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Experience of workplace violence among clinical faculty members of Isfahan University of Medical Sciences: A qualitative study

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Abstract:

BACKGROUND: Workplace violence is considered an important and common issue in organizations related to the provision of health services. The aim of this study was to explain the experiences of violence toward clinical faculty members.

MATERIALS AND METHODS: In this study, inductive content analysis was conducted with nine clinical faculty members (six specialists and three subspecialists) of Isfahan University of Medical Sciences with at least 6 months of experience working in clinical settings. The interviews were recorded and transcribed, coded, categorized, and analyzed. In order to strengthen the study, the Guba and Lincoln criteria were used.

RESULTS: Data analysis showed that there were four main themes (Causes of violence, Experience of violence, Consequences of Violence, Controlling violence), five subthemes (Society, System, Cause of violence, Type of violence, Complications of Violence, Ways to prevent and deal with violence), and 19 subcategories, which were extracted from 4100 codes after in-depth analysis.

CONCLUSION: Among the most important factors are the importance of the role of the social environment, the service delivery system, and ethics. The social environment can be categorized into factors such as economic and social conditions, advertising and the spread of false beliefs through the media, patients, and their companions. The ethical principles of doctors, patients, and companions can also be categorized as factors related to violence. It is suggested that a training program be developed and implemented to empower staff in healthcare settings.

Keywords:

Clinical faculty members, qualitative study, violence, workplace

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Introduction

Workplace violence refers to any type of physical or verbal aggressive behavior, including abuse, threats, or assault, that occurs in the workplace^[1] and is considered a significant and prevalent issue in organizations related to the provision of health services.^[2]

In health-related crises, the severity of violence against clinical staff increases

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significantly. The overall prevalence of violence during the COVID-19 epidemic in the world has been estimated at 47%, with physical and psychological violence being 17% and 44%, respectively. Also, the prevalence of this violence in the Americas and Asia has been estimated at 58% and 44%, respectively.^[3] In another study, the prevalence of verbal violence in the emergency department was reported to be 68%.^[4] Among the reasons that have been emphasized in various studies for violence against clinical staff, we can mention long waiting times,^[5] male gender, having long

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shifts, employment in midlevel hospitals, and working shifts of more than 50 hours per week.^[6] In a study in China,^[7] the experience of violence against nurses was about 87%. In various studies that have also been conducted in Turkey and Jordan, all indicate that violence against clinical staff is high in most developed and developing countries.^[8] Other consequences of workplace violence include reduced productivity, reduced quality of life, increased stress, sleep disturbances, and burnout.^[9] Workplace violence causes job dissatisfaction among doctors and nurses and can lead to absenteeism and shift changes, as well as impacts on patient care.^[10] In addition, workplace violence can cause financial losses and problems with shift scheduling for nurses and doctors.^[11] Workplace violence in healthcare settings has been widely studied, with numerous articles exploring its prevalence and impact on healthcare professionals, particularly nurses and emergency department personnel. However, limited research has specifically examined the experiences of clinical faculty members, who simultaneously serve as educators and healthcare providers. This dual role may expose them to unique forms of workplace violence that are influenced by their academic responsibilities, interactions with students, colleagues, and patients, as well as institutional factors.

Moreover, workplace violence is highly context-dependent, and cultural, organizational, and policy-related differences can shape its manifestations and consequences. While international studies have contributed valuable insights, there remains a gap in qualitative research focusing on faculty members within medical universities, particularly in Iran. Therefore, this study aims to address this gap by exploring the lived experiences of workplace violence among clinical faculty members at Isfahan University of Medical Sciences, providing insights that can inform targeted interventions and institutional policies.

Since clinical faculty members' experiences of workplace violence reflect their feelings and intellectual background toward patients and actions related to caring for their illness, it also reflects the effects of violence on them, so it is necessary to examine these experiences more closely in order to identify these effects and propose necessary measures for their management. Therefore, this study aims to explain the experiences of clinical faculty members at Isfahan University of Medical Sciences.

Materials and Methods

Study design and setting

This is a qualitative study using inductive content analysis method, which was conducted in 2019. The research setting of this study was Isfahan University of Medical Sciences, in central Iran.

Study participants and sampling

Using purposive sampling, clinical faculty members of the university with at least 6 months of experience working in clinical settings were invited to participate in the study. Due to saturation, ultimately, nine faculty members participated in the present study.

Face-to-face and semistructured interviews were used to collect data. A sample of interview questions is shown in Table 1, and following each of these questions, probing questions such as "If possible, could you explain more? Can you explain more?" and so were asked based on the participants' responses.

The duration of each interview was on average 45 minutes and in the range of 30 to 60 minutes. Data saturation was achieved after nine interviews. All interviews were conducted by one of the authors of the article, and after the interview, all nonverbal data, including the interviewee's movements and the interviewer's feelings about the interview stages, were recorded, and immediately after the interview, a written version of the interview was prepared.

Data collection tools and technique

Then, the data were entered into Excel software to facilitate systematic organization, error-checking, and categorization. Excel was chosen due to its ease of use for managing qualitative data, sorting responses, and preparing the dataset for further thematic analysis using qualitative data analysis software.

The interview transcripts were read repeatedly by the interviewing researcher, and the desired codes were extracted. The sentences obtained from the interviews were considered as semantic units. These obtained codes were named, and then more abstract subcategories and categories were formed. In order to ensure the accuracy and precision of the data,^[12] four methods of Guba and Lincoln were used, including Credibility, Dependability, Confirmability, and Transferability. In this regard, by interacting with the participants for a year and sending the extracted codes to some participants as well as the research team (including psychiatric and medical education specialists), Credibility was confirmed. Also, by selecting informed participants who had work experience and background, Transferability was accepted. Dependability was confirmed by similar responses of the participants to similar questions in different ways. To establish Confirmability, any bias regarding the research topic was prevented before and after the interview.

Table 1: Sample interview questions

Describe your experience of dealing with workplace violence?
Describe the problems that lead to workplace violence?
Describe your experience of dealing with anger?

We employed an inductive content analysis approach, as described by Elo and Kyngäs,^[13] to allow themes to emerge directly from the data without predefined coding structures. The analysis followed three main stages: open coding (identifying key concepts from the data), categorization (grouping similar codes into broader categories), and abstraction (developing overarching themes that explain the findings).

Ethical consideration

Ethical considerations in the present study are focused on individuals' freedom to participate or not to participate in the research, confidentiality of participants' names, and obtaining written informed consent from participants.

Results

The participants were faculty members of clinical medical disciplines in the field of Emergency Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Cardiology, Infectious Diseases, Anesthesiology, and Psychiatry, six of whom had a specialty degree and three had a subspecialty degree. From all three academic ranks, assistant professor, associate professor, and professor participated in this study. A descriptive summary of demographic variables is shown in Table 2. According to Table 3, four main themes, five subthemes, and 19 subcategories were extracted from 4100 codes after in-depth analysis.

Causes of violence

The main theme of causes of violence includes two subthemes: society and system.

1. Society. The experiences of the research participants have shown that the social environment can play a role in the violence of the faculty members under study. This category consists of several subcategories as follows:

A) Economic and sociocultural situation. This section explains how economic and cultural issues may affect violence in healthcare settings. Resolving the economic problems and concerns of staff may increase their focus and commitment to emergency and patient services, which may play an important role in reducing violent incidents. Cultural norms

and societal attitudes significantly influence the perception and expression of workplace violence. In some cultures, certain verbal expressions or gestures may not be perceived as offensive, while in others, they may be considered acts of aggression. Additionally, cultural attitudes toward hierarchy and authority may affect how healthcare workers respond to violence. In cultures where respect for authority is strongly emphasized, staff may be less likely to report incidents. Conversely, in cultures with higher tolerance for confrontational interactions, physical or verbal violence may be more prevalent. Some of the points made by participants in this regard include: "The issue of violence in the workplace is cultural. Some words may not be considered offensive in my culture and physical violence may not be considered" (Interview 9). Other points are given in Appendix 1.

B) Media

The participants believed that the actions taken against doctors in the media have created a negative view of doctors, which is conducive to violence from patients or their companions. In this regard, a wide range of opinions were presented by the participants, one of which is mentioned below:

"The media creates an additional pessimism towards doctors in society and destroys the trust between the patient and the doctor. Then this patient is prone to get upset with the slightest mistake he sees." (Interview 8)

C) Patients

To reduce violence in healthcare settings, not only one should focus on the education and preparation of hospital staff but also patients and their families should gain the necessary knowledge about appropriate behavior and interaction with healthcare staff.

"Violence is something between the patient and the staff, meaning that family and social education should be considered on the other side, not just force on hospital staff" (Interview 4).

D) Patient's companions and family. Pretreatment dialog between the doctor, patient, and patient's companions is of paramount importance. Establishing clear communication and informing them about the treatment process and possible problems may help reduce misunderstandings and false expectations and as a result prevent violence [Appendix 2].

2. System

This category has played a very important role in violence and therefore has formed several subcategories, which are mentioned below.

A. Workplace: Participants stated that one of the important factors related to the occurrence of

Table 2: Descriptive summary of demographic variables of study participants

Variable	Frequency
Education status	
Specialist	6
Subspecialist	3
Has managerial experience	
Yes	6
No	3
Work experience	
Years	5–30
Gender	
Male	7
Female	2
Age range	
Years	35–60

Table 3: Characteristics of the main themes, subthemes, and subcategories identified

Main themes	Subthemes	Subcategories
Causes of violence	Society	Economic and sociocultural situation
		Media
		Patients
		Patient's companions and family
		Workplace
	System	Behavior of colleagues in the clinical environment
		Insurances
		Doctor complaint system
		Lack of structure and process to support physicians
		Lack of facilities and human resources
Experience of violence	Cause of violence	Lack of monitoring and feedback
		Violence from the patient and the patient's companions
	Type of violence	Violence from colleagues
		Verbal violence
		Physical violence
Consequences of violence	Complications of Violence	Job burnout
		Job Stress
		Fatigue
		Training
Controlling violence	Ways to prevent and deal with violence	Calming the environment

workplace violence is the type of workplace where doctors and staff work, and among them, they mentioned the emergency department, which is a stressful environment [Appendix 3].

B. Behavior of colleagues in the clinical environment: including doctors, medical staff, and medical students:

The cases mentioned by the participants in this regard are:

In the case of medical colleagues, "They were colleagues who caused the patient's companions to complain against me and create problems for me." (Interview 7). The patient's respect must be maintained and according to one participant, "Doctors should not look at the patient as a table and chair" (Interview 3) [Appendices 3-6].

In the case of medical staff: Participants noted that workplace hierarchy influences how staff members express opinions about the healthcare system. Some participants commented on the tendency of lower-ranking personnel (i.e. nonphysician staff members) to openly criticize medical professionals, potentially influencing patient attitudes. As one participant stated: "Unfortunately, the lower the job ranks, the more frequently such comments occur. For example, a ward cleaner might openly criticize the medical team to a patient's companion, shaping their perception of the healthcare system" (Interview 8).

C. Insurance: Delayed and irregular insurance payments were identified as a significant concern, distinct from general economic difficulties. Participants noted that inconsistent payments

from insurance companies directly impact their financial stability and job satisfaction, potentially contributing to workplace tension. As one participant stated: "For a year, the insurance did not pay for our services at all. Sometimes doctors say we are crazy, we are working, if they want to consider it financially" (third interview).

D. Doctor complaint system:

Introduction of a complaint system by the ministry has increased humiliation and debt in healthcare settings, instead of reducing tensions [Appendix 3].

E. Lack of structure and process to support physicians: Some of the challenges related to insufficient support for clinical faculty members in healthcare settings have created a sense of helplessness and insecurity, attention to physical violence and ignoring other cases, and lack of emotional and psychological support [Appendix 7].

F. Lack of facilities and human resources:

Issues related to the lack of human resources include the lack of medical staff (as a part of the workplace environment): Increasing human resources from patients to nurses and doctors can help reduce violence caused by patient delays [Appendix 8].

Experience of violence

The main theme of experience of violence and the subtheme of the type and agent of violence included the following subcategories:

1. Cause of violence: All participants stated the agents of violence in the workplace:

- A) Violence from the patient and the patient's companions: In general, it may be said in this context that the patient's companions need cultural and social education before entering the hospital. In addition, experiencing violence from colleagues can also provoke their companions and patients to commit violence [Appendix 9].
 - B) Violence from colleagues: This issue can negatively impact mental health, job satisfaction, team dynamics, and patient care quality.
2. Type of violence: All participants reported types of workplace violence: The most reported violence was verbal, with subcategories of A) verbal and B) physical violence [Appendix 10].

Consequences of violence

Regarding the main theme of consequences of violence, a subtheme of consequences of violence was included, with subcategories of A) Job burnout, B) Job Stress, and C) Fatigue [Appendix 11].

Controlling violence

The main theme of controlling violence and the subtheme of ways to prevent and deal with violence includes the following subcategories:

- A) Training: One of the important issues is the training of personal skills, which includes: stress management, emotional intelligence, problem solving in critical situations, communication skills, personality, self-knowledge, and experientialism. Participants all pointed to the training of communication skills as the main cornerstone of controlling workplace violence for doctors, staff, and medical students. According to participants, the way of communication and body language are even more important than the content of the speech in such situations. Teaching these skills to doctors and other staff can help create a calmer environment and reduce the incidence of violence [Appendix 12]. Interaction with others is a part of communication skills. In this regard, when interacting with other people in clinical settings, professional ethics should be considered and each person has their own dignity and status as a human being, and issues such as respect for others and patients are discussed [Appendix 12].
- B) Calming the environment: Controlling the environment and calming the clinical environment play a very important role in preventing and even controlling violence. This includes issues such as leaving the place of violence, calling for calm, removing stress-causing factors from the place of tension, silence, and creating happiness in the space [Appendix 13]. In more severe cases, external interventions, including the presence of police or security forces, may be necessary to ensure safety and prevent further escalation of violence. However, these

measures are typically considered as a last resort, after other de-escalation strategies have been attempted.

Discussion

This study showed that violence related to clinical faculty members originates from several factors. The most important factors include the importance of the role of the social environment, the service delivery system, and ethics. The social environment can be categorized into factors such as economic and social conditions, advertising, and dissemination of false beliefs through the media, patients, and their companions. The ethical principles of the physician, patient, and companions can also be categorized as factors related to violence. Addressing these issues requires a comprehensive understanding of the dynamics in the clinical care environment and the implementation of targeted interventions.^[14] Violence in clinical settings is shaped by interrelated factors that create an environment in which confrontations may occur.

In a qualitative study,^[15] four main themes were identified, including types of violence, staff responses to violence, causes of violence, and experiences of violence. In another qualitative study,^[16] three themes related to violence in clinical staff were identified: factors attributed to violence, responses to violence, and recommendations and suggestions.

The social environment plays an important role in the development of violence in clinical settings. Economic inequalities can lead to tension between patients and clinical staff as individuals from lower socioeconomic backgrounds may perceive inadequate treatment and increase the likelihood of confrontation.^[17] Furthermore, the dissemination of misinformation through social media creates unrealistic expectations of clinical care, which, if not met, may lead to aggressive behavior toward clinical care providers.^[18] Moreover, cultural beliefs and previous experiences of clinical care shape the attitudes of patients and their companions, increasing the risk of violent incidents.^[19]

The impact of family, economic problems, and concerns that doctors or hospital staff are involved with can be reduced by designing and implementing intervention programs in their career path. In this context, by improving the communication skills of nurses, educating patients and companions, and more serious follow-up of cases of violence against nurses, violence can be reduced and the quality of health services can be improved.^[20] However, in the study of Alipour *et al.*,^[21] they pointed out the role of morning shifts and work in the women's and children's wards in relation to violence. It is possible that by strengthening the important factors obtained

in this study, a greater focus can be placed on these wards and morning shift personnel to reduce violence. The structure and functioning of the health service delivery system also contribute to violence. Systemic inefficiencies such as delays in insurance payments, inadequate complaint procedures, and inadequate communication mechanisms can exacerbate tensions.^[22] According to the results of the present study, when patients perceive these systemic shortcomings, it erodes trust in the clinical care system and increases hostility toward clinical staff. Effective monitoring and feedback systems are often absent, and unresolved grievances remain that can manifest in aggressive confrontations.^[23] A study^[5] identified long waiting times, high patient expectations, inadequate security, staff shortages, poor communication, and overcrowding as the most common factors associated with violence. In Italy, an average of 1600 incidents of violence against healthcare staff are recorded annually.^[24]

Learning to be patient and nondirective when confronted with triggers for violence can be helpful. A combination of classroom learning and simulation training is an effective and evidence-based method for preparing staff to respond to violence.^[25] In one study, in the qualitative part, violence was seen as a result of interacting factors including staff behavior, patient behavior, hospital departments, professional roles, and waiting time. Half of the reasons given by doctors and nurses for violence were related to patient dissatisfaction with the quality of service, the level of professionalism of staff, or unacceptable comments from nursing staff. Furthermore, consistent with the present study, data from focus group discussions indicated a lack of understanding of the hospital system by patients, as well as poor communication between patients and service providers and gaps in expectations in this regard.^[26] Therefore, it is necessary to design appropriate interventions for both users and providers of health systems in order to better prevent and deal with hospital violence. Ethical issues complicate the landscape of violence in clinical settings. Differences in understanding of medical ethics between clinical faculty members and patients can lead to conflict, especially when medical decisions are perceived as unethical or negligent.^[27] Furthermore, the ethical responsibilities of patients and their companions, such as adhering to medical advice and treatment plans, are sometimes ignored, increasing the likelihood of confrontation.^[28] Ethics education in clinical care may help reduce these risks. The findings of the present study suggest that a multifaceted approach is needed to address violence against clinical faculty. This approach should include community strategies to educate the public and reduce misinformation, restructuring service delivery systems to improve complaint and communication mechanisms, and ethics education for clinical faculty,

patients, and caregivers.^[14] Addressing these factors can significantly reduce violence.

Limitations and recommendations

The qualitative nature of this study may limit generalizability to other clinical settings. It is recommended that a legal policy on the threshold of tolerance for workplace violence be developed and implemented. Furthermore, for reducing workplace violence in healthcare settings, it is recommended to conduct and implement de-escalation training for staff, enhance security measures, establish clear reporting and response protocols, improve workplace conditions and staffing levels, strengthen legal and policy frameworks, foster a supportive work environment, and enhance public awareness and patient education.

Conclusion

Among the most important factors are the importance of the role of the social environment, the service delivery system, and ethics. The social environment can be categorized into factors such as economic and social conditions, advertising, and the spread of false beliefs through the media, patients, and their companions. Regarding the service delivery system, factors such as personnel and colleagues, government policies and the medical system, insurance payments to patients and doctors, defective systems for complaining about doctors, and insufficient monitoring and feedback systems can also be mentioned. The ethical principles of doctors, patients, and companions can also be categorized as factors related to violence. It is suggested that a training program be developed and implemented to empower staff in healthcare settings.

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Ethic consideration

This study was approved by ethic committee of In Isfahan University of Medical Sciences (Ethic code: IR.MUI.RESEARCH.REC.1399.097). Ethical considerations in the present study are focused on individuals' freedom to participate or not to participate in the research, confidentiality of participants' names, and obtaining written informed consent from participants.

Author Contributions Statement

All authors were contributed similarly in conducting, drafting, analysis and final editing.

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Conflicts of interest

There are no conflicts of interest.

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Appendix

Appendix 1

Economic, Cultural and Social Situation “The economic problems and concerns that are on the mind of the doctor or hospital staff can be easily resolved so that their thoughts and concerns can be resolved so that they can serve the emergency department and the patient with all their might” (Interview 4). “It’s enough that society has turned a negative light on the problem, which has caused many of our colleagues to work illegally, meaning that the test they give is not for this patient at all, the antibiotic they give should not be given legally and by the book, they say this is legal”. (Interview 7)

Appendix 2

Companions and Family of the Patient “The companions of the patient cannot be taught much in the hospital; they must have received this training before. Now that is the level of society, education and upbringing, the bedrock of society. That is, this society that is constantly filled with verbal and physical violence, you should not expect that when they enter the hospital, they will become the Messiah” (Interview 9). “If before the surgery, every doctor talked to the companion of the patient and if possible, with the patient himself a little and informed him of his problems, violence would definitely be prevented”. (Interview 8)

Appendix 3

Service Area Section

“Why do we have more conflict in the hospital emergency room? It’s because of the conditions that prevail. First, there are emergency conditions, everyone is stressed, they expect their work to be done in a short time. The goal was to have a doctor come and see him quickly, do his work and discharge him. This goal may not be achieved in the first place. The people who are in that emergency room environment are stressed and restless people, and expectations that may not be met in the emergency room environment.” (Interview 5)

Physician colleagues

“One (of the colleagues) sees that you are better than him, he wants to gain a scientific position in front of the interns and residents. One of the reasons for the tension is that when he sees that the ward is busy, he thinks that he is understaffed and keeping the patient and he gets tense. Another point is that he wants to show himself. Does he want to say that no one in my ward can interfere and whoever comes, I will deal with him?” (Interview 7).

Physician complaint system: The cases mentioned by the participants in this regard are:

“The ministry announced a number that anyone who has a complaint can complain, and the result was that the humiliations increased, the demands increased.” (Interview 2).

Appendix 4

Physician Ethics

“This stems from the education system of the country, that every educated person who works in this environment, no matter how good his/her educational background is, should consider himself/herself to know his/her duties from the first stage, which happens to him/her in that educational system” (Interview 4).

Appendix 5

Physician Colleague Ethics

The points stated by the participants in this regard are:

“Yes, it is very ethical, it is behavioral. We can work together. We don’t need to say that so-and-so was our student. This doesn’t diminish him/her, it humiliates us more. No, he/she is one of our new and good colleagues, this word is much better”. (Interview 1).

Appendix 6

Ethics of Medical Students

“I remember well, one of our residents had gone to see Dr. X, at a time when the diabetic wound ward was about to write the consultations. Then he said the resident had to go there. He was a very respectable resident, with a family, his whole family was a doctor, and he was very respectable. He had gone to see the doctor and said that

there were a lot of patients in the diabetic ward, and if we wanted to go there, they would be in trouble. Then the doctor complained a lot and said, "What kind of talk is this?" (interview 2).

Appendix 7

- Lack of support from hospital officials for doctors: The issues mentioned by the participants in this regard are: "Well, the system should support a person. When it knows its faculty, when it knows, for example, what Dr. So-and-so does, the system should support me." (Interview 2).
- Lack of support guidelines: The issues mentioned by the participants in this regard are: "The system should let the patient, the patient's companion, colleagues, and staff know that there is a place in the system where their profession is also addressed. That is, only physical violence is allowed, and it is handled very quickly" (Interview 9).
- Lack of recovery after the incident: The issues mentioned by the participants in this regard are: "After a fight, a beating, and a chair being thrown at me by a patient, I returned to work the next day and no one followed up on my work or asked how I was doing. Do you want to talk? Do you need counseling?" (Interview 3).

The government, the medical system

"It is possible that (the patient and his companion) will show unwanted reactions, but this government has intensified it. It has incited society against doctors, portrayed doctors as bloodthirsty, selfish people who are only sucking people's blood and buying themselves cars and villas." (interview 2)

Appendix 8

Lack of human resources

- The issues mentioned by the participants regarding the lack of facilities are: "If you go to Al-Zahra Hospital, for example, and ask what the most important problem is for the people, you might not believe that the most important problem for the people is blankets, pillows, beds, and patient transport." (Interview 6).

"For example, if they see that the number of patient transporters is low or other personnel, for example, if they see that the patient load is high, they can increase the number of nurses and doctors." (Interview 4).

And the presence of police and guards in clinical wards: The issues mentioned by the participants in this regard are: "The deterrent forces are very effective, even if it is necessary for the police to be present. When the number of attendants (due to the lack of guards) increases, the possibility of violence and the possibility of even physical problems increases greatly" (Interview 4).

g) Lack of monitoring and feedback: Feedback from evaluations to doctors and nurses from several sources can be helpful. "Our performance evaluation is only done by one person, for example, the group manager, which I think is not very complete because one person, unfortunately, only gives an opinion and may include personal things, while there should be a 360-degree evaluation, meaning that even the patient and the patient's companion are asked about the doctor" (interview 4).

Appendix 9

Experience of violence from patients and their companions

. "The companions of the patient cannot be taught much in the hospital, they must have received this training before. Now that is the level of society, education and upbringing, the bedrock of society. That is, this society that is constantly filled with verbal and physical violence, you should not expect that when the patient enters the hospital through the hospital gates, he will become the Messiah" (Interview 9)

"The companion of the patient came to the ward and said, "I heard you made fun of the Bakhtiari people. I said, what do I have to do with the Bakhtiari people? In front of the students and them, he said, 'I told you, you are a Bakhtiari people, don't think we are joking.'" (Interview 2).

Experience of violence from colleagues

"We have a collaboration right now; in front of interns, students and residents, he tears up my consultation when the resident comes and tells me that so-and-so is doing this, this is not good enough. You see, the resident says this. Now what does the patient's companion say?" (Interview 7).

Supervision and feedback:

"For example, our performance evaluation is only done by one person, for example, the group manager, which I don't think is very complete because one person unfortunately only gives an opinion and may include personal things, while there should be a 360-degree evaluation, meaning that even the patient and the patient's companion are asked about the doctor" (Interview 4).

"I also received medical ethics training, I also learned professional principles, but this training alone, when there is no supervision from me for implementation, can't have the results we want." (Interview 6).

Appendix 10

Types of Violence

- a) Physical Violence: "As for workplace violence, I don't have any academic education on this subject, but I have had experiences, such as: physical violence and verbal violence; physical violence may have several causes, one is that the patient's problems have not been resolved before and these are piled up." (Interview 9).
- b) Verbal Violence: "As for verbal violence, there is usually a bit of a cultural debate as it goes up, does verbal violence become more prevalent than physical violence?" (Interview 9).

"One is personality differences, these personality differences, for example, there is one person who has a loud voice, and when he talks to another person who is calm, he thinks he is shouting at him. "The issue of correct communication is also important" (Interview 9).

The theme of the consequences of violence and the sub-theme of the consequences of violence, of which burnout is a subcategory:

The issues expressed by the participants in this connection are: "If we do not have the skills to deal with or understand the situation, we may easily suffer from burnout, job stress, and we may even have to leave this job and choose another job." (Interview 5).

Appendix 11

Burnout: The items mentioned in this connection by the interviewees are:

"If we do not have the skills to deal with or understand the situation, we can easily get Burnout; burnout, job stress, we may even have to leave this job and choose another job. This is inevitable anyway" (Interview 5).

Fatigue: The items mentioned in this connection by the interviewees are:

"What is individual is that I teach people how to have anger control skills, stress management, interpersonal relationship management. If this colleague of mine is a person whose violence is due to burnout and fatigue and depression caused by heavy work or other problems, I help him improve his mental state. That is, "improving mental health" in one word" (Interview 6).

Job stress: The things mentioned by the interviewees in this regard are:

"By learning skills, it may not be possible on its own, these are already part of burnout. The skill I have is that I can communicate and the next skill is stress-management, how do I manage this stressful work environment? These are psychological skills that I have, but really, when you are in a situation where you see 50 patients instead of five, you are tired, you are less mentally flexible, you may even be subjected to violence, this is already part of our work burnout" (Interview 5).

Appendix 12

Ways to prevent and deal with violence:

"He should be able to manage his stress completely, behave correctly. Because he makes the wrong decision" (Interview 3).

"I think a series of psychology classes on what people do during stress." (Interview 7).

"He should strengthen his personality a little, not talk to everyone" (Interview 7).

“As soon as people know under what circumstances and factors, they may show certain reactions. First, they should be able to control themselves” (Interview 9).

Training has different dimensions, which include the following:

Training Content

One of the important things is personal skills, which include: stress management, emotional intelligence, problem solving in critical situations, communication skills, personality, self-knowledge, etc.

- **Stress Management:**

When a person is under stress, they may make wrong decisions that lead to tension and violence. Therefore, one of the educational contents that is included in the discussion of individual skills is stress management:

“He should be able to manage his stress completely, to behave correctly. Because he makes the wrong decision, then this wrong decision is like saying, “I left the first brick crooked and Soraya, the next one will go after me and other problems” (Third interview)

“The next skill is stress management, how do I manage this stressful work environment? These are the psychological skills that I have” (Sixth interview)

“I think a series of psychology classes should be held on what people do during stress? People should recognize these states and what they do when they are stressed? Go back to yourself. Then sometimes you see that he swears, we also swear when we are stressed, so obviously we are facing each other. We should manage stress the opposite way we manage our patients.” (Interview 7)

“There is an approach to stress and conflict, it is called a management approach. We have a term called SGP or shared governance program. It is a great way to reduce departmental conflict. I am currently looking at how we should control it because I did it myself. Now what does it do? What is the purpose of SPG? The purpose is that we do not blame the people and put the blame on someone else, we just correct the processes, that is, we use the opinions of all the people involved in the conflict and we get their ideas, we respect and value them, we get their critical feedback and we avoid blaming people; this is a way to control stress.” (Interview 5).

Emotional intelligence: When faced with violent situations, it is necessary for people to use their emotional intelligence and be able to understand how to deal with them in order to achieve the best outcome.

“Strengthening emotional intelligence, training in emotional intelligence or EI can be very helpful in the emergency field, but we are still following up with our students. It is one of the methods” (Interview 5).

“People don’t know that the doctor himself feels sympathy for the patient when faced with a complication that arises, not because he feels guilty, but because he feels sorry for them; many times I have seen my colleagues shed tears and cry. Not because they haven’t done anything or feel guilty, but because they are heartbroken, they have tried everything they can, everything they can to make the patient sick but they haven’t gotten results. Society doesn’t understand this at all and they think that a doctor is someone who is not what they think they are, they do their job and it works, they do it but it doesn’t work, it doesn’t work, and many times if it doesn’t work, they have failed.” (Interview 3)

“Empathizing with your patient, making them feel that you understand them, making them feel that you did everything you could for them, speaking to them with compassion and kindness rather than harshness and aggression, reduces the intensity of violence.” (Interview 6).

Problem solving in critical situations: If a person can make the right decisions in critical situations and solve the problems that arise in the best possible way at the moment, one can expect correct interaction with those around them, which will result in a reduction in violence in the workplace.

“Training to deal with stressful situations and stressful environments and learning how to solve problems in stressful situations are things that can be done” (Interview 5).

"In the emergency room, we should learn problem-solving skills and teach them to others. One of these methods is trust-building. What does trust-building mean? For example, I, who am an emergency room doctor, I, who am a supervisor or head of the department or head of the hospital, as long as I sit in my room and give orders and only get up to scold and reprimand, I don't build trust in the staff. I have to walk with the staff, keep up with them and beside them, so that they feel that I am an effective person and understand their situation." (Interview 5)

- Communication skills: By using communication skills such as body language, eye contact, and verbal expression, we can best persuade others and prevent violence.

"The ways we deal with conflict in the emergency room are different.

You have to learn a number of skills to deal with others.

For example, Albert Mehrabian's book talks about Persuasion in the emergency room and all that. There's a saying that there are three main components to having good relationships in the emergency room. One of these components is visual cues, body language, which is 57 percent of our communication based on body language.

Learn to make more eye contact with the patient or staff, and that can help. Vocal expression can have a 30 to 40 percent impact. The content of what we say may not be that at all. I mean, for example, when I'm talking to a patient who's angry or a staff member who's nervous, the answer I give is not primarily important, the type of communication I have and my body language are important." (Interview 5).

"A doctor should learn some skills in dealing with others. Learning to have more eye contact with the patient or the staff can help. Our expression, our verbal expression, can have a 30 to 40 percent impact. The content of what we say may not be that at all. I mean, for example, when I am talking to a patient who is angry or a staff member who is nervous, the answer I give is not the most important thing. The type of communication I have and my body language are important. For example, if I reassure them with my eyes, or tell them with my hand, this has a greater impact. We should learn this and teach our staff." (Interview 5).

"Doctors need to understand that they work with people, meaning that this client of ours is something called a human being, not a table. This person is a dynamic atmosphere, a dynamic environment with all its own issues. When you want to say something to him and move him, give him a point, punish him, you should never forget that this is a person, a human being. For this reason, there must be a mutual understanding from the managers that just as they deal with the patient and the patient's companion, I don't want to say this sentence, but we are slowly forgetting that the patient is also a human being." (Interview 9).

Personality: The style of dealing with each person is different and one should adopt the right approach to different people with the right personality.

Strengthen one's personality a little, don't talk to everyone. For example, it is much easier to *get along* with some mothers, but it is impossible to *get along* with some mothers at all. Therefore, one should not *get along* with the mother, one should ask for the father and *get along* with the father. That is, it is true that they are together, but one of them is usually more logical. It is better to talk to the more logical member. (Interview 7)

"One thing that can happen with physical violence is that you don't anticipate it and in fact, there's a kind of scoring that could lead to physical violence. Again, I'll repeat my example, I don't want to be a brand, but when you encounter a 25-year-old with a certain style of dress and a tattoo on his hand, the scoring is high and at any moment physical violence could happen between you. You have to anticipate it so that, for example, a 60-70-year-old man comes, he's calm." (Interview 9).

Self-awareness: If people have sufficient self-awareness, they will know what actions to take in which situations to have the best outcome. Conversely, if a person makes decisions at bad times, then we will witness bad consequences.

"First, know yourself. When you don't make decisions when you're hungry, you shouldn't make decisions when your blood sugar is low. When you come back from an exam and you've failed your exam, you shouldn't make decisions. Know yourself first. Of course, if you want to leave it to her, she shouldn't make any decisions anymore. I want to tell her to know what she's making decisions on. If you say something to a fellow nurse, give yourself

some feedback. Tell her, did I say this because I failed my exam? Then you slowly learn that you had self-control before, despite all these problems. You can't help but fail your exam, because you'll fail your exam again, you'll have another failed exam in your life." (Interview 9).

Another content of the training is the discussion of anger control, which includes the individual's self-control. The following are the participants' opinions in this regard:

- Self-control: In certain situations where actions or reactions out of anger may occur by individuals, it is necessary to overcome the fire of this anger by controlling oneself and reducing subsequent violence.

"In my opinion, one of the most serious shortcomings of the academic staff is that they do not control themselves and do not have self-knowledge. Not from the beginning of their student life, perhaps they wanted a preliminary course there, but before entering the academic staff, we must definitely come to the manner of dealing with others, tolerance of others, sympathy for others, such topics or especially behavior in a state of anger, we must definitely see our reactions in a state of anger." (Interview 7).

"As soon as people know under what circumstances and what factors they may show a series of reactions. First, they must be able to control themselves. For example, why do you come down with low blood sugar and ask a nurse why he did this or that? You go and fix your own problem first. So, a series of physical issues must be observed. When a person is tired, when a person is hungry, when a person is aroused by other issues, one should not introduce new challenges to oneself. When you come in the morning and they give you bad news, you must control yourself and not go, now start the second challenge for yourself and start the third challenge for yourself." (Interview 9).

"Confrontations that should be done when angry; drink cold water, take a deep breath, leave the situation, these are very effective in controlling anger and self-control." (Interview 7).

Empiricism is another dimension that is discussed in the field of education. Empiricism includes things such as paying attention to professional behavior in the field of practice, student teachers, reviewing existing cases, lectures by experienced teachers, etc., some of which are discussed below:

- Paying attention to professional behavior in the field of practice: Experienced teachers can teach the younger ones important points that play a role in reducing violence through practice. Teachers who are less exposed to violence indicate that they are performing correctly in their behavior with those around them.

"For example, look, we go to a patient, this happens a lot. The resident says, for example, this is a patient with a metastatic cancer, and now he's very indifferent, let's just go and quickly pass. I explain this to him. I say, look, all this you're saying is true, after all, this is for a dear family, for his sons, his children, it's dear to bring him to the hospital." (Interview 2)

"Anyway, gradually, a person tests many things in his work experience, but a professor who has been working for 28 years is providing his residents with the dos and don'ts and his work experience" (Interview 3).

"It becomes more of a manner, meaning you, for example, rely on the manners of a professor. Over time, slowly, in the work, in the encounters, in the conversations, over the years that they have been together, the temperament of that professor may slowly take root in your mind." (Interview 8)

"Let's use the experience of experienced and veteran people for others; let's use it both for ourselves and for others." (Interview 9).

Review of existing cases: By reviewing existing cases, it is possible to identify the causes and consequences of past violence and make better decisions about possible future violence.

"Why don't we show them the medical records where these things happened, so that they can see what happened. I always give an example, I tell the kids, give them five minutes to relax about the five years of coming and going in the Tehran medical system. Give them five minutes. All of this should be done with the feedback that comes with it. Look at this case, for example, a resident or intern didn't come at two in the morning, give them five minutes to write this note, see what kind of trouble they caused. Or they didn't take two minutes to explain to the patient's

companion what happened, and the patient's companion went to the hospital director and complained, to the court, to the police station. Now the whole story is over, now they won't let go of the story." (Interview 9).

"All these cases are being buried in this forensic medicine and in these courts, so let's talk about some of them." (Interview 9).

Lectures by experienced professors: By organizing conferences, seminars, etc., on the topic of workplace violence, you can invite prominent and experienced professors to give lectures and benefit from their experiences.

"It once occurred to me that these are TED shows that are being held? I said, why don't we have these TED Shows in our hospitals? For example, we now have a doctor who has been a faculty member for 30 years. He will speak for a quarter of an hour (he speaks beautifully) and convey his 30-year experience to you on a specific topic. Why don't we have a TED Show where this faculty member comes to tell this to the young people?" (Interview 9)

- Professional ethics training is another dimension that is related to the content of the training, which includes things such as respect for others, respect for the patient, etc., Some of these issues are discussed below:

Medical ethics

"They need to understand that they don't work in a TV factory, for example, they work with people. This means that our client is something called a human being, not a table. Sir, let's take this table and leave it, let's bring that one. People can't be moved like this. Let's leave this person in that department, let's take a person from that one and bring him here. This person is a dynamic atmosphere, a dynamic environment with all its own problems. When you want to say something to him and move him, give him a point, punish him, you should never forget that this is a person, a human being. For this reason, there must be a mutual understanding from the managers that just as they deal with the patient and his companion, I don't want to say this sentence, but we are slowly forgetting that the patient is also a human being." (Interview 9).

Appendix 13

- Training methods are one of the basic topics in the category of training, which, according to the participants in this study, can be carried out in various ways, such as: cascade training, face-to-face training, theoretical and practical training (training in the field and alongside the teacher), film therapy, empowerment workshops.
- Training time is the last topic that is discussed in relation to training. According to the participants, the student period and before entering the field, while in the field and on the bedside, after graduation (continuous training), etc., are appropriate times for training.
- Calming the environment: The last topic that is discussed in relation to ways to prevent and deal with violence is the topic of calming the environment, which includes things such as leaving the place of violence, calling for calm, removing stress-causing factors from the place of tension, silence, creating happiness in the space, etc.

. "Sometimes I tell students that when you see a patient who is very angry and has become involved with you, there is nothing wrong with it. You should lock your room door and sit in your room. At least you will prevent further physical confrontations until it calms down and someone can come and help and calm the environment." (Interview 3)

"If I see a patient who is tense, I don't talk to them. I say, 'You are not in a good mood right now. When you calm down a little, we will talk, and then I will come out.'" (Interview 7).

"I try to calm the angry person down. Verbal calming means that first of all, he feels that I empathize with him, that I understand his pain, that's the beginning. Once that's done, we have gone most of the way. (Interview 6)

"I think our silence is the best thing to do to deal with violence. Our silence and not responding and showing that we are doing our best and we did our best. "When they are angry, they don't accept even our best justifications." (Interview 1).