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PHYSICAL AND PSYCHOLOGICAL VIOLENCE IN THE WORKPLACE OF HEALTHCARE PROFESSIONALS

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ABSTRACT

Objective: to analyze the presence of physical and psychological violence among health workers, identify their perpetrators and understand the origin of the aggressions.

Method: a mixed approach study. The quantitative data were collected from a random sample of 269 professionals from the health team in a public hospital in the Southern Region of Brazil. Among these 269 professionals 20 were victims of violence and composed the qualitative step.

Results: physical violence affected 15.2% (n=42) of the professionals and psychological violence affected 48.7% (n=135) of the workers by means of verbal aggression, 24.9% (n=69) moral harassment, 8.7% (n=24) racial discrimination and 2.5% (n=7) sexual harassment. Women were the main victims of physical violence, bullying and racial discrimination ($p<0.05$). Nursing technicians were the most exposed to physical violence and moral harassment ($p<0.05$). The patient was the main aggressor to the health team (35.4%, n=98), followed by coworkers (25.3%, n=70), management (21.7%, n=60) and companions (15.5%, n=43). Neurological diseases, alcohol and other drug abuse were related to the origin of the aggression, reasons which absolve the patients from the guilt of their violent behavior. The improper work conditions caused acts of aggression in patients and among professionals. Aspects of work organization in the public hospital were highlighted as causes for conflicts which cause violent repercussions.

Conclusions: psychological violence was prevalent, women and nursing technicians were the most exposed and patients were the main perpetrators. Containment and prevention measures are required, as well as investments for the work organization in the hospital.

DESCRIPTORS: Violence at work. Worker's health. Work conditions. Human resources in health. Human resources of nursing. Professional-patient relations. Health services.

VIOLÊNCIA FÍSICA E PSICOLÓGICA PERPETRADA NO TRABALHO EM SAÚDE

RESUMO

Objetivo: analisar a presença da violência física e psicológica entre trabalhadores da saúde, identificar seus perpetradores e compreender a origem das agressões.

Método: estudo de abordagem mista. Os dados quantitativos foram coletados sobre amostra aleatória de 269 profissionais da equipe de saúde em hospital público da Região Sul do Brasil, dentre os quais, 20 sujeitos, vítimas de violência, compuseram sequencialmente a etapa qualitativa.

Resultados: a violência física atingiu 15,2% (n=42) dos profissionais e a violência psicológica 48,7% (n=135) dos trabalhadores por meio de agressões verbais, 24,9% (n=69) sofreram assédio moral, 8,7% (n=24) discriminação racial e 2,5% (n=7) assédio sexual. Mulheres foram as principais vítimas da violência física, assédio moral e discriminação racial ($p<0,05$). Técnicos de enfermagem foram os mais expostos à violência física e assédio moral ($p<0,05$). O paciente foi o principal agressor da equipe de saúde (35,4%, n=98), seguido pelos colegas de trabalho (25,3%, n=70), chefia (21,7%, n=60) e acompanhantes (15,5%, n=43). Agravos neurológicos, abuso de álcool e de outras drogas foram relacionados à origem da agressão, razões que atenuaram a culpa dos pacientes pela violência. As condições impróprias de trabalho geraram revolta dos pacientes e entre os profissionais. Aspectos da organização do trabalho no hospital público foram apontados como causas para conflitos que repercutem em violências.

Conclusões: a violência psicológica foi prevalente, mulheres e técnicos de enfermagem foram os mais expostos e pacientes os principais perpetradores. São necessárias medidas de contenção e prevenção, bem como investimentos sobre as condições e a organização do trabalho no hospital.

DESCRITORES: Violência no trabalho. Saúde do trabalhador. Condições de trabalho. Recursos humanos em saúde. Recursos humanos de enfermagem. Relações profissional-paciente. Serviços de saúde.

VIOLENCIA FÍSICA Y PSICOLÓGICA PERPETRADA EN EL TRABAJO EN SALUD

RESUMEN

Objetivo: analizar la presencia de violencia física y psicológica entre trabajadores de la salud, identificar a sus perpetradores y comprender el origen de las agresiones.

Método: estudio de enfoque mixto. Los datos cuantitativos fueron recolectados sobre muestra aleatoria de 269 profesionales del equipo de salud en hospital público de la Región Sur de Brasil, entre los cuales, 20 sujetos, víctimas de violencia, compusieron secuencialmente la etapa cualitativa.

Resultados: la violencia física alcanzó el 15,2% (n=42) de los profesionales y la violencia psicológica 48,7% (n=135) de los trabajadores por medio de agresiones verbales, el 24,9% (n=69) sufrieron acoso moral 8,7% (n=24) discriminación racial y 2,5% (n=7) acoso sexual. Las mujeres fueron las principales víctimas de la violencia física, el acoso y la discriminación racial (p<0,05). Los técnicos de enfermería fueron los más expuestos a la violencia física y el acoso moral (p<0,05). El paciente fue el principal agresor del equipo de salud (35,4%, n=98), seguido por los compañeros de trabajo (25,3%, n=70), jefatura (21,7%, n=60) y acompañantes (15,5%, n=43). Agravios neurológicos, abuso de alcohol y otras drogas se relacionaron con el origen de la agresión, razones que atenuaron la culpa de los pacientes por la violencia. Las condiciones impropias de trabajo generaron revuelta de los pacientes y entre los profesionales. Los aspectos de la organización del trabajo en el hospital público fueron señalados como causas para conflictos que repercuten en violencias.

Conclusiones: la violencia psicológica fue prevalente, mujeres y técnicos de enfermería fueron los más expuestos y pacientes los principales perpetradores. Se necesitan medidas de contención y prevención, así como inversiones sobre las condiciones y la organización del trabajo en el hospital.

DESCRIPTORES: Violencia en el trabajo. Salud del trabajador. Condiciones de trabajo. Recursos humanos en salud. Recursos humanos.

INTRODUCTION

Health services can be considered fertile grounds for the exposure of workers to various health problems. In addition to exposure to accidents with biological materials, radiation, chemicals and ergonomic injuries, health professionals are faced with violence in their workplace.[1-2]

Nursing professionals have been identified as a vulnerable group for violence at the workplace.[2] The frequent experience of this behavior contributes to the seriousness of the problem, since workers experienced more than one violent episode in the year,[3] and in some places it can occur daily.[4]

The World Health Organization defines violence at work as a result of the complex interaction of several factors, with emphasis on work conditions and organization, as well as worker-aggressor interaction.[5] The International Labor Organization characterizes it as incidents involving abuse, threat or assault in work circumstances. Thus, the manifestation of violence is the explicit or implicit harm to the worker's safety, well-being or health.[6]

The harmful effects of violence can be difficult to identify, especially when they do not have physical repercussions. However, studies have already revealed the negative impacts on the psychic health of workers[7-8] and on physical health, manifested by symptoms such as pain and palpitations, as well as reflections on work performance which can sometimes cause the worker to give up the profession.[9]

In the Brazilian scenario, there are still few studies on the subject,[10-12] particularly in the perspective of seeing violence as a complex study object with quantitative and qualitative dimensions, of physical and psychological presentations, under the engenderment of human relationships which generate aggression in work environments in the health sector. Considering the above, the objective of this study was to analyze the presence of physical and psychological violence among health workers, and to identify their perpetrators and understand the origin of the aggression.

METHOD

A cross-sectional study, with a mixed approach and a quanti-qualitative design, was performed in a public hospital specialized in trauma in the Southern Region of Brazil. The hospital operates 24 hours a day and attends outpatient specialties and all medical and dental specialties needed to attend poly trauma patients.

The study included nursing assistants and technicians, nurses, physicians and other health professionals (nutritionists, physiotherapists, social workers, dentists, psychologists and radiology technicians) who worked in the emergency department, intensive care units, hospitalization units, blood bank as well as radiology, physiotherapy, psychology and social service sectors. The study considered nursing assistants and technicians in the same category, naming them as nursing technicians.

In the quantitative stage of the investigation the demographic and labor characteristics of the workers were measured, and the Survey of Workplace

Violence in the Health Sector, proposed by the World Health Organization, International Organization of Labor and Public services and the International Nursing Council,[13] were translated and adapted into the Portuguese language.[14] This questionnaire measures the occurrence of physical violence and psychological violence, with psychological violence consisting of verbal aggression, moral harassment, sexual harassment and racial discrimination.

The random selection of the workers in the sample (n=269) occurred by a draw proportional to the professional categories, defined according to a probabilistic sample calculation of the population of 1,025 workers from the health team, considering a 95% confidence level and an error estimate of 5%. The draw was carried out by means of the list of hospital employees, including the workers in effective position, with a minimum of one year of service in the hospital and assets in the period of data collection.

At the qualitative stage of the study, 20 subjects who were victims of violence in the last year were interviewed, intentionally selected from their willingness to report their experiences and feelings about what happened, which was identified during the quantitative collection. The number of workers interviewed was defined by the saturation of data.[15] A semi-structured script was used to understand the origin and situations in which violence in the workplace occurs.

Data collection took place between June and September 2011. Approval was obtained from the Research Ethics Committee of the study site (nº. 001.014667.11.8) and all participants signed the Informed Consent Form.

Descriptive and analytical statistics were used for the quantitative data, considering $p \leq 0.05$ as statistically significant. Categorical variables were described by means of relative and absolute frequencies and continuous variables were described with central tendency measurements and dispersion. The chi-square test was used for the association analysis.

The data originated from the transcripts of the interviews were submitted to thematic analysis technique.[15] Floating reading of the material and the identification of keywords, cutouts and codification configured the pre-analysis of the material. Next, the thematic units were constructed, which were interpreted with the literature, giving rise to the following categories: patients: blameless aggressors and guilt profile; revolt as a manifesto: aggression practiced by the attacked; work without rules and the rules of the trade: causes of violence between professionals. In order to guarantee the anonymity of the participants in the use of the speech fragments, the letter E (interview) followed by the Arabic number was used which chronologically ordered the interviews.

RESULTS

The sample comprised of 269 subjects, 122 (45.4%) were nursing technicians, 90 (33.5%) were physicians, 27 (10%) were nurses and 30 (11.1%) were professionals from other health categories; 157 (58.4%) were women, who were 49 (+7.4) years old on average, 24.8 (+7.8) years of professional experience in the health area and 16.2 (+7.7) years in the institution. In the sample, 63.2% (n= 70) reported working exclusively at this institution and 8.9% (n = 24) had a managerial position.

The study recorded 277 violent events among the 170 workers who reported having suffered violence, one type of violence (35%, n=94) or more (28.2%, n=76) in the last 12 months. Among the victims, 15.2% (n=42) suffered physical violence. 48.7% (n=135) reported psychological violence through verbal abuse, 24.9% (n=69), and 8.7% (n=24) experienced bullying. 2.5% (n=7) experienced sexual harassment (Table 1).

41.2% (n=111) of the sample reported having already witnessed some kind of physical violence in their workplace.

83% (n=112) of the victims of verbal aggression classified the situation as typical in their workplace. The victims of bullying reported that the violence had been repeated about four times in the past year. The repeated experience of racial discrimination occurred around two times in the last year. Despite little numerical expression, sexual harassment had been repeated more than three times in the past year.

Regarding the perpetrators of violence (n=277), the patient was confirmed as the main aggressor to the health team (35.4%, n=98). 25.3% (n=70) of the violent situations were caused by co-workers, followed by managers (21.7%, n=60), companions (15.5%, n=43) and others (2.1%, n=6).

The data indicated that the patients were the main perpetrators of physical violence and verbal aggression, reaching respectively 90.5% (n = 38) and 35.5% (n=48) of these aggressions, and were also among the main perpetrators of racial discrimination (25%, n=6) and sexual harassment (42.9%, n=3).

Patient's companions or family members were the second highest group of perpetrators of verbal aggression (23.7%, n=31) and physical violence (7.1%, n=3), as well as bullying (4.3%, n=3), racial discrimination (16.7%, n=4) and sexual harassment (14.3%, n=1).

Table 1 - Distribution of workers exposed to physical and psychological violence at work, according to sex and professional category. Porto Alegre-RS, 2011. (n=269)

Variables	Physical violence (n=42)		Verbal agression (n=135)		Moral harassment (n=69)		Sexual harassment (n=7)		Racial discrimination (n=24)	
	n (%)	p*	n (%)	p*	n (%)	p*	n (%)	p*	n (%)	p*
Sex										
Feminine	31 (19.7)	**0.027**	86 (54.8)	0.075	51 (32.5)	**0.002**	5 (3.2)	0.477	19 (12.1)	**0.030**
Masculine	11 (9.8)		49 (43.8)		18 (16.1)		2 (1.8)		5 (4.5)	
Category										
Nurse Technician	30 (24.6)		69 (56.6)		41 (33.6)		3 (2.5)		15 (12.3)	
Nurse	4 (14.8)	**0.001**	15 (55,6)	0.129	6 (22.2)	**0.015**	0 (0.0)	0.434	2(7.4)	0.256
Physcian	4 (4.4)		40 (44,4)		13 (14.4)		2 (2.2)		4 (4.4)	
Other	4 (13.3)		11 (36,7)		9 (30.0)		2 (6.7)		3 (10.0)	

* Chi-square calculated on the distribution of the total sample in groups exposed and not exposed to violence.

Co-workers shared second place with the companions with regards to verbal aggression (23.7%, n=32). The managers were responsible for the occurrence of moral harassment (47.9%, n=33), and were identified as practicing racial discrimination in 20.8% (n=5) of cases. In cases of verbal aggression, they were mentioned in 16.3% (n=22) of the occurrences, however, there was no situation involving the manager in the practice of physical violence or sexual harassment at work.

It was also possible to observe that 'other agents' from outside the work environment, such as professionals from different health services used for patient transfers, for example, taxi drivers and ambulances that bring patients to the service, also practiced violence against workers at the hospital under study. These agents were identified as perpetrators of bullying (5.8%, n=4), verbal aggression (0.8%, n=1) and racial discrimination (4.2%, n=1).

The categories from the qualitative analysis aid the understanding regarding the relationship between the victim, the type of violence, the stimulus that generates the aggression, and the space for violence in the health work world.

Patients: blameless abusers and guilt profile

In discussing situations involving violence perpetrated by patients, the workers sought to rationally justify their experiences, while making it clear that they did blame the patient for the incident. According to professionals, neurological changes, history of alcohol/drug abuse and mental disorders were the main causes of aggression.

I've been assaulted by a patient, she was confused because of her illness and she spit in my face, she was a HIV patient, it's normal for us (E3).

Sometimes it happens with a drunk patient, something like that, they push or kick you (E4).

In addition, when speaking about aggressive patients, the victims often described the patient's profile in a similar way, attributing the image of the aggressor to the male sex.

[...] *the patient raised his fists to punch me and the family member went and held his hand. He was a strong, muscular guy* (E16).

If they are lucid and do not have a distraction, they use you as a distraction, do you understand? [...] *they call you a "saint," you know?* (E15).

Another aspect mentioned in the interviews was about the hospital's priority to the attention and care for external causes, which results in bringing urban violence from the streets into the hospital. Professionals reported that this puts them at greater risk of being assaulted at work.

Usually drug users are more aggressive, those who

already come with such stories of physical aggression, were beaten, stabbed, shot (E14).

In this hospital you deal a lot with the violence itself, bloodshed and stress, always dealing with prisoners who come from the prison or are on the streets. Then you attend the guy who assaulted and shot the worker [...] *you attend this thug* (E19).

The reports highlight the representation that the workers have regarding the profile of the aggressive patients, who become the object of care, the workers require skills to deal with the violence, and show power relations in the space in the hospital environment.

Most patients are somewhat uncultured. Most of them with little education, they live in a village, so they have no limits ... the type of patient we have, they have difficulty with leadership and this generates a sense of power or right that they didn't have before (E12).

While they blamed patients for their violence, the workers who were victims of violence caused by patients blamed them for their choices.

Unfortunately we suffer a lot from patient violence, and you cannot blame the patient, because many are drug addicts, they are alcoholics, they go into withdrawal and they do not know wha they are doing [...] *some don't want treatment, some run away, then you think: why not take the opportunity? They receive all this expensive treatment, but then goes back to the street and continues doing what he was doing, and tomorrow or later he returns to the hospital. Or they run away because they do not want the treatment, that's the biggest joke, you know?* (E18).

The statements also revealed that, in addition to aggression, the worker experiences violence that materializes in front of him: the brutality of the streets, the misery, the stories of vulnerabilities; which adds to the feeling of insecurity.

The stories [of patients] *that they have, they have often been victims of street violence, which sounds bad to us, because it is a person like us, who was on the street and suddenly suffers violence., Whether you like it or not, it affects us* (E19).

They have very complicated stories like that, tragedy, violence, sometimes I try to distance myself away a little, to stop listening so I don't absorb it. It seems that sometimes it affects us (E14).

From with these statements, it can be said that patients are aggressors devoid of guilt of the violent action, but guilty of the choices that bring them to the hospital. However, the approach to urban violence, to marginality and exclusion threatens and causes suffering to the workers in their everyday work life.

Revolt as a manifesto: aggression practiced by the attacked

The approach to the workers' experiences faced with the aggressions suffered in their workplace made it possible to identify the organizational structure which allows, instigates, incites or even perpetuates violence. Regarding the aggressions perpetrated by the patients, these were interpreted as users aggravated by the quality of the service provided by the hospital.

The doctor is slow to see me. Then, the patient is lucid but he doesn't understand, he already harasses you, the family member harasses you because the doctor passed by but went away again, you know? The whole structure, or that he [the patient] has to 'go in the bedpan' is in front of everybody, then he gets mad at you. If you are busy and it takes 5 minutes to 'take the bedpan away,' they verbally attack you (E15).

Deficits in care are added to the requirements of immediate care for patients, previously expected from a hospital emergency room. This issue aggravates conflicts in the sectors which receive outpatients, because when the expectation of immediate attention is not fulfilled, the revolt occurs.

Often the professional is not giving you a satisfactory response because the workers are slow [...]. *So this is aggravating* [...]. *Everyone who comes in here: 'My case is more urgent, I'm next* (E12).

If they are drunk or high, they move them up the line, [...] *everything for them is serious, they do not understand that a cut on the finger can wait. Then, the SAMU* [Mobile Emergency Medical Service*] arrives with a drunk person who has fallen, cut their forehead, and they go to the front of the line, or the prisoners, they also pass in front of you. It annoys anyone who has been waiting for more than an hour.* [...] *So, what happens? They do not curse at the doctor, they do not curse at the nurse, they do not curse at the director, they curse at us, because we are the front line* (E2).

This statement highlights aspects which contribute to the greater exposure of nursing assistants or technicians to workplace violence, either through greater physical interaction or greater contact with patients. In addition, nursing auxiliaries or technicians feel vulnerable due to the perception of low socio-professional prestige when they are the target of attacks that do not reach the other professionals

with similar frequency.

The lack of appropriate conditions for care did not only affect the users of the service, but also the workers:

there is a certain stress among the professionals due to the contingency of work, [...] *people fight a lot among themselves due to lack of beds here, because they have to transfer patients to other hospitals* (E3).

[...] *there is just one: it's the lack of employees!* [...] *they put pressure on each other and end up fighting.* [...] *we cannot do some of the work. So it's frustrating* (E14).

In addition to understanding that these behaviors are instigated by the work context, interviews have shown that peer aggressions which are often ways to vent frustration caused by a type of violence which although is not quantified in this research, makes workers mass casualties: Structural violence. The impact of structural violence breeds other violence, and thus the moral integrity of the worker is shaken, and suffering begins.

We need support from outside, from the Health Department, we need them to intervene in these difficulties of bed shortages, lack of ICU beds. It takes more than the professionals quarrelling among themselves, we need government support (E10).

The workers highlighted that their immediate leaders were equal victims of structural violence, due to their autonomy becoming a prestige or injunction, rhetorical in the face of the degrading mission of producing health in the work context.

Work without rules and the rules of the trade: the cause of violence between professionals

In most of the participants' reports, the violence originated from the socio-professional relationships which was linked to the fact that it is a public service, in which the stability of employment justifies the forms of expression.

[Aggression] *happens because the people are not afraid of losing their jobs* [...] *we abuse this privilege a little* (E10).

Because it is a public service, no one wants to be indisposed, they [managers] do not want to disagree [...] the result of this is that there is an increase in disrespect (E17).

The statements revealed that passivity in the face of injustice and the acceptance of aggression are used as a form of language, thus victim and aggressor share roles as the same character.

I have been a victim of aggression, but I've also been the one cursing somebody, you know? [...] *there is also no hierarchical respect for the managers, nor do the managers respect the subordinates* (E2).

The statements also showed that many situations of violence originate from conflicts caused by the disagreements regarding care.

You put a guedel airway in the patient because it helps to keep the mouth area clean and so that the patient doesn't bite the tube, the patient oxygenates better and it facilitates aspiration of the tube, but when you turn around, and the guedel airway is out of the patient's mouth. This is one thing that does not have a routine, there is no protocol, and that is bad. [...] *They are small things that become the most horrible thing in the world, violence ... we are fighting each other unnecessarily, because we don't take action* (E10).

Without investment in conflict management, conflicts escalate to the point of violence between peers and even between hierarchical levels.

Things are in accordance with the decision of who is on duty, who is experiencing that situation at that moment. There is no protocol, so there are many misunderstandings (E3).

The mention of protocols shows the need for the development of cooperation which is aimed at change, and this cooperation requires that passive acceptance continuously evolves.

It is a public service, and there are people who have been here for years [...]. *And this fact, in the head of the person who is the aggressor, makes them believe they have safety margin. So I can go back to assaulting my colleague because he won't do anything to stop me, I've been here for so many years* (E6).

Thus, faced with the reality of work without rules, the power of the oldest employee prevails as a rule of law, and violence manifests itself in the abuse ensured by the inexistence of control measures, prevention or punishment.

DISCUSSION

International studies corroborate findings regarding frequent exposure to violence in the workplace of health professionals, be it physical or psychological in nature.[16-17] Psychological violence has shown to be more prevalent than physical violence, [3,16-23] which can reach to an average of 2.29 episodes of verbal aggression per 8-hour- shift and 1.18 episodes of physical aggressions.[24]

The prevalence of verbal aggression identified in the literature (62% to 85%),[3,17-18,20-22] is higher than

the findings of this study (48.7%), and may even be found in 100% of workers during the six months.[25]

The findings of the present study revealed a 10% higher prevalence in cases of physical violence than what is seen in a study conducted in Lebanon.[21] On the other hand, 62.3% of physical aggressions included the use of knives which were previously made using pieces of wood or furniture from the wards in Chinese hospitals.[26]

A systematic review of 136 studies, which estimated exposure rates in different regions of the world, revealed that non-physical violence occurred in more than 50% of cases in all regions, the lowest rate in Asia and non-physical violence was almost twice as prevalent in the Middle East.[1] Bullying had the lowest incidence rate in Europe and the highest in the Middle East[1] and reached 30.2% of the nursing staff in a Greek hospital,[27] where the episodes occurred several times a week (12%) or almost daily (4%).[28] The presence of bullying in the nursing profession has been considered accepted and reproduced as part of the organizational culture, leading to sickness and impairment of professional functions.[11] Studies have pointed out that nurses are more exposed to violence than other members of the multi-professional team[4] and that they had a 39% to 53% greater risk of suffering violence in the workplace than nursing technicians.[19,23]

As for gender, there are differences in the results of previous studies, since there is a study pointing out women as the main victims,[16] men[29] or without significant difference between the sexes.[19]

Regarding the perpetrator of the different types of violence in the workplace of health professionals, it is corroborated by what is shown by most studies, which cites that the patients followed by their companions are the most frequent aggressors.[1,9,21,25,30-31] Most of the physical assaults and threats are perpetrated by patient, and verbal abuse is often perpetrated by their companions.[3] On the contrary, a Lebanese study has shown that the most common perpetrators of verbal abuse were the patients' companions, followed by doctors, nurses and managers.[21]

Six US hospitals reported that 50.4% of violent episodes were perpetrated by patients and their companions, with 39% occurring in the 12 months prior to the survey.[3] Other studies report that professionals who work more frequently with patients, and who have direct physical contact with them, are at increased risk of suffering physical violence.[26,30] The majority of violent episodes occurred in the patients' own rooms.[3,21]

Considering the findings regarding the perpetrator, it was possible to unveil an ambiguity of feelings and thoughts regarding the patient as the perpetrator of the aggressions suffered by the workers, due to the workers making excuses for the patients, which were based primarily on the rationalization of the effects of the clinical condition, and sometimes they blamed the patients, based on the stereotype of being crooks and criminals. The study states that victims of violence in the workplace distinguish intentional violence from unintentional violence, with a tendency to see the latter in less negative terms.[4]

Long waiting times and substance abuse have been causes for episodes of aggression towards health workers.[4] Behavioral mental health issues were highlighted by an American study as contributing factors for 63.7% of violent episodes involving patients, followed by medication withdrawal, pain and substance abuse (37.8%), and being dissatisfied with the care and/or experiencing a conflict with the medical staff (72.7%).[3] A Swiss study found that nurses who have heavier workloads were more likely to be exposed to physical violence in their workplace.[17]

In this study, organizational and working conditions were closely related to the violence that causes health workers to become victims in their workplace and which constitutes a type of institutional violence,[32] as well as in relation to the workers' dissatisfaction.[33] However, violence can be understood as a product of the human interactions that take place in a precarious and turbulent work environment, or as a manifestation of the discontent of those involved (workers and users) with the precariousness to which they are exposed.

This can be seen with workers from two Athenian hospitals who mentioned that the main causes of violence practiced by doctors against nursing were due to the lack of professionals (84.0%) and delays in the provision of nursing care (67.9%). The main causes were the lack of professionals (77.6%) and disagreements and lack of communication between the team (58.0%).[16] Factors related to the mismanagement of the institution including staff and resources, were cited by a study in Jordan as contributing factors to violence in their workplace.[20]

The consequences of the precariousness of

the health sector affect the professionals, who fight among themselves when feeling somehow unjustly blamed. Thus, violent behaviors are interpreted as expressions of discontent when faced with abuse, in the form of negligence, for conditions essential to the worker's dignity as a representative of the health system for the population.

Nurses who work in public hospitals are at greater risk of suffering workplace violence than those working in private hospitals.[23] In addition to considering public investments in safety measures to contain and treat cases of assault, in the present study, employment stability is a factor which allows the use of violence without having risk of losing employment. Aggression among professionals is interpreted as responding to organizational values that worship virility as a value, as a virtue of the group, and thus denies weakness and fear in the face of precarious working conditions and social relations.

The focus on a single work context is considered a limitation of the study, which does not prevent reflection from being transferred to other scenarios, since the study site has organizational and demand characteristics similar to the different public contexts of health services. Thus, the results presented here can encourage managers and workers to analyze this phenomenon which is present in the health institutions: the violence suffered by professionals who are responsible for the provision of care to the population. We suggest follow-up studies that evaluate the effectiveness of interventions to prevent and combat violence in workplace of health professionals.

CONCLUSION

Psychological violence was prevalent, principally in the form of verbal aggression and moral harassment, but physical violence was also frequent. Women were statistically more exposed to physical violence, bullying and racial discrimination, and nursing technicians were also more exposed to physical violence and bullying. The patient was the main aggressor to the health team, followed by colleagues, managers and companions, respectively.

It was possible to understand that the origin of the aggressions was related to the neurological diseases, alcohol abuse and other drugs, reasons for which the patients were not to blame for their violent actions. The improper work conditions generated the patients' revolt and also among the professionals. Aspects of work organization in the public hospital were pointed out as causes for conflicts which had violent repercussions.

The study contributes to the analysis of the phenomenon of violence in the workplace of health professionals, which has been naturalized in the daily life of Brazilian services, rarely measured, typified or understood and therefore uncontested, treated or prevented. The mixed approach was considered promising choice for the analysis of the phenomenon of violence at the workplace, since it integrated complementary elements and potentiated the interpretations and inferences regarding the findings.

It is believed that the present investigation could aid health professionals in recognizing the problem, as well as instigate future professionals to reflect on the subject and identify circumstances potentially capable of inciting violence or even seeing the physical and psychological aggression sometimes inherent to the health context. In the field of management, the study highlights deserving aspects for investments, in order to guarantee more safety and quality of life for workers, as well as to prevent health problems, work absences and resignation.

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