

# An investigation into healthcare workers' exposure to workplace violence in a medical center in Ahvaz

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## ABSTRACT

Workplace violence (WPV) is a significant challenge for healthcare systems globally, impacting both the well-being of healthcare workers and the quality of patient care. This study investigates the prevalence, types, and impacts of WPV in a tertiary hospital in Ahvaz, Iran, employing a cross-sectional approach and mixed methods. Data from 200 healthcare workers were analyzed to examine correlations between occupational characteristics, demographic factors, and experiences of violence. The findings indicate that over 60% of participants had experienced verbal abuse, while physical violence and sexual harassment affected smaller but notable proportions. Nurses and shift workers were identified as the most vulnerable groups, particularly in high-stress departments such as the emergency room and psychiatry. Psychological and occupational consequences of WPV, including stress, burnout, and job dissatisfaction, were evident among affected workers. Cultural and systemic factors, such as overcrowding, long waiting times, and inadequate security, were significant contributors to the prevalence of violence. This study emphasizes the urgent need for multi-level interventions, including legal reforms, staff training in conflict resolution, and enhanced workplace safety measures. By addressing the systemic and cultural underpinnings of WPV, healthcare systems can improve worker safety, job satisfaction, and the overall quality of care.

**Keywords:** Workplace, Violence, Healthcare, Hospital, Physical, Verbal abuse

## Introduction

Workplace violence (WPV) has become a global concern, particularly in the healthcare sector, where personnel frequently encounter physical, verbal, and emotional abuse. The World Health Organization (WHO) defines workplace violence as situations in which employees are abused, threatened, or assaulted in circumstances related to their work, posing explicit or implicit risks to their safety and well-being [1]. Healthcare workers (HCWs) are especially vulnerable due to the nature of their work, which involves close interaction with patients and their relatives, often under stressful conditions, and experience violence at rates four to sixteen times higher than other professions [2]. The COVID-19 pandemic has exacerbated this issue, with studies reporting a substantial increase in workplace violence globally, stemming from heightened anxiety, resource shortages, and extended wait times [3].

Violence within healthcare settings is not merely a human rights concern; it presents a significant obstacle to the delivery of effective and compassionate care. Research demonstrates that WPV undermines healthcare systems, leading to increased staff turnover, absenteeism, and reduced productivity [4]. It also inflicts long-lasting psychological consequences, including post-traumatic stress disorder (PTSD), depression, and burnout among affected professionals [5]. These repercussions seriously compromise patient care, making this a professional and public health crisis.

The prevalence of WPV varies considerably across different regions and settings, reflecting cultural, systemic, and organizational differences. In high-risk environments such as emergency departments, intensive care units, and psychiatric wards, violence is almost endemic. A meta-analysis conducted by Liu *et al.* (2019) reported that approximately 61.9% of healthcare workers globally had experienced some form of WPV [6], with verbal abuse being the most prevalent (57.6%),

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followed by physical violence (24.4%). These figures highlight the pervasiveness of violence and its multifaceted nature. However, local studies, particularly in the Middle East and North Africa (MENA) region, including Iran, indicate even higher rates of exposure, with cultural dynamics and systemic inefficiencies compounding the risks [7].

Ahvaz, a major city in Iran, exemplifies the challenges of managing WPV in healthcare. As a regional hub for medical care, its hospitals frequently contend with high patient loads, staffing shortages, and inadequate security infrastructure, all of which contribute to an increased risk of violence against HCWs. Despite these realities, WPV remains underreported due to fear of reprisal, normalization of violence, and a lack of robust reporting mechanisms [8]. This study seeks to address this critical gap by systematically investigating the prevalence and impact of WPV in Ahvaz's healthcare settings, providing evidence for targeted interventions.

This study aims to achieve the following objectives:

### Primary objective

To determine the prevalence and types of WPV experienced by HCWs in Ahvaz, focusing on both verbal and physical forms.

### Secondary objectives

- Identify demographic and occupational characteristics (e.g., gender, age, role, shift patterns) associated with increased vulnerability to WPV.
- Evaluate the psychological and occupational consequences of WPV on HCWs, including job satisfaction, mental health outcomes, and intention to leave.
- Provide evidence-based recommendations for mitigating WPV in healthcare settings.

Addressing WPV is not solely about protecting healthcare staff; it is a vital step in enhancing healthcare delivery systems. The findings of this study will provide localized insights into the dynamics of WPV in Ahvaz, complementing global and regional literature. By highlighting the specific vulnerabilities of HCWs in this context, this study aims to inform the development of tailored interventions that prioritize safety, communication, and organizational support.

Furthermore, this study contributes to the broader discourse on occupational safety, emphasizing the need for multi-level strategies encompassing policy reforms, educational programs, and infrastructure improvements. For instance, systematic reviews have consistently shown that multi-component interventions, including training, enhanced security, and post-incident reporting, are effective in reducing WPV [9]. By integrating these insights, this research seeks not only to document the problem but also to guide practical solutions.

In conclusion, WPV is a pressing occupational hazard with profound implications for healthcare workers, patients, and the wider healthcare system. This study seeks to address this

multifaceted issue with a focused lens on Ahvaz, advancing academic understanding and practical responses to ensure safer and more supportive healthcare environments.

### Literature Review

Workplace violence (WPV) against healthcare workers is a pervasive and multifaceted issue affecting healthcare systems worldwide. Defined as physical assaults, verbal abuse, threats, or any other form of aggression experienced in the workplace, WPV is recognized as a significant occupational hazard with profound implications for the mental, physical, and occupational well-being of healthcare personnel [1]. Recent studies have illuminated the complexity of this issue, emphasizing its global, regional, and local dimensions while identifying persistent gaps in understanding and addressing this challenge.

The global prevalence of WPV in healthcare settings is alarmingly high. A meta-analysis by Liu *et al.* (2019) reported that approximately 61.9% of healthcare workers worldwide had experienced some form of WPV [6], with verbal abuse being the most prevalent (57.6%), followed by physical violence (24.4%). This study highlighted that WPV is not confined to specific regions but is a global issue, with slightly higher prevalence rates in Asian and North American countries. Factors such as high patient volume, resource constraints, and a cultural tolerance of aggression contribute to these figures.

The COVID-19 pandemic further exacerbated this issue, exposing healthcare workers to unprecedented levels of stress and aggression. Dopelt *et al.* (2022) revealed that during the pandemic [3], 71% of healthcare workers in a study conducted in Israel reported experiencing WPV, with verbal abuse being the most common form. These incidents stemmed from heightened patient frustration, long wait times, and anxieties surrounding COVID-19 treatment protocols. Similarly, in the UK, Donald and Lindsey (2023) observed a significant increase in violence against emergency department staff during the pandemic [10], with reports indicating a worrying rise in both verbal and physical assaults.

In the MENA region, WPV poses unique challenges due to cultural, systemic, and institutional dynamics. Studies in Saudi Arabia, for example, report high levels of verbal and physical violence against healthcare workers, particularly nurses. Alshammari *et al.* (2022) documented that over 17% of healthcare workers at King Khalid University Hospital activated "Code White" alerts, signifying workplace violence incidents [7], with younger and less experienced staff disproportionately affected. Verbal abuse was most prevalent, often stemming from communication breakdowns and unmet patient expectations.

Iran is another WPV hotspot, with structural inefficiencies and under-resourced hospitals compounding the problem. In Ahvaz, the location of this study, anecdotal evidence suggests that WPV is underreported, reflecting systemic barriers to acknowledging and addressing this issue [8]. A lack of standardized reporting mechanisms and the normalization of violence within healthcare

settings contribute to this phenomenon, emphasizing the need for comprehensive, region-specific research.

### *Local Context: Ahvaz, Iran*

In Ahvaz, as in many other parts of Iran, WPV remains a pressing concern. The healthcare system here grapples with chronic staff shortages, inadequate security measures, and high patient loads. These factors combine to create an environment where healthcare workers are frequently exposed to aggression from patients and their families. Preliminary findings from this region suggest that emergency departments and psychiatric wards are particularly high-risk areas, with female healthcare workers disproportionately affected [7]. However, there is a scarcity of localized data, highlighting a critical research gap that this study aims to address.

WPV in healthcare settings manifests in various forms, including verbal abuse, physical attacks, and psychological aggression. Trends indicate a global increase in WPV incidents over the past decade, with specific settings, such as emergency departments and psychiatric units, exhibiting higher rates. This is attributed to the stressful nature of these environments, coupled with frequent staff-patient interactions. Mento *et al.* (2020) emphasized that the consequences of WPV extend beyond immediate physical harm [1], significantly impacting the mental health, job satisfaction, and overall quality of life of healthcare workers.

The psychological repercussions of WPV are particularly profound. Lanctôt and Guay (2020) identified post-traumatic stress disorder (PTSD) [4], depression, and anxiety as common consequences among affected healthcare workers. These psychological burdens often lead to burnout, a state characterized by emotional exhaustion, cynicism, and reduced professional efficacy. Burnout not only affects healthcare workers but also jeopardizes the quality of care delivered to patients, creating a cyclical detriment to the healthcare system.

Physically, WPV can result in injuries ranging from minor bruises to severe trauma, depending on the nature of the violence. Verbal abuse, while not causing direct physical harm, significantly contributes to emotional distress and diminished morale among healthcare staff. Fricke *et al.* (2022) highlighted that repeated exposure to verbal aggression erodes professional confidence, exacerbates interpersonal conflicts, and reduces job satisfaction [9].

Occupationally, WPV leads to increased staff turnover, absenteeism, and reduced productivity. Dopelt *et al.* (2022) observed that healthcare workers exposed to frequent violence are more likely to consider leaving their profession, a trend that exacerbates existing workforce shortages in the healthcare sector [3]. These occupational consequences underscore the need for robust interventions to mitigate WPV and support affected workers.

Despite extensive research on WPV, significant gaps remain. One major limitation is the underreporting of incidents, which skews prevalence data and hinders the formulation of effective

policies. Devnani (2021) noted that healthcare workers often refrain from reporting WPV due to fear of reprisal [5], lack of trust in reporting systems, and the normalization of violence within healthcare settings. Addressing these barriers is crucial for understanding the true scope of WPV.

Another gap lies in the lack of longitudinal studies that examine the long-term effects of WPV on the mental health and career trajectories of healthcare workers. Existing research, such as that by Lanctôt and Guay (2020), has primarily focused on immediate consequences [4], leaving questions about the enduring impact of WPV unanswered. Furthermore, there is a scarcity of studies examining the effectiveness of interventions, especially in resource-constrained settings like Ahvaz.

The prevalence and consequences of WPV in healthcare settings are well-documented but inadequately addressed, particularly in regional and local contexts. This literature review emphasizes the urgent need for targeted research and interventions to mitigate WPV and its multifaceted impacts. By addressing the identified research gaps, this study intends to contribute to the growing body of evidence on WPV, providing actionable insights for policymakers, healthcare administrators, and frontline staff.

## Materials and Methods

This study employs a cross-sectional approach and mixed methods, integrating quantitative and qualitative methodologies to provide a comprehensive understanding of workplace violence (WPV) against healthcare workers. The cross-sectional design was chosen to capture a snapshot of the prevalence of WPV and associated factors at a specific point in time within the healthcare sector of Ahvaz, Iran. The mixed methods framework ensures that statistical analysis is complemented by qualitative insights, offering a nuanced understanding of both the measurable and subjective aspects of WPV.

The quantitative component utilized a structured survey instrument to gather data on the prevalence, types, and impacts of WPV. This survey was designed to ensure reliability and validity, employing standardized measures previously validated in similar studies. The qualitative component involved semi-structured interviews with a subset of participants to explore their personal experiences, perceptions, and coping strategies in greater depth. This dual approach allowed for data triangulation, enhancing the credibility and robustness of the study.

### *Study Setting*

This research was conducted in a large, tertiary hospital in Ahvaz, Iran, which serves as a referral center for the region. This hospital was selected due to its high patient volume, diverse healthcare workforce, and representation of various departments, including the emergency department, intensive care unit, psychiatric ward, and general wards - environments known for a high prevalence of WPV [4].

### Sample Population

This study targeted all healthcare workers employed at the hospital, including physicians, nurses, paramedics, and administrative staff, acknowledging that WPV affects individuals across various roles. To ensure a representative sample, inclusion criteria required participants to have at least six months of experience in their current role. Exclusion criteria included part-time employees and those on extended leave during the study period.

### Sampling Method

A stratified random sampling method was employed to ensure proportionate representation across departments and roles. Based on hospital records, the workforce was stratified by department, and participants were randomly selected within each stratum. The sample size was calculated using Cochran's formula, aiming for a 95% confidence interval and a 5% margin of error. The final sample comprised 200 participants, representing approximately 20% of the total workforce.

### Demographics

The demographic characteristics of the sample included:

- **Gender:** Approximately 65% female and 35% male.
- **Age range:** 25 to 55 years, with a mean age of 37.4 years.
- **Professional roles:** 40% nurses, 30% physicians, 20% administrative staff, and 10% paramedics.
- **Experience:** Ranging from 1 to 25 years, with a mean tenure of 8.7 years.

### Data Collection

Data were collected over a two-month period using a combination of standardized questionnaires and semi-structured interviews.

### Quantitative Component

- **Survey Instrument:** A validated questionnaire developed by the International Labour Organization (ILO) and the World Health Organization (WHO) was adapted to the local context. This questionnaire comprised 60 items divided into four sections:
  1. Demographics and occupational characteristics: age, gender, role, years of experience, and department.
  2. Types and frequency of WPV: questions assessing exposure to physical, verbal, and sexual violence within the past year.
  3. Psychological and occupational impact: items measuring stress, burnout, job satisfaction, and intention to leave, using Likert scale responses.
  4. Reporting and organizational response: questions on reporting behaviors and perceived support from management.

- **Translation and Validation:** The questionnaire was translated into Farsi and back-translated to ensure accuracy. A pilot test with 20 participants confirmed its clarity and cultural relevance, yielding a Cronbach's alpha of 0.89, indicating high internal consistency.

### Qualitative Component

- **Interviews:** Semi-structured interviews were conducted with 20 participants purposefully selected from the survey respondents to ensure diversity in gender, role, and department. The interview guide focused on:
  - Personal experiences with WPV.
  - Perceived causes and triggers.
  - Coping mechanisms and organizational support.
- **Interview Procedure:** Each interview lasted 30 to 45 minutes and was conducted in a private setting to ensure confidentiality. Interviews were audio-recorded with participant consent and transcribed verbatim for analysis.

### Analysis Techniques

#### Quantitative Analysis

- **Descriptive Statistics:** Frequencies, percentages, means, and standard deviations were calculated to summarize demographic characteristics and the prevalence of WPV. These statistics provided an initial understanding of the extent and distribution of violence.
- **Inferential Statistics:**
  - Chi-square tests: Used to examine associations between categorical variables such as gender, department, and type of violence experienced.
  - Logistic regression: Used to identify predictors of WPV, including professional role, shift type, and years of experience. Odds ratios (ORs) and confidence intervals (CIs) were reported to quantify risk factors.
  - ANOVA (Analysis of Variance): Conducted to assess differences in psychological outcomes (e.g., stress and burnout) across groups based on WPV exposure.
- **Software:** Data were analyzed using SPSS version 26.0, with the significance level set at  $p < 0.05$ .

### Qualitative Analysis

- **Thematic Analysis:** Braun and Clarke's six-step framework was applied to identify recurring themes within the interview transcripts:
  1. Familiarization with the data.
  2. Coding for initial patterns.
  3. Generating themes.
  4. Reviewing and refining themes.
  5. Defining themes.
  6. Producing the final report.
- **Coding Framework:** Both inductive and deductive approaches were used, allowing predefined categories (e.g., triggers of WPV) to be expanded upon with emergent insights.
- **Trustworthiness:** Triangulation was achieved by comparing interview findings with survey data. Member checking ensured that participants validated the interpretation of their responses.

### Integration of Findings

Quantitative and qualitative findings were integrated during the interpretation phase to provide a holistic perspective on WPV. For example, statistical associations identified in the survey were further explored through qualitative insights, illuminating underlying mechanisms and subjective experiences.

## Results and Discussion

### Demographic Distribution and Types of Violence

This study, aimed at investigating workplace violence (WPV) in the healthcare sector, examined the demographic characteristics of healthcare workers, including gender, age, marital status, and education level. The results showed that the majority of the employees were female (65%) and in the age group of 30 to 39 years (45%). Also, most of them were married (60%) and held a bachelor's degree (70%).

In this study, types of violence, including physical violence, verbal abuse, and sexual harassment, were analyzed. The findings indicated that physical violence was experienced by 25% of the participants, which is less prevalent than verbal abuse. This study, by providing detailed information on the demographic characteristics of employees and types of workplace violence, contributes to a better understanding of the dynamics and prevalence of WPV in the healthcare sector. This data can be used to plan and implement effective interventions to prevent and reduce workplace violence.

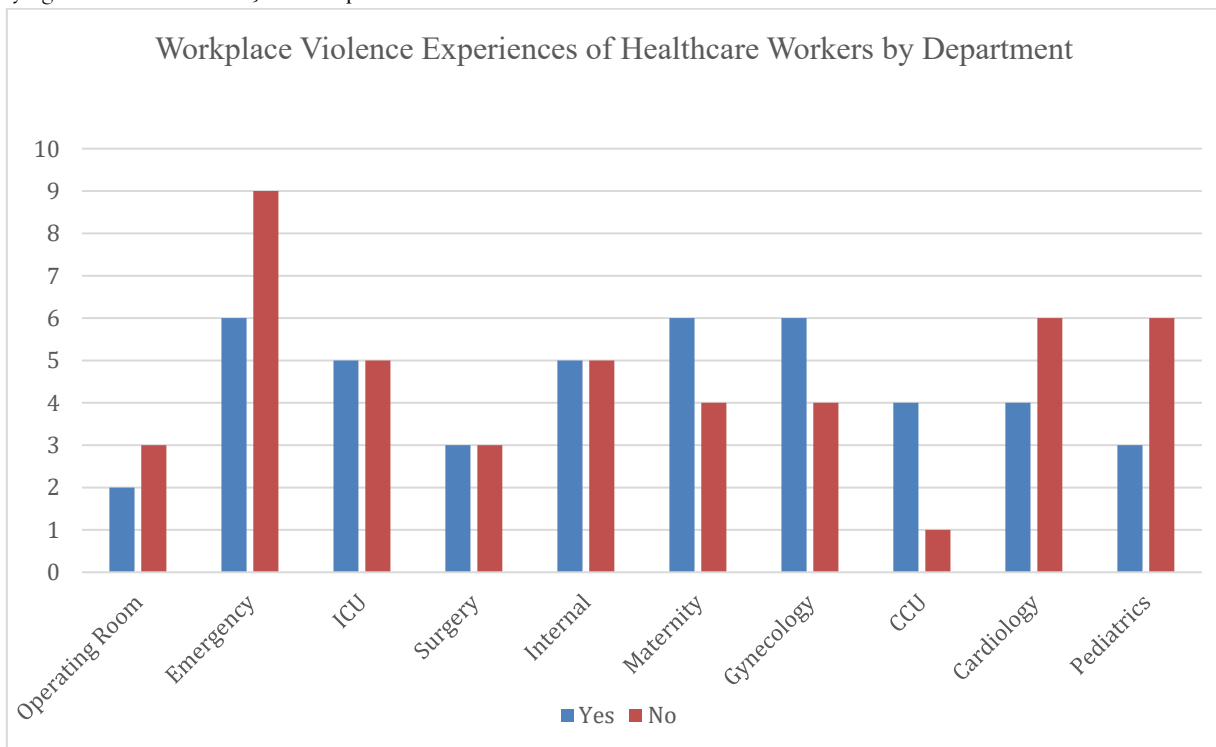
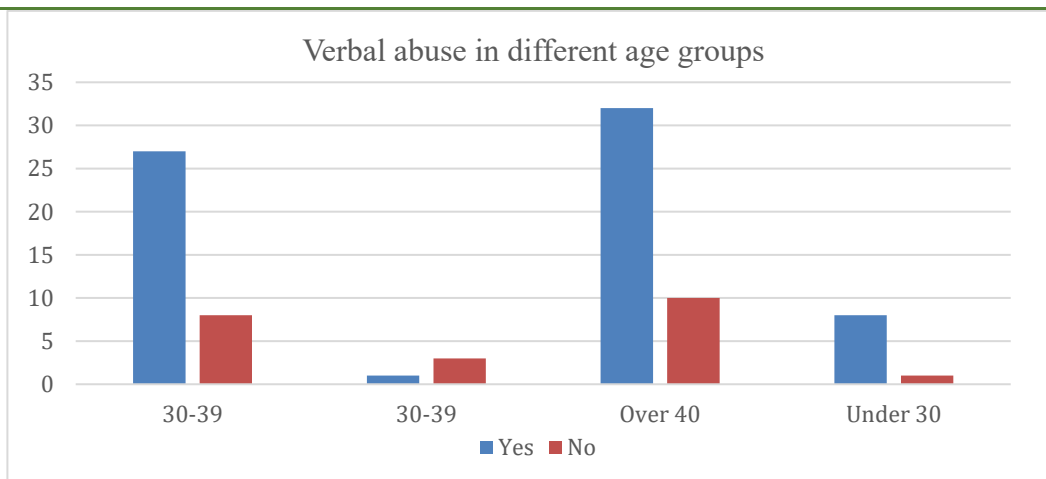


Figure 1. The frequency of physical violence in different sectors

Verbal abuse was the most prevalent type of WPV, with over 60% of participants experiencing it.



**Figure 2.** Trends in verbal abuse across age groups

Sexual harassment, although less frequent, was reported by 10% of the participants. It was mostly experienced by female healthcare workers in specific departments. Demographic analysis highlights notable patterns in WPV exposure. Female healthcare workers, particularly those aged 30 to 39, reported the highest rates of verbal abuse. The prevalence of violence in the emergency and psychiatric departments emphasizes the need for targeted interventions in high-risk areas. The findings on physical violence and sexual harassment underscore the importance of implementing robust reporting mechanisms and support systems. Educating staff about their rights and equipping them with de-escalation techniques can mitigate these challenges.

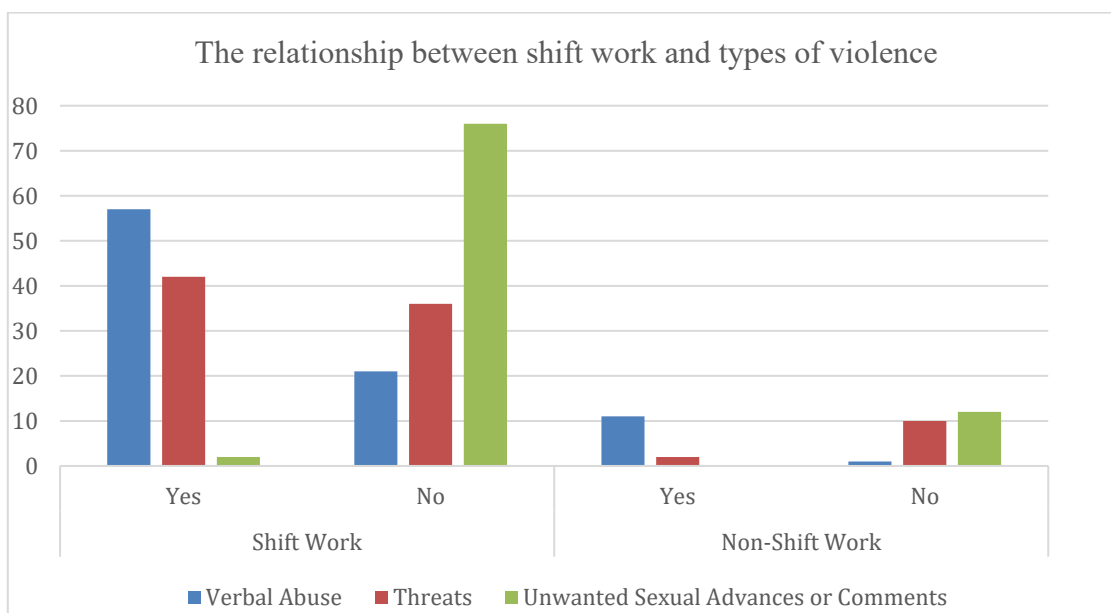
### Correlations: Relationships between Occupational Characteristics and Violence

The relationships between occupational characteristics – such as shift work, professional roles, and departmental assignments – and experiences of workplace violence (WPV) reveal significant insights into the dynamics of aggression in healthcare settings.

### Shift Work and Violence

Analysis of shift types (day, night, and rotating) demonstrated a strong association between rotating shift workers and increased exposure to WPV. Nearly 70% of rotating shift workers reported at least one type of violence, compared to 45% of day shift workers.

### Correlations and Impact on Job Satisfaction



**Figure 3.** Diagram of the relationship between type of work shift and types of violence

This correlation underscores the role of irregular hours and prolonged patient contact in exacerbating stress and conflict within healthcare settings.

Nurses experienced the highest rates of WPV, with 60% reporting verbal abuse and 30% reporting physical violence. Physicians reported lower overall rates but were more likely to experience violence from disgruntled patients.

### Role and Violence

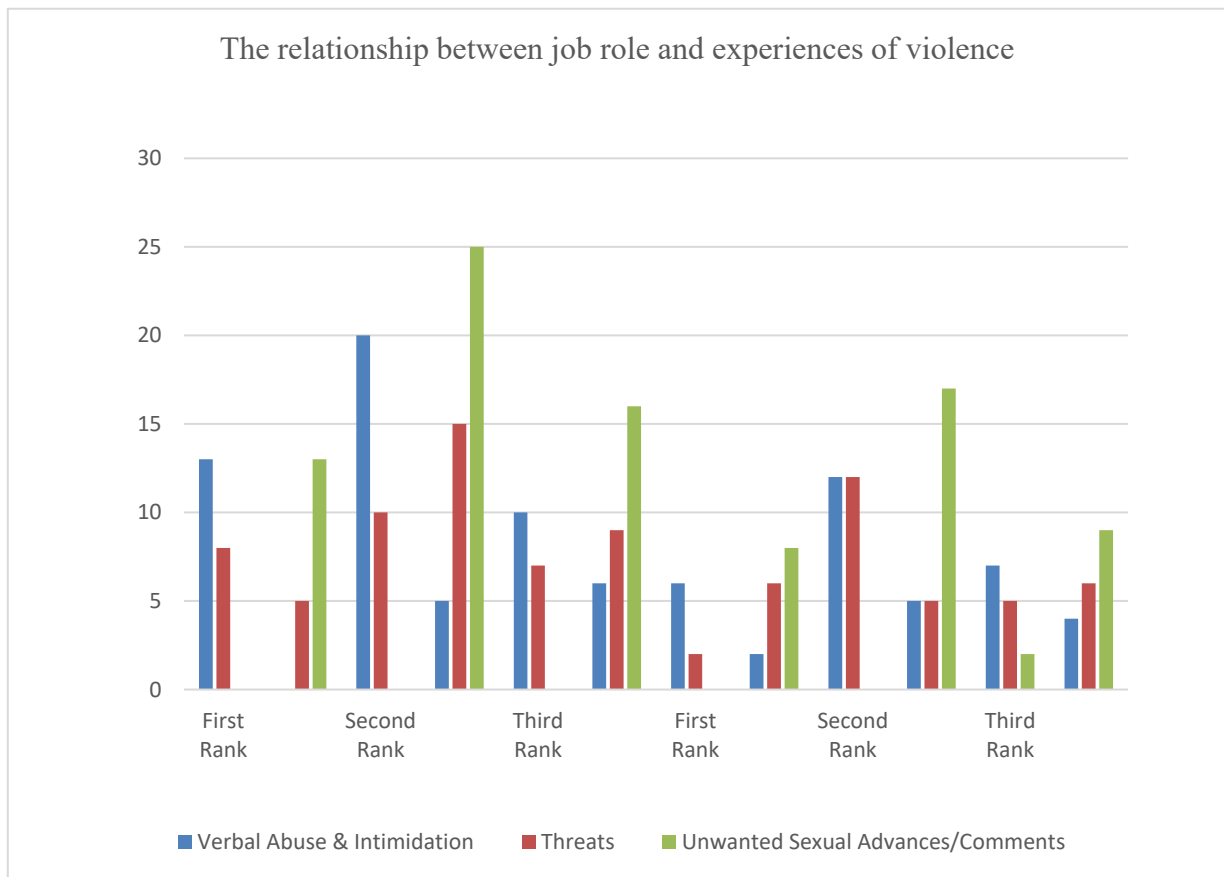


Figure 4. Relationship between job role and experiences of violence

*Departmental Variations*

Departments with high patient turnover, such as the emergency and critical care units, exhibited the highest rates of WPV. Emergency departments accounted for 40% of reported incidents, followed by psychiatric units at 25%.

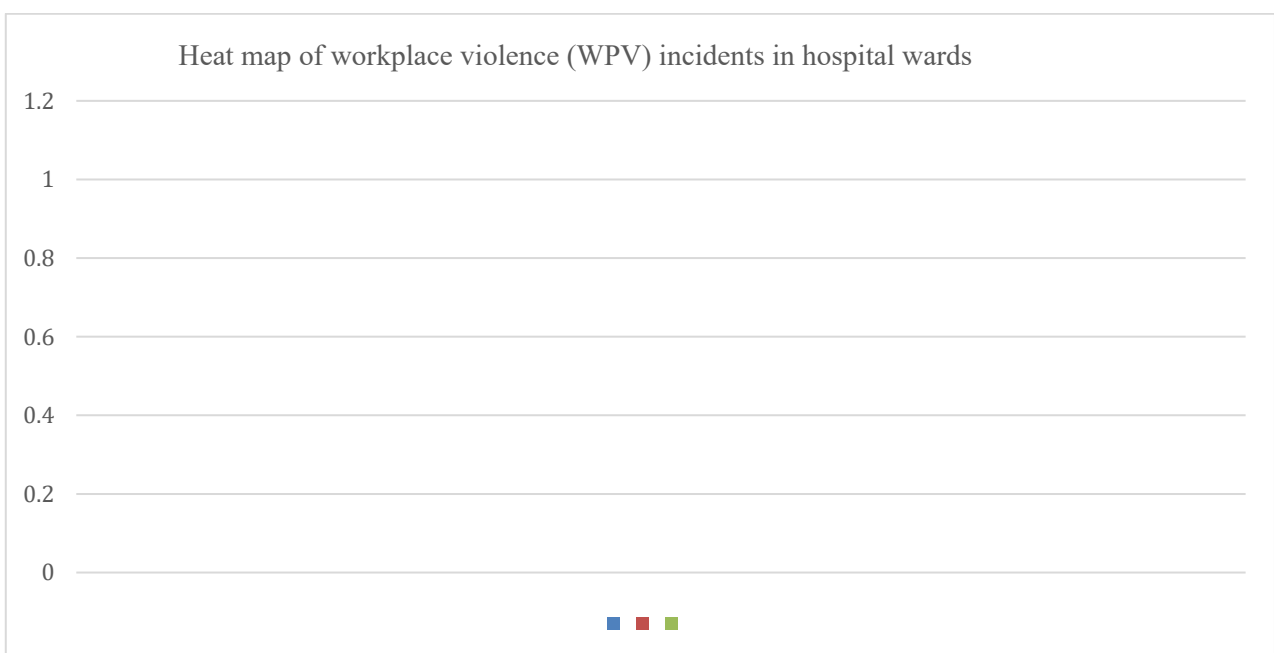
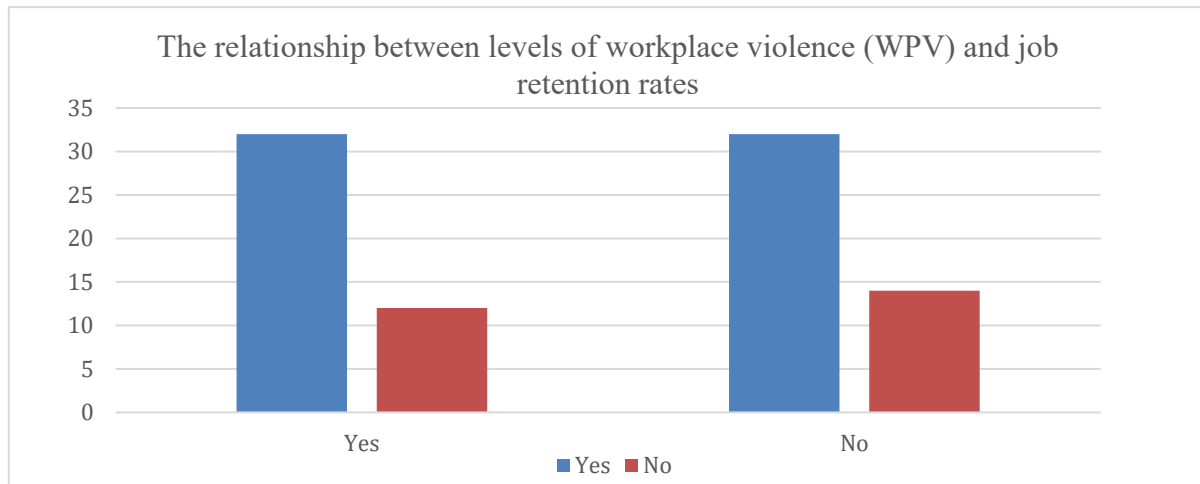


Figure 5. Heat map of WPV incidents in hospital wards

### Impact on Job Satisfaction

WPV significantly impacts job satisfaction, mental health, and career goals among healthcare workers. This analysis examined

how exposure to violence influenced the likelihood of job retention and overall well-being of workers. Among healthcare workers who experienced high levels of WPV, 60% expressed their intention to leave their current roles, compared to 20% among those with minimal or no exposure.



**Figure 6.** Relationship between the level of workplace violence and job retention rates

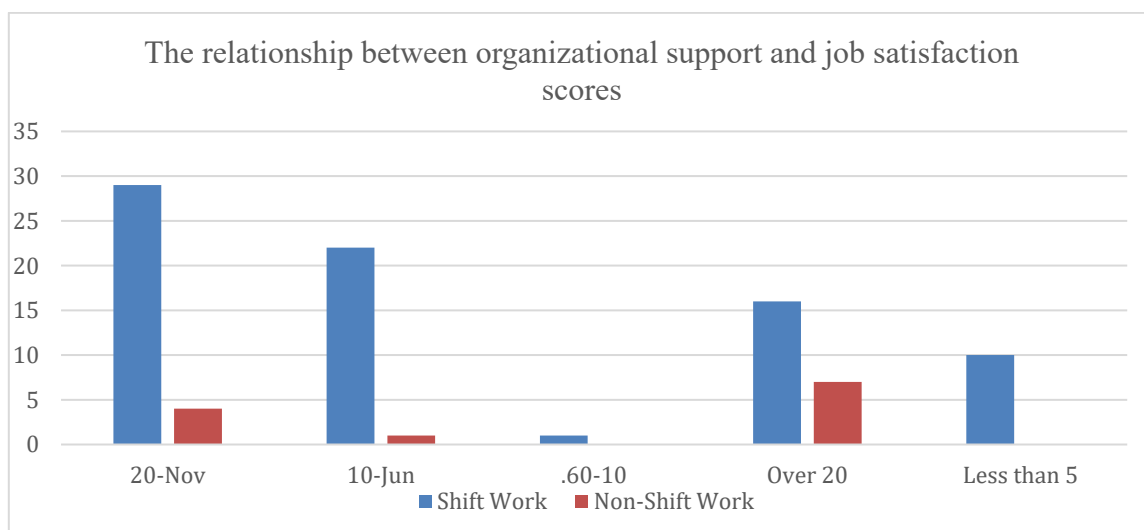
### Mental Health Impacts

Psychological consequences such as stress, burnout, and symptoms of anxiety or depression were reported by 80% of workers exposed to frequent WPV. Interviews revealed that many healthcare workers internalize aggression, leading to feelings of hopelessness and helplessness. These findings align with previous research emphasizing the cyclical nature of WPV:

stressed healthcare workers are more vulnerable to aggression, perpetuating a harmful cycle.

### Organizational Support

Workers who reported incidents of violence and received timely organizational support – such as counseling or adjustments in their roles – demonstrated greater resilience and job satisfaction.



**Figure 7.** Relationship between organizational support and job satisfaction scores

This analysis clearly demonstrates that occupational characteristics such as shift work, professional role, and departmental assignment play a significant role in determining exposure to WPV. Rotating shift workers and nurses, particularly those in high-stress departments such as the emergency room and psychiatry, are disproportionately affected.

Furthermore, the psychological and occupational consequences of WPV, including reduced job satisfaction and mental health challenges, underscore the urgent need for systemic interventions. Organizational measures such as improving staff-to-patient ratios, providing training in conflict de-escalation, and offering robust support systems can mitigate the adverse impacts

of WPV. Additionally, targeted policies to address the unique challenges of high-risk departments are crucial for fostering a safer and more supportive work environment.

The findings of this study align with and expand upon the existing literature, underscoring the pervasive nature of workplace violence (WPV) in healthcare settings and its multifaceted consequences. Globally, WPV is recognized as a critical occupational hazard, with healthcare workers facing a disproportionate risk compared to other professions [4]. The high prevalence of verbal abuse reported in this study (over 60% of participants) mirrors the findings of previous meta-analyses, such as Liu *et al.* (2019), which identified verbal aggression as the most common form of WPV worldwide [6].

The notable vulnerability of nurses, as highlighted in this study, also aligns with global trends. Nurses often serve as the frontline of patient care, frequently interacting with patients and their families in stressful situations. Studies by Alshammari *et al.* (2022) and Dopelt *et al.* (2022) similarly emphasize that nurses are disproportionately affected by WPV, particularly in emergency and critical care settings [3, 7].

This study's finding that rotating shift workers are more likely to experience violence corroborates previous research, such as the work of Donald and Lindsey (2023), which indicated that irregular and extended work hours exacerbate stress and conflict, creating a fertile ground for aggression [10].

The novel contribution of this study is its focus on WPV in Ahvaz, Iran, a region where localized data has been scarce. By examining demographic factors, occupational roles, and departmental variations, this research provides granular insights into the specific challenges facing healthcare workers in this context. The high prevalence of violence in the emergency and psychiatric departments reflects global patterns while highlighting the unique stressors of the Iranian healthcare system, including resource constraints and cultural norms surrounding aggression.

Cultural and regional factors play a pivotal role in shaping the prevalence and dynamics of WPV. In the Middle East and North Africa (MENA) region, including Iran, systemic and cultural factors compound the risks faced by healthcare workers. In Iranian hospitals, high patient-to-staff ratios, inadequate security measures, and limited awareness regarding WPV contribute to the normalization of aggression. The study by Alshammari *et al.* (2022) similarly identifies a cultural acceptance of verbal aggression and dissatisfaction with healthcare services as significant drivers of violence in Saudi Arabia [7].

In Ahvaz, the cultural dynamics of respect and authority intersect with frustrations stemming from long wait times, overcrowding, and perceived inefficiencies in healthcare delivery. Patients and their families often perceive healthcare workers as representatives of systemic failures, directing their anger towards frontline staff. This aligns with the findings of Dopelt *et al.* (2022), who observed that frustration with resource shortages and long wait times during the COVID-19 pandemic significantly increased WPV incidents [3].

The regional emphasis on family-centric decision-making in healthcare further complicates the dynamics of WPV. In Iranian culture, families play a central role in patient care, often advocating fiercely on behalf of their loved ones. While this support can be constructive, it also increases the potential for conflicts, particularly in high-stress departments such as the emergency room and psychiatry. The study by Mento *et al.* (2020) highlights similar patterns in culturally comparable contexts [1], where family involvement often exacerbates verbal and physical aggression.

Gender dynamics also influence WPV in the region. Female healthcare workers, particularly nurses, face the dual burden of professional and gendered aggression. This study's finding that 70% of nurses experiencing WPV are female resonates with global literature, such as the work of Vento *et al.* (2020), which emphasizes the intersection of gender and occupational vulnerability in healthcare [2].

The implications of these findings for healthcare policy and practice are profound. WPV not only jeopardizes the physical and mental health of healthcare workers but also undermines the quality of patient care and the overall efficiency of healthcare systems. Addressing this issue requires a multifaceted approach that integrates policy reforms, staff training, and targeted workplace interventions.

Establishing clear legal frameworks to address WPV is crucial. Countries such as India and the United States have introduced legislation criminalizing violence against healthcare workers, setting a precedent for Iran and other MENA nations [5]. These laws should include stringent penalties for perpetrators and robust mechanisms for reporting and investigating incidents.

Institutional policies must prioritize the safety and well-being of healthcare workers. Hospitals should develop comprehensive WPV prevention programs that include risk assessment, incident reporting systems, and ongoing monitoring of workplace dynamics. Incorporating occupational safety standards, as outlined by Fricke *et al.* (2022), can provide a structured framework for implementation [9].

Training healthcare workers in conflict resolution and de-escalation techniques is essential. The qualitative findings of this study indicate that many workers feel ill-equipped to handle aggressive patients and their families, exacerbating tensions. Training workshops and simulation-based learning can build confidence and competence in managing volatile situations.

Raising awareness about WPV among staff, patients, and the community is equally important. Educational campaigns should emphasize the unacceptability of aggression in healthcare settings, fostering a culture of respect and collaboration. Studies such as Huang *et al.* (2024) highlight the effectiveness of such campaigns in reducing WPV [8].

Improving security measures in high-risk departments is a practical and immediate step. Deploying trained security personnel, installing surveillance systems, and implementing controlled access to sensitive areas can deter violent incidents. These measures have been particularly effective in reducing

violence in emergency departments, as demonstrated by Donald and Lindsey (2023) [10].

Providing psychological support for affected healthcare workers is crucial. Counseling services, peer support groups, and post-incident debriefings can help mitigate the emotional toll of WPV. The study by Lanctôt and Guay (2020) emphasizes the importance of addressing the long-term psychological impacts of WPV to prevent burnout and attrition [4].

Adjusting staffing patterns to reduce workload and stress is another vital intervention. Ensuring adequate staff-to-patient ratios can alleviate some of the systemic pressures that contribute to WPV. This aligns with the findings of Mento *et al.* (2022), which indicated that better staffing correlates with lower rates of WPV [1].

This study provides a comprehensive examination of WPV in Ahvaz, Iran, situating its findings within the broader context of regional and global literature. By highlighting the prevalence, dynamics, and consequences of WPV, it underscores the urgent need for systemic interventions that prioritize the safety and well-being of healthcare workers. Addressing WPV is not only an ethical imperative but a practical necessity to ensure the sustainability and effectiveness of healthcare systems. Through targeted policies, robust training programs, and proactive workplace interventions, the healthcare sector can create safer environments that empower staff and enhance patient care.

## Conclusion

Workplace violence (WPV) against healthcare workers is a critical issue with far-reaching implications for individual well-being, organizational efficiency, and overall healthcare delivery. This study delves into the prevalence, dynamics, and impacts of WPV in Ahvaz, Iran, providing both quantitative and qualitative insights into this pervasive occupational hazard.

The findings confirm that WPV is not only widespread but also disproportionately affects certain populations, notably nurses, rotating shift workers, and those in high-stress departments such as the emergency room and psychiatry. The analysis revealed that verbal abuse is the most prevalent form of WPV, followed by physical violence and sexual harassment. Cultural and systemic factors, such as long wait times, overcrowding, and inadequate security, exacerbate the risk of violence. Gender dynamics further influence exposure to aggression, with female healthcare workers being more vulnerable.

This study also highlighted the detrimental psychological and occupational consequences of WPV, including stress, burnout, job dissatisfaction, and a high intention to leave. These repercussions not only harm affected workers but also jeopardize the quality of patient care and the stability of healthcare systems. Addressing WPV requires a multifaceted approach that combines policy reforms, targeted training, and workplace interventions. Strengthening legal protections, implementing comprehensive WPV prevention programs, and promoting organizational support systems are essential steps. Training healthcare workers

in conflict resolution and de-escalation techniques, coupled with improved staffing patterns and security measures, can help mitigate the risks of violence. Furthermore, fostering a culture of respect and accountability within healthcare settings is crucial for breaking the cycle of aggression.

This study offers actionable insights for healthcare administrators, policymakers, and frontline staff. By addressing the systemic and cultural drivers of WPV, the healthcare sector can create safer and more supportive environments that empower employees and improve patient outcomes.

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