

Violence in emergency service: The situation of general surgeons in Turkey

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ABSTRACT

BACKGROUND: Violence in healthcare in public health is a problem about socio-economic and personal development that is unfortunately seen in every service but more frequently in emergency departments. In our study, we aimed to determine the violence experiences of general surgeons in the emergency room and their perceptions about it.

METHODS: The study is designed in a cross-sectional type. We sent a survey containing 11 questions to the e-mails of 941 general surgeons registered in the National Trauma and Emergency Surgery Association in August–September 2019. The rate of participation to the online survey was 9.98%.

RESULTS: The participants who have been subjected to violence in anyway and who have never encountered violence were 64.9% and 16.0%, respectively. Female surgeons composed 10.6% of the participants and their rate of exposure to violence was 90.0%. When the number of patients accepted by the surgeon increased, the rate of being exposed to violence rose ($p=0.014$). Those who're exposed to verbal violence applied to courts less frequently ($p=0.046$). The surgeons whose had to applied to courts could not receive remarkable support from their institutions. The participants stated that who're source of violence should get effective punishments and victims should be strongly supported.

CONCLUSION: The specialists exposed to violence in the emergency room include general surgeons. Increase of the risk of exposure to violence for surgeons correlates workload. Verbal violence moved to the court stage has observed less frequently than the physical. It would be appropriate to take serious sanctions strengthened by legal regulations as the first step toward a solution.

Keywords: Emergency; hospital; surgeon; thematic; violence.

INTRODUCTION

Violence in hospitals is an important workplace problem. It has been reported that violence occurs more frequently in the field of health compared to other workplaces, and 25% of workplace violence is experienced in the health-care services.^[1] The risk of being subjected to violence of healthcare workers (HCWs) can increase up to 16 times compared to other workplaces.^[2] Emergency services (ER) are the leading units where violence occurs.^[3–10] The health-care professionals in surgery are exposed to more violence than other branches.^[8,10,11] In a study for news about the doctors exposed physi-

cal violence in press in Turkey between 2008 and 2018, general surgeons are ranked 9th among medical specialties.^[12] In Turkey, there are hospitals where general surgeons accept the patients in ER directly or “on-call.” Because this close relationship, we aimed to examine general surgeons’ situations of exposed to violence in ER, the factors that may be associated with these, their status of receiving support from their institutions and their thoughts on solution.

MATERIALS AND METHODS

Our study is designed in a cross-sectional type. The results

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were planned to be shared at the 12th Trauma and Emergency Surgery Congress organized by the National Trauma and Emergency Surgery Association (UTACD), and a survey consisting of 11 questions titled “Violence in ER” was prepared for this purpose (Table 1). The survey was sent through

Table 1. The survey’s questions

1. How old are you?
2. What is your gender?
3. How many years have you been a general surgeon including your residency period?
4. Your institution is a ...?
 - University Hospital
 - Training and Research Hospital of Health Ministry
 - State Hospital
 - Private Hospital
 - Other (please specify)
5. Where is your institution’s location?
 - Metropolitan central district
 - Metropolitan remote region
 - Central district of a small city
 - Smalltown of a small city
 - Other (please specify)
6. How many surgical emergency cases are accepted daily in the your hospital?
7. Do you think that the “White Code” system which is defined to ensure the safety of the hospital staff and activated by dialing 1111 from the hospital internal telephone system, is effective?
 - Yes
 - No (If No, please briefly explain)
8. If you have exposed, what type of violence was you subjected to in ER?
 - Verbal
 - Physical
 - I didn’t encounter any violence incident in ER. (Please don’t answer other questions except the last)
 - I was a witness, not a victim of the incident.
9. Has the incident taken to court?
 - Yes
 - No (Please don’t answer the question below.)
10. If the incident was taken to the court, did your institution provide legal support?
 - I paid the expenses.
 - The expenses were paid by my institution.
 - Other (Please briefly explain)
11. Is there anything else you want to add?

e-mail to 941 general surgeons in the registry of the UTACD. The necessary information was also sent to the participants along with the questions in August and September 2019. It was stated the results will be shared in the round table session at the congress. In our study, the minimum sample size was calculated as 88 people in PASS 15.0 package program by predicting the effect size of 0.3, alpha error of 0.05, 95% confidence interval and 80% power (1-beta error). Totally 155 general surgeons (16.5% of sent) viewed the survey and 94 of them (9.98% of sent) answered. This study was approved by the ethics committee at Kilis 7 Aralik University.

Data Analysis

Continuous variables were presented as mean, standard deviations (SD) and median. The compliance of continuous variables to normal distribution was examined using visual (histogram and probability graphs) and analytical methods (Kolmogorov–Smirnov). Categorical variables were presented as frequency and percentage. To compare paired groups, those suitable for normal distribution was evaluated with Student’s t-test, and those not suitable for normal distribution was evaluated with Mann–Whitney U test. Chi-square and Fisher’s exact tests were used to evaluate categorical variables. Thematic content analysis was used to evaluate the answers obtained from open-ended questions. In the thematic analysis process, the stages of data-coding, creating and organizing themes, defining and interpreting the findings were followed. Open-ended answers were read in written form, first as a whole and then in parts. The two researchers coded on the text together and the whole text was re-read. Then, the codes were reviewed and checked for new codes. After a code list created, themes were composed. Researchers codified all the answers and when there were differences of opinion, a final decision was reached by discussing them together. The statistical significance level was accepted as <0.05. Statistical evaluation was performed using the Statistical Package for the Social Sciences (SPSS) for Windows 25.0 (IBM SPSS Inc., Chicago, IL).

RESULTS

The median age of the participants was 44 (26–64); 84 (89.4%) of them were men and 10 (10.6%) were women. The mean duration of work including residency was 17.06 ± 9.51 years. The surgeons are 20 (21.3%) people in the university hospitals, 32 (34.0%) in the training and research hospitals of Health Ministry, 21 (22.3%) in the state hospitals, 17 (18.1%) in the private hospitals. There were 4 (4.3%) surgeons who chose to answer using the “Other” option, as pre-hospital emergency health service, private office, affiliation hospital (mix of university and ministry) and foundation university. The participants were 74 (78.7%) surgeons in metropolitan central districts, 8 (8.5%) in metropolitan remote regions, 11 (11.7%) in central district of a small cities, and one surgeon in a small town of a small city (1.1%). About the accepted sur-

gical emergency cases daily, three surgeons did not respond and excluded from the evaluation. As the result, a median of 15 (0–1000) with a mean of 78.52 ± 191.44 cases was reached. While 36 (38.3%) of the participants did not view the “White Code” system efficient, 58 (61.7%) viewed it efficient. When asked the reasons for those who view it inefficient, the open-ended answers were collected under six subtitles with thematic content analysis (Table 2).

Sixty-one surgeons (64.9%) stated that they were exposed to violence, and the majority (39.4%) pointed out this was limited to verbal. Of the 33 participants (35.1%) were not exposed to violence, 18 (19.1%) stated they only witnessed to violence. Fifteen participants (16.0%) indicated they had never experienced violence in their work life. About 6.4% of the participants stated they were subjected to both verbal and physi-

cal violence and they also witnessed in other cases they lived. When the type of violence experienced was examined at all, it was found that 22.5% was physical and 59.6% was verbal.

The female general surgeons are exposed to violence at a higher rate ($p=0.093$). While 52 (61.9%) of 84 male surgeons stated that they were subjected to violence, this rate was 90% among ten female surgeons. It is concluded that violence was most frequently encountered in training hospitals but university hospitals were affected less ($p=0.124$). Only the general surgeon working in pre-hospital health-care service out of the four people, who marked the “Other” option as the institution’s type, informed whose exposure was verbal. The rate of experienced violence by surgeons working in private hospitals was observed as 64.7% as 56% verbal and 17% physical. We saw that the surgeons working in a central

Table 2. The reasons stated by those who think that the “code white” system is ineffective (The open-ended responses received were grouped under six subtitles with thematic content analysis)

• Following the “White Code”, the constabulary should be involved in the intervention rather than the hospital security.	(6/36=16.7%)
• I don’t think the “White Code” works effectively.	(16/36=44.4%)
• During the complaint process, the HCW feels lonely and can’t receive support from the administration.	(1/36=2.8%)
• The White Code implementation is not deterrent enough.	(5/36=13.9%)
• In the White Code application, the procedures are too many and turn into drudgery for the physician.	(6/36=16.7%)
• Post-White Code process are very slow.	(8/36=22.2%)

Table 3. Characteristics of general surgeons and correlation between violence

	Exposed to violence (n=61)	Not exposed (n=33)	p-value
Age			
Median (Min-Max)	45 (26–64)	45 (29–64)	0.849 ¹
Duration of the work including residency(year)			
Median (Min-Max)	16 (0–40)	19 (4–40)	0.239 ¹
Sex, n (%)			
Male	52 (61.9)	32 (38.1)	0.093 ²
Female	9 (90.0)	1 (10.0)	
Institution, n (%)			
University hospital	10 (50.0)	10 (50.0)	0.124 ³
Training and research hospital of health ministry	25 (78.1)	7 (21.9)	
State hospital	14 (66.7)	7 (33.3)	
Private hospital	11 (64.7)	6 (35.3)	
Other	1 (25.0)	3 (75.0)	
Settlement of the hospital, n (%)			
Metropolitan central district	48 (64.9)	26 (35.1)	0.656 ³
Metropolitan remote region	4 (50.0)	4 (50.0)	
Central district of a small city	8 (72.7)	3 (27.3)	
Small town of a small city	1 (100.0)	0 (0.0)	

¹Mann-Whitney U Test; ²Fisher’s Exact Test; ³Chi-squared test.

district of a small city experienced a higher rate of violence (p=0.656). Although not statistically significant, it's observed that the surgeons with less experience exposed to violence more frequency (Table 3).

The median number of surgical emergencies accepted per day of 60 surgeons who were subjected to violence was 20 but it is 7.5 for the 31 who were not subjected to violence (p=0.014). The three surgeons who stated not accept the surgical emergencies were not included in this evaluation because they left this question unanswered (Table 4).

Table 4. The relationship with the surgical emergencies accepted by surgeons in 24 hours and violence

Violence	n	Surgical emergencies in 24 hours		p-value
		Mean±SD	Median (Min-Max)	
Yes	60	96.67±220.80	20.00 (0–1000)	0.014 ¹
No	31	43.39±110.16	7.50 (1–500)	

¹Mann-Whitney U Test. SD: Standard deviation.

While 56 surgeons indicated the violence they experienced was not taken to the court, 10 (10.6%) participants did not answer this question. The rate of experienced an event reflected in legal process was 29.8%. There were nine surgeons witnessed but not exposed to violence within went through a legal process (9.6% of all participants). When the type of violence experienced and/or presence of witnessing examined, no significant difference was found in terms of applying to the court (p=0.282). Although no statistically significant difference was found, the rate of court proceedings seems to be higher in metropolitan central districts (p=0.902). If the institution was a private hospital, the court process was more frequent (45.5%) but the state hospital was less (21.4%). The incidents that gained a legal dimension were less than half of all cases in any type of institution (p=0.877). Gender was not a factor for taking the case to court (p=1000). Physical violence experience had not a statistically significant difference in applying to the court (p=0.445). On the other hand, it had been revealed the surgeons subjected to verbal violence apply to the court less (p=0.046) (Table 5).

Fifty surgeons who never faced violence were excluded from

Table 5. The number of general surgeons subjected to violence applied to court (Those who were not exposed to violence but only witnessed were also included in the evaluation; +n=18)

	After being subjected to violence (n=61) and only witnessing (n=18); (n=79)		p-value
	There is court process	No court proceedings	
Type of violence, n (%)			
Verbal			
Yes	16 (28.6)	40 (71.4)	0.046 ³
No	12 (52.2)	11 (47.8)	
Physical			
Yes	10 (41.7)	14 (58.3)	0.445 ³
No	18 (32.7)	37 (67.3)	
Institution, n (%)			
University hospital	6 (42.9)	8 (57.1)	0.877 ³
Training and research hospital	10 (33.3)	20 (66.7)	
State hospital	6 (31.6)	13 (68.4)	
Private hospital	6 (40.0)	9 (60.0)	
Other	0 (0.0)	1 (100.0)	
Settlement of the hospital, n (%)			
Metropolitan central district	22 (36.1)	39 (63.9)	0.902 ³
Metropolitan remote region	2 (33.3)	4 (66.7)	
Central district of a small city	4 (36.4)	7 (63.6)	
Smalltown of a small city	0 (0.0)	1 (100.0)	
Sex, n (%)			
Male	25 (35.7)	45 (64.3)	1.000 ³
Female	3 (33.3)	6 (66.7)	

³Chi-squared test.

the evaluation about counseling and court-related costs. It was seen that 31.8% of participants paid it by himself and 34.1% by his/her institution. When examining the status of 19 who had gone through a legal process out of 61 surgeons who faced violence, in spite no statistically significant difference, the public hospital employees and female surgeons were mostly supported by their institutions. However, who're working at the university hospitals and physical violence victims paid the court-related expenses themselves. It was seen that 64.7% of surgeons working in private hospitals were subjected to violence but the rate of to move through court remained only half of them. These surgeons paid the costs by themselves at a rate of 60.0% (Table 6). Thirteen surgeons who chose the "Other" option in terms of court-related payment did that explanations: "I don't know, I didn't live; A lawyer was given by the ministry, not by the hospital management but the deputy chief came to the court that day for the support; It happened to my wife, we were left alone at the court stage and it was turned into an individual application, thus the case was dropped when it ceased to be a corporate application and we did not follow-up; there was no such thing about supporting; it was resolved through mediatorship by the hospital administration; There is no professional unit in this matter." In addition to the comments such as "NO," they made two statements each as "Medical Chamber" and "not

moved to court." The number of the participant surgeons in the survey gave additional opinions were 83 out of 94. When similar responses received are grouped under sub-headings with thematic content analysis, the frequency of "the wish to impose serious sanctions on the people who are the source of violence" becomes prominent (4.54%). This was followed by "not leaving HCW alone, more effective support by administration" (27.3%), "increasing security measures and ensuring their effective functioning" (18.2%), and "strengthening legislation to prevent violence" (9.1%), respectively.

DISCUSSION

The most of the violence suffered in the field of health is experienced in ER.^[3,7,13] According to a study conducted in Turkey, 78.1% of the physicians working in ER that they were exposed to violence in the past year.^[14] Studies examining violence in ER focus on emergency medicine specialists, and there are few studies in this area that include data on other consultants in ER.^[14] While the article on trauma surgeons in USA by Zakrison et al.^[15] was interested in the role of surgeons in preventing violence, they did not address the situation of exposure. Our survey study, which includes general surgeons who accept trauma and surgical emergency cases with both on-call and direct emergency admission, reveals a

Table 6. The status of getting legal support of general surgeons who applied to the court (Those who were not exposed to violence but only witnessed were also included in the evaluation)

	Court cost			p-value
	I paid	My institution paid	Other	
Type of violence, n (%)				
Verbal				
Yes	7 (43.75)	7 (43.75)	2 (12.5)	0.362 ³
No	2 (20.0)	5 (50.0)	3 (30.0)	
Physical				
Yes	6 (60.0)	2 (20.0)	2 (20.0)	0.066 ³
No	3 (18.8)	10 (62.5)	3 (18.8)	
Sex, n (%)				
Male	8 (50.0)	5 (31.3)	3 (18.8)	0.618 ³
Female	1 (33.3)	2 (66.7)	0 (0.0)	
Institution, n (%)				
University hospital	2 (40.0)	3 (60.0)	0 (0.0)	0.645 ³
Training and research hospital	3 (33.3)	3 (33.3)	3 (33.3)	
State hospital	1 (16.7)	4 (66.7)	1 (16.7)	
Private hospital	3 (50.0)	2 (33.3)	1 (16.7)	
Settlement of the hospital, n (%)				
Metropolitan central district	7 (35.0)	9 (45.0)	4 (20.0)	0.455 ³
Metropolitan remote region	1 (50.0)	0 (0.0)	1 (50.0)	
Central district of a small city	1 (25.0)	3 (75.0)	0 (0.0)	

³Chi-squared test.

different data in terms of the absence of studies that examine general surgery clinics that meet patients in emergency departments. In addition, non-physicians were prevented from participating through the survey. The rate of HCWs' exposure to violence last 1 year in a single center survey study from Turkey is 73% and ER staff's is 94.4%. The study reveals that 69.7% of the violence is verbal and the violence experienced in healthcare is more common in ER.^[13]

Different results related to gender have been obtained in HCWs' exposure to violence. There are studies indicating that there is no significant difference regarding gender.^[1,4,14] In the review presented by Al et al.,^[3] they reported 40–48% of male HCWs and 52.5–60% of women were exposed to violence. In Ayranci et al.^[7] study, 60.4% of the HCWs exposed to violence are women. In a study in UK, it is observed the most of the victims of violence in hospital staff are women.^[5] There are studies indicating that women are more exposed to violence in Turkey.^[6] It has been observed that female HCWs are significantly more exposed to psychological violence at work than men.^[16] Although there is no significant difference between exposure to other types of violence and gender, it is determined that women are exposed to violence more in Aydın's^[17] study involving predominantly female participants. Camci and Kutlu^[1] highlighted examining the reasons for this problem in their research. The percentage of women working in the health sector is high and violence cannot be practiced easily against males, they say. The high rate of female surgeons' violence experience in our study involving only general surgeons draws attention. The need to examine this result which emerged different from the studies in ER, with new studies, will help in terms of the precautions to be taken. In addition, as a limitation of our study, there may be voluntary response bias that may arise from surgeons' who exposed to violence willingness to participate in the survey.

The studies investigating violence are lacking specific data to general surgeons. Among these studies aimed at ER staff, there are some that report the rate of HCWs' being subjected to violence increases at a younger age and little duration of work experience.^[7] Hahn et al.^[18] reported that the age range at the highest risk for be a victim of violence is 30–45. Cause the physicians in ER usually are in the 1st years of their profession and with little experience, it may increase the risk of violence.^[19] In a multicenter survey study examining this situation among surgery residents, it is reported that the residents with 1–4 years of experience were significantly more likely to exposure than those with more than 5 years of experience. It is stated that 280 of the 475 participants included in the study witnessed one or more physical attacks and 179 were physically attacked, also the high rate of violence occurred in ER units. In the same study, the probability of being subjected to violence is found to be significantly higher for surgical residents in state hospitals compared to private institutions. The rate of female residents calling hospital security in a potentially violent situation is found to be

higher than males.^[11] Ayranci et al.^[7] indicated that violence occurs mostly in primary health-care centers and the least in university hospitals. There are a few studies examining the differences in the varied institutions of the victims of violence in studies limited to ER. Similar to our study, Bayram et al.^[14] found a higher rate of exposure to violence in ER of training and research hospitals and state hospitals. The fact that the studies are predominantly designed for a single center or region reveals the need for studies in which different types of institutions are examined and compared to ensure standardization at the solution point. Our study can be regarded as an original study in terms of evaluating general surgeons with and without a public employee. It is a stunning result that especially the surgeons working in private hospitals did not have the same rate of applying to the courts despite the intensity of their violence experience and that they mostly covered their own legal costs.

Comparing the number of patients admitted and the violence experience, Bayram et al.^[14] showed that as the number of patients increased, the exposure to violence significantly increased in their study examined the emergency surgery services in the centers that accept more than 1000 patients. When we asked about the number of daily accepted surgical emergencies in our survey, the fact that the several answers such as 1000 cases were received in the answers may be due to the participants' perception and response to cover all emergency cases rather than the surgical emergencies. The clustering of the responses we received in our survey between 0 and 200 cases saves this question from being excluded because it contains reasonable acceptance numbers of answers from surgeons accepted surgical emergencies as on-call and directly at the first application (Table 3).

In our study, it is possible to conclude that as the higher workload increases the likelihood of violence exposure. In the study of Hahn et al.,^[18] they conclude that the specialties that are in direct contact with the patient in more than 60% of the working hours significantly being more subjected to violence. The study states that the violence in ER was significantly higher, but they are categorized surgical units separately from the emergency.

Verbal violence is more common than physical.^[20–22] Boz et al.^[23] reported that 88.6% of ER staff are subjected to verbal violence and 49.4% to physical. In a ER study in Turkey, 100% of the participants stated that they were subjected to verbal violence at least once in each shifts. It is also shown that the encountered aggressive actions was 53.2% and physical violence 38.5% in 1 month working period.^[9] Oztunc^[24] states that while verbal abuse is mostly seen in surgical clinics (78.8%). There are also studies reporting that up to 66% of ER staff are exposed to physical violence.^[3] Gulalp et al.^[9] pointed out the risk factors for a physical attack as male gender, age ≥ 31 , being an emergency physician and having worked in ER for 5 years or more. In a Egyptian study, vio-

lence is recorded 58.2% of verbal and 15.7% of physical. Only 29.5% of the HCWs subjected to verbal violence and 23.8% of those who were subjected to physical violence reported this to the authority. While 75% of the HCWs thought violence can be prevented with the precautions to be taken, 60% said that no action has been taken against the aggressor by the authorities.^[25]

Insufficient reporting of violence against HCWs is an important problem and makes it difficult to generate accurate statistics.^[11] It has been observed that only incidents such as injuries are perceived as violence and other types of violence (verbal and psychological) are ignored, not reported or being attacked while working is perceived as the nature of the job. Lack of management support and poor reporting processes are the prominent reasons for not reporting violence.^[21] It is shown 67% of HCWs reported their violence exposure to authorities in a survey study in UK.^[5] Also in some studies in Turkey, 62% of physicians, 60% of ER staff are determined to not make any complaints in spite of violence occurred. Among the reasons for not making a complaint, there is a lack of confidence in the administrators and justice mechanism.^[17,23] It has been noted that 41.0% of HCWs subjected to violence reacted by calling a security guard, 85.6% did not report the violence to judicial units and 67.9% of those indicated the lengthy judicial trial process as reason.^[13] They are hesitant to complaint or report the incident of violence against them with worry about not getting support.^[26] In the study of Camcı and Kutlu,^[1] the rate of who said "I found it unnecessary" as the reason for not reporting the incident of violence is 73.8%, the rate of who said "I was afraid of the negative consequences" is 51.3%, and the rate of "I thought it as part of my profession" is 12.5%. In another study is showing that 96.6% of the nurses did not report violence, it is engrossing that 45.3% of the nurses stated they thought not getting results, and 43.7% saw it as a part of their job.^[27] It is also observed that nurses mostly behaved as "nothing had happened" after their violence experiences.^[28] Cause HCWs are more likely to report this as they suffer more from physical attacks, they consider other types of violence as inherent in the business and they are afraid of not getting result or being accused when reporting.^[3] In another study shown that 12% of the incidents reflected in judicial authorities, it is shown the violence most frequently occurred in ER in the form of loud yelling and reviling. Violence cause psychological problems in 25% of the ER staff. A single center study in Canada states that 57% of ER staff experienced physical violence; 38% of the victims of violence want to switch to another job outside the health field, 18% do not want to work in ER, and 67% leave their job for a short time. It is observed 24% of subjected to violence performed poorly in the 1st week after the incident, and 19% of them were affected by their performance later on.^[29] Since our study did not include questions about the post-violent psychological states and performances of general surgeons, it may have lacked to examine this point. This point was tried to be remedied by including the group

that only witnessed in the analysis while examining the legal dimension of the violence incident.

Rapid changes in healthcare and shortcomings in legal practices leave gaps in preventing violence and ensuring employee safety.^[2] In Turkey, the Ministry of Health enacted "White Code" application in 2012 for the purpose of legal assistance to HCWs exposed to violence. It is planned as when there is a threat to harassment or a possibility of a fight, to arrive, analyze, and record the incident by the security guards closest to the scene.^[30] Thus, it has been put into force to ask the staff who are victim of crime requesting legal support immediate from own public institution. However, it is seen that violence in health institutions continues; the considered reasons for these are the inadequacy of physical facilities, the deficiencies caused by the security personnel, the pathologies in the society's perspective toward the HCWs and the service at night. It is emphasized the penalties and sanctions are not sufficient despite the damages suffered by HCWs. In crimes against the HCWs in the public sector, the perpetrator does not blamed for special responsibility except that the employee is a public official.^[31] About 63.9% of the HCWs subjected to violence despite the regulations do not make any complaints after the incident because impunity. In case of application, it is determined the issue generally resulted in apology-conciliation (46.1%) and banishment of the aggressor by security (28.1%).^[20] In a Turkish study included 713 doctors, 33% of them continued to work followed taking a short break after the incident and that remained at 54.1% of the use of the White Code. The rate of reporting to the security forces is found to be 37.2%. About 69.4% of the physicians state the type of experienced violence will affect their decision about criminal complaint. Despite all the regulations, 97.3% of the physicians think that the laws against violence are insufficient and 76% consider increasing the severity of the punishments as a precaution.^[14] In our survey, we received the comments indicated that the surgeons could not get legal support by their institutions. Although legal support to be given to HCWs in case of violence is defined in the legal regulations, the some part of surgeons participating in our survey stated they covered the legal costs by own. The reasons of this should be examined. The absence of a comprehensive study on whether the HCWs getting adequate legal support after the encountered violence makes it difficult to obtain real data in this field. Although our study provides limited information on this subject, it may be an initiator for the studies in this area.

Conclusion

Experience of violence in the emergency room is not uncommon for general surgeons. The exposure to violence increases as the workload increases. Verbal violence does not reach the legal stage as much as physical violence. The surgeons offer to impose serious sanctions on people the source of violence and to be supported the doctors exposed to violence more effectively by the management.

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ORIJİNAL ÇALIŞMA - ÖZ

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AMAÇ: Sağlıkta şiddet ne yazık ki her serviste olan ancak acil servislerde daha sık görülen bir halk sağlığı ve gelişmişlik sorunudur. Çalışmada, genel cerrahların acilde yaşadıkları şiddeti ve buna yönelik algılarını saptamayı amaçladık.

GEREÇ VE YÖNTEM: Araştırmamız kesitsel tipte tasarlandı. Ülke genelinde Ağustos–Eylül 2019 döneminde Ulusal Travma ve Acil Cerrahi Derneği'nde kayıtlı 941 genel cerrahın e-postalarına 11 soru içeren anket gönderildi. Çevrimiçi yanıtlanan ankete katılım oranı %9.98 oldu.

BULGULAR: Katılımcılardan herhangi bir şekilde şiddete maruz kalanlar ve şiddetle hiç karşılaşmamış olanlar sırasıyla %64.9 ve %16.0'dır. Ankete katılanların %10.6'sını oluşturan kadın cerrahlarda şiddete maruz kalma oranı %90.0'dır. Cerrahin karşılaştığı hasta sayısı arttıkça şiddete uğrama oranı da artmaktadır (p=0.014). Sözel şiddete uğrayanlar hukuki mercilere daha az başvurmaktadır (p=0.046). Mahkemeye başvuran bağlanan cerrahlar kurumlarından dikkate değer derecede destek görememektedir. Ankete katılanlar, şiddete başvuranların etkin cezalar alması ve uğrayanların da güçlü bir şekilde desteklenmesi gerektiğini bildirdiler.

TARTIŞMA: Acil serviste şiddete maruz kalan uzmanlar arasında genel cerrahlar da yer almaktadır. Cerrahların şiddete maruz kalma riskinin artması iş yükü ile ilişkilidir. Mahkeme aşamasına taşınan sözlü şiddet, fiziksel şiddete göre daha az görülmektedir. Yasal düzenlemelerle güçlendirilmiş ciddi yaptırımların çözüm için atılacak ilk adım olması uygun olacaktır.

Anahtar sözcükler: Acil; cerrah; hastane; şiddet; tematik.

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