environment	No.	%
Yes	20	83,3
No	4	17
Total	24	100

Types of assaults reported

Analysis of the nature of the assaults experienced by the physicians surveyed revealed a clear predominance of verbal manifestations (table 5.5 and figure 5.1). This type of assault was the most frequently reported category, far exceeding physical forms and other less specific modalities.

Physical aggression, although present, represented a considerably smaller proportion within the group analyzed. Similarly, responses were grouped under categories that included other forms of aggression, suggesting the existence of experiences that do not strictly fit traditional classifications.

A small group of professionals reported not having experienced situations of aggression. This distribution shows that, within the context studied, verbal violence emerges as the most common expression of interpersonal conflict directed at medical personnel.

From an interpretative perspective, this finding is particularly relevant. Compared with physical violence, verbal abuse, which is often underestimated, can have a significant psychological impact, damage the working environment, and contribute to the normalization of hostile communication practices within the healthcare setting.

Likewise, the presence of different types reflects the complexity of the phenomenon, where experiences of violence can take various forms, both explicit and subtle.

Table 5.5. Distribution of physicians according to the type of aggression received		
Type of aggression received	No.	%
Verbal	14	58,3
Physical	3	13
Other	3	12,5
None	4	16,7
Total	24	100

Identification of aggressors

The distribution of responses allowed us to identify the patient as the actor most frequently associated with the episodes of aggression reported by physicians (table 5.6 and figure 5.2). This category accounted for the highest proportion of mentions within the analyzed set.

Second, patients’ relatives, whose participation in aggressive events was also significant,

were included. The inclusion of coworkers as the third relevant category introduces an additional dimension linked to the internal dynamics of the healthcare team.

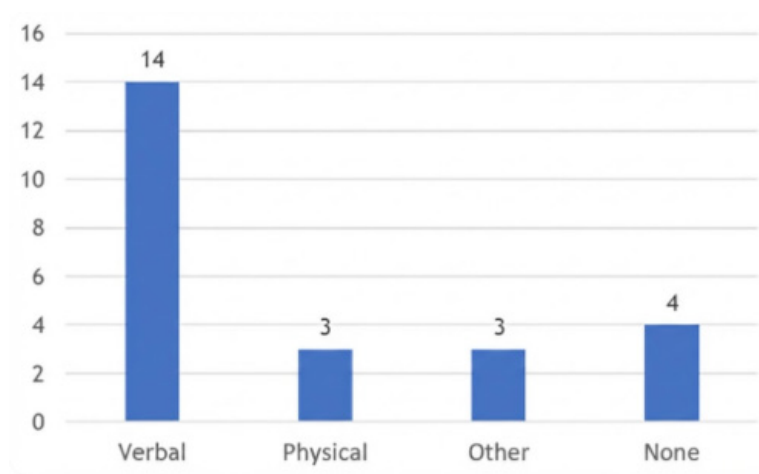


Figure 5.1. Distribution of physicians according to the type of assault received

Table 5.6. Distribution of physicians by type of aggressor		
Aggressor	No.	%
Patient	10	41,7
Patient’s family member	8	33
Work colleagues	6	25
Total	24	100

This pattern shows that situations of aggression are not limited exclusively to the doctor-patient relationship but can arise at multiple levels of interaction within the healthcare setting.

From an analytical perspective, the presence of the patient as the main aggressor can be linked to contexts of vulnerability, anxiety, pain, diagnostic uncertainty, or tensions arising from waiting and the perception of the care received. Moreover, the involvement of family members refers to scenarios where the emotional burden and concern for the patient’s clinical progress can amplify conflicting responses.

The reference to aggression from colleagues suggests the need to consider organizational, relational, and hierarchical factors that permeate institutional life.

Responses adopted in situations of aggression

Analysis of the behaviors adopted by physicians in response to episodes of aggression revealed diverse coping strategies. The most frequently reported response was to report the event within the workplace, indicating that a significant proportion of professionals chose to formalize the situation through available institutional channels.

Second, responses associated with direct defense behaviors were identified. This pattern suggests the presence of self-protection mechanisms that emerge in contexts where the professional perceives an immediate threat or a lack of external support.

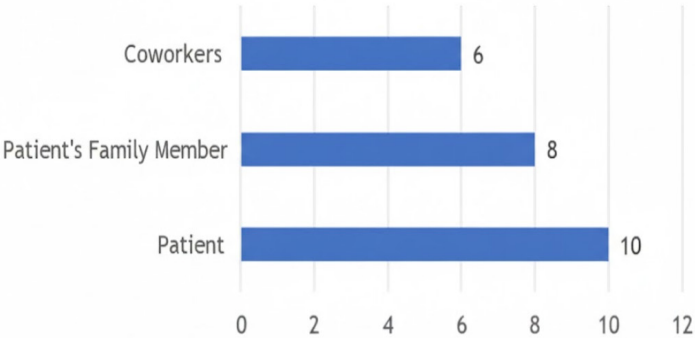


Figure 5.2. Distribution of physicians by type of aggressor

A smaller group of respondents reported not having taken any action after the aggressive episode. This behavior can be interpreted from multiple dimensions, including the normalization of violence, the perception of the futility of reporting, or the fear of work or relational consequences.

From an analytical perspective, the observed variability reflects differences in the perception of risk, the degree of institutional support expected, and the trust placed in formal incident management mechanisms. The responses adopted express not only individual decisions but also features of the organizational environment in which those decisions are made.

Table 5.7. Distribution of physicians according to their response to aggression		
Response to aggression	No.	%
I report the event at the workplace	10	50
Defended themselves	6	30
Did nothing	4	20
Total	20	100

Perception of institutional support and follow-up

The responses obtained in relation to institutional support following situations of aggression revealed a predominant pattern of perceived lack of support. Most physicians reported not having received follow-up, support, or formal intervention from the institution after the event.

A considerably smaller proportion reported having experienced some form of institutional support. This distribution suggests that, within the context analyzed, the organizational response to episodes of violence is not a uniform or systematically consolidated experience.

From an interpretive perspective, the perception of a lack of support can affect multiple dimensions of professional practice. These include trust in reporting mechanisms, a sense of job security, a willingness to report future incidents, and the subjective experience of the institutional climate.

Similarly, the absence of institutional follow-up can contribute to the normalization of violence as part of the work environment, weakening the construction of organizational cultures oriented toward the protection of healthcare personnel.

Table 5.8. Distribution of physicians according to support or follow-up from the institution where they work		
Support or monitoring from the institution where they work	No.	%
Yes	5	25
No	15	75
Total	20	100