Chapter 06

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

Violence can occur anywhere, but those most at risk are people who work in community or residential settings with significant contact with the public (including social workers and healthcare workers). Recent studies highlight that workplace violence is a universal problem in the healthcare sector. Local characteristics vary, but they affect both men and women and compromise, overall, more than half of healthcare workers, for whom they constitute an emerging risk (Algieri et al., 2014; León, 2010).

The predominant gender in the sample studied was female, accounting for 58,3 % of the sample. Studies such as those by Matile et al. (2016) and Algieri et al. (2014) reported that their populations consisted of 50 % and 47,79 % females, respectively, which is similar to the results of our study.

Age was analyzed as a continuous variable, and given its particular association with the reporting of assaults, it was divided into subgroups using twenty-year intervals with a final group over 55 years of age. In terms of age distribution, doctors aged between 35 and 55 years predominated at 75 % age, which differs from the results reported by Travetto et al. (2015), with 42 % of professionals aged between 35 and 44 years, and those reported by Farias (2010), where 62,9 % of participants aged between 17 and 35 years and 37,1 % aged between 36 and 61 years.

In relation to the field of work of the doctors surveyed, it is noteworthy that more than half work in public institutions; a study with a similar sample reports that the declared field of work corresponded to 137 (37,84 %) municipal establishments, 118 (32,60 %) provincial establishments, and 9 (2,49 %) national establishments, whereas in the private sector, 89 (18,86 %) worked in sanatoriums, 97 (20,55 %) in clinics, 59 (12,50 %) in polyclinics, 98 (20,76 %) in private practices, 84 (17,80 %) in social welfare organizations, 27 (5,72 %) in “companies,” and 18 (3,81 %) in “others.”

Martínez Amezaga et al. (2018), in a sample of 351 physicians, reported that 23,1 % (n=81) belonged to the private sector, 35 % (n=123) to the public sector, and 41,6 % (n=146) to both.

The results of this study show that more than 80 % of the healthcare personnel surveyed had experienced at least one type of aggression in their institution, whereas 17 % stated that they did not believe they had experienced this type of situation.

Algieri et al. (2014), in a study that included 362 doctors from the city of Buenos Aires and the province of Buenos Aires, reported that 91,99 % experienced aggression during their work. A study that included more than 23 countries, with a strong presence of professionals from Argentina (56,3 %), of the 19,967 surveys analyzed, 13,323 (66,7 %) reported having experienced some type of aggression in the past year (Travetto et al., 2015).

The results of the analysis of the types of assaults revealed that verbal assaults (58,3 %) predominated in this study, followed by physical assaults (13 %), with the remaining 12,5 % corresponding to other types of assaults.

A study conducted on 351 doctors in Rosario (Argentina) revealed that 80,1 % (n=281) had

experienced an episode of aggression in the past year, of which 86,8 % (n=244) were verbal and 13,2 % (n=37) were physical-verbal (; these findings coincide with our results.

Many of these results confirm those previously reported by Algieri et al. (2014), where 171 (51,35 %) of the aggressions were verbal, 119 (35,74 %) were psychological, 43 (12,91 %) were physical, and 134 (40,24 %) involved combined verbal and psychological attacks.

Similar results have been obtained by Muñoz Pascual et al. (2008), who analyzed the type of aggression: 15,1 % shouted and used insults to achieve their goal; 13,2 % used insults and verbal threats; 11,3 % used shouting and verbal threats; 9,4 % used shouts, insults, and verbal threats; and 7,5 % used shouts, insults, verbal threats, and physical aggression.

The fact that most of the assaults were committed by patients and family members is consistent with the figures reported by Travetto et al. (2015), where 60,5 % and 75,2 % correspond to assaults by patients and family members, respectively.

Matile et al. (2016) reported that 60 % of perpetrators were family members of patients, 31 % were patients, and others included colleagues (16 %) and supervisors (28 %), among other members of the healthcare team.

In general, 50 % of the assaulted staff reported the incident, 20 % took no action, and 30 % defended themselves against the assault. The characteristics of the organization (microsystems and mesosystems) influence the way professionals respond to aggression (McCann et al., 2014; Travetto et al., 2015), which is why it is important to have institutional protocols in place to guide the attitude of the person attacked in a systematic manner to reduce unwanted consequences.

In this context, researcher Mercedes Martínez León of the University of Valladolid stated the following: "The physician must avoid counteraggression by all means available; appear calm and in control of the situation; speak softly, without provoking the patient or passing judgment on them; try to keep the patient and themselves seated; not get too close to the user; avoid maintaining a distant or fixed gaze on them; listen attentively if they start to speak; give the impression, especially with patients with personality disorders, that they are able to put themselves in their shoes; and recognize the signs that predispose the patient to violence: their gait, the repetition of the same word or phrase, or any other warning signs. " (León, 2010)

Surprisingly, 75 % of the respondents did not receive support or follow-up from the institution for which they worked.

It is therefore essential for any occupational health and safety management system to recognize the risk of violence early on to intervene before it occurs. Although predicting violence is difficult, the first steps are aimed at identifying, assessing, and diagnosing risk situations to develop effective plans and measures that should include continuous monitoring and periodic publication of the results of the measures implemented; the participation of workers in the preparation of evaluation criteria; providing regular feedback and comments to verify the results and make any necessary modifications; organizing regular joint meetings between management and workers to discuss the measures implemented; periodically reviewing the management plan and evaluating the implementation of the general policy; and reassessing the workplace culture, work organization, and quality of the environment to respond effectively to workplace violence and activate a risk management cycle to make the fight against workplace violence an

ongoing process in the organization (Algieri et al., 2014; Bernardi et al., 2013).

In the literature review prior to this study, the diversity of studies analyzing attacks on healthcare personnel was evident. However, there is no standardized consensus for their analysis and measurement, which makes it difficult to compare their results.

Violence in the workplace is not an individual issue but rather a structural and strategic problem rooted in social, economic, organizational, and cultural factors. Therefore, it is necessary to achieve and promote an approach that addresses the root of the problem, engages and serves all stakeholders, and considers the special cultural and gender dimensions of the problem. It is essential that any intervention adopted be developed systematically to make the most effective use of resources, which are often limited in this sector. The approach must be integrated, participatory, gender- and culture-sensitive, nondiscriminatory, and systematic (Algieri et al., 2014).

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