SOME CAUSES, CONSEQUENCES, AND PREVENTIVE SOLUTIONS FOR WORKPLACE VIOLENCE AGAINST HEALTHCARE WORKERS AT THE HOSPITAL FOR REHABILITATION - PROFESSIONAL DISEASES

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ABSTRACT

Introduction: Workplace violence against healthcare workers is increasingly becoming a global phenomenon, with growing causes and consequences. In Vietnam, however, there is a notable lack of research describing effective prevention strategies. **Objective:** To describe the causes, consequences, and preventive measures for violence against healthcare workers at the HCMC Hospital for Rehabilitation – Professional Diseases in 2025. **Subjects and Methods:** A cross-sectional study was conducted from June to September 2025 on 209 healthcare workers employed at the Hospital for Rehabilitation and Occupational Diseases. Descriptive statistics, including frequencies and percentages, were used to present the findings. **Results:** The majority of incidents involving violence against healthcare workers stem from patients or their family members having to wait for extended periods (82.8%), heightened emotional sensitivity (81.3%), understaffing (74.6%), and ineffective communication (71.8%). Such violence has led to severe psychological consequences and has negatively impacted professional commitment. The most commonly proposed solutions include increasing staffing levels (87.6%), enhancing security measures (78.9%), and implementing stricter access control to hospital premises (76.6%). **Conclusion:** Violence against healthcare workers is a multifactorial issue with profound consequences, requiring comprehensive intervention. Identifying causes, consequences, and proposing specific solutions is essential for healthcare facilities to build a safe and stable working environment, effectively protecting the healthcare workforce.

Keywords: *Causes, consequences, prevention, violence, healthcare workers.*

I. INTRODUCTION

Workplace violence against healthcare workers has increasingly become a serious issue, not only in Vietnam but also worldwide [1–3]. Such violence may take various forms, including physical assault, verbal threats, and sexual harassment, all of which can have profound consequences for mental health, job performance, and the quality of patient care [4]. In specialized hospitals such as the Hospital for Rehabilitation - Professional Diseases, where patients often require prolonged treatment and long-term care, the high demand for interaction and communication with healthcare workers further intensifies occupational pressure, thereby increasing the risk of conflict and workplace violence [5].

Although several domestic studies have begun to address this issue [1,6], in-depth investigations in specialized healthcare settings remain limited. Identifying the underlying causes and consequences is an essential foundation for developing effective prevention strategies, thereby contributing to improvements in the working environment and the protection of the healthcare workforce. In response to this practical need, the present study was conducted to describe the causes and consequences of violence against healthcare workers and to propose preventive measures at the Hospital for Rehabilitation - Professional Diseases in 2025, thereby providing empirical evidence to support management practices and policy development.

II. MATERIALS AND METHODS

2.1. Study design: A cross-sectional study.

2.2. Study period: From June 2025 to September 2025.

2.3. Study setting: The Hospital for Rehabilitation - Professional Diseases.

2.4. Study participants: Healthcare workers employed at the Hospital for Rehabilitation - Professional Diseases.

Inclusion criteria: Healthcare workers, including physicians, nurses, technicians, nursing assistants, security staff, and cashiers, who had contact with patients and their relatives and

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were directly involved in patient care and treatment.

Exclusion criteria: Healthcare workers who were absent during the study period and those who declined to participate in the study.

2.5. Sample size and sampling method

A total of 209 healthcare workers were included in the study and selected using systematic random sampling, following these steps: (1) a list was compiled of all healthcare workers at the hospital who met the study eligibility criteria; (2) participants were numbered sequentially from top to bottom, and the sampling interval was calculated as k = N/n = 658/209 ≈ 3 (N: the total number of healthcare workers at the Hospital for Rehabilitation - Professional Diseases in 2025 [5]); and (3) the first participant was selected by random draw. Thereafter, one healthcare worker was selected for every three individuals on the list. The process continued until the minimum required sample size was reached.

2.6. Measure

The study used the questionnaire developed by Dao Ngoc Phuc et al. [6]. After obtaining copyright permission, the questionnaire was adapted to suit the target population of healthcare workers. The validity and reliability of the revised instrument were re-evaluated after adaptation. A panel of six experts assessed the content validity of the instrument and reached a high level of agreement, with the CVI, I-CVI, and S-CVI/Ave all equal to 1. The Kuder–Richardson 20 (KR-20) coefficient was 0.823 in a pilot survey conducted among 30 healthcare workers with characteristics similar to those of the study participants. The healthcare workers involved in the pilot study were not included in the main study.

The questionnaire consisted of 46 items investigating the causes, consequences, and effective preventive measures related to workplace violence. Each item was designed as a multiple-choice question with a single best answer. Participants required approximately 30 minutes to complete the survey questionnaire.

2.7. Procedure

Step 1: The study protocol was reviewed and approved by the Biomedical Research Ethics Committee of the Hospital for Rehabilitation - Professional Diseases as a non-interventional study under an expedited review process.

Step 2: Approval was obtained from the Board of Directors of the Hospital for Rehabilitation - Professional Diseases.

Step 3: The researchers contacted the hospital's Department of Personnel and Organization to obtain the list of healthcare workers and screen those who met the study eligibility criteria. At the same time, the researchers coordinated with head nurses, chief technicians, and heads of units in the clinical departments, paraclinical departments, and functional offices.

Step 4: The researchers clearly explained the study objectives, procedures, confidentiality of information, and the method for checking completion of the self-administered questionnaire, and then distributed the questionnaires to the head nurses, chief technicians, and heads of units in the clinical departments, paraclinical departments, and functional offices.

Step 5: After the morning briefing session ended (7:30 a.m.), the head nurses, chief technicians, and heads of units re-explained the study information to healthcare workers in the briefing room if they were working the morning or night shift. For those working the afternoon shift (1:30 p.m.), data were collected at the beginning of the shift. Healthcare workers who agreed to participate were asked to sign the informed consent form before taking part in the study. The researchers also provided contact information in the participant information sheet so that participants could reach the research team at any time if they had questions.

Step 6: Healthcare workers completed the self-administered questionnaire. The average time required to complete the questionnaire was approximately 30 minutes. During completion of the questionnaire, if participants had any questions, the head nurses, chief technicians, or heads of units provided on-site clarification.

Step 7: The head nurses, chief technicians, and heads of units checked the questionnaires for completeness and thanked the healthcare workers for their participation.

2.8. Data analysis

After collection, the data were coded using Microsoft Excel 2016 and statistically analyzed using SPSS version 22.0.

2.9. Ethical considerations

The study was approved by the Biomedical Research Ethics Committee of the The Hospital for Rehabilitation - Professional Diseases.

III. RESULT

3.1. General characteristics of the study participants

The median age of the study participants was 30 years (interquartile range: 27 – 38), with ages ranging from 19 to 58 years. When asked about hospital security and their sense of safety at work, 89.5% of healthcare workers reported that hospital security was adequately ensured, and 67.0% stated that they felt safe while performing their duties.

The study found that 56.9% of healthcare workers had experienced workplace violence (119/209).

3.2. Causes of workplace violence against healthcare workers

Table 1. Some causes of violence against healthcare workers (n = 209)

Causes	Frequency (n)	Percentage (%)
Delayed waiting time for patients/patients' relatives	173	82.8
Heightened emotional sensitivity among patients/patients' relatives	170	81.3
Shortage of healthcare workers	156	74.6
Patients/patients' relatives' suspicion of preferential treatment in service delivery	148	70.8
Patients/patients' relatives under the influence of alcohol	114	54.5
Patients/patients' relatives not being provided with clear guidance	115	55.0
Healthcare workers not having received training in violence response skills	124	59.3
Inadequate facilities and equipment	114	54.5
Differences in culture, language, or religion	125	59.8
Inappropriate communication by healthcare workers	116	55.5
Inappropriate communication by patients/patients' relatives	150	71.8
Mental disorders among patients/patients' relatives	124	59.3

Table 1 shows that the most commonly reported cause of violence against healthcare workers was prolonged waiting time for patients or their relatives (82.8%). This was followed by heightened emotional sensitivity among patients or their relatives, shortage of healthcare workers, inappropriate communication by patients or their relatives, and patients' or relatives' suspicion of preferential treatment in service provision, with corresponding proportions of 81.3%, 74.6%, 71.8%, and 70.8%, respectively. Other causes were reported at lower frequencies.

3.3. Consequences of workplace violence against healthcare workers

Table 2. Some consequences of workplace violence against healthcare workers (n = 119)

Consequences	Frequency (n)	Percentage (%)
Psychological consequences		
Fear	97	81.5
Anger	109	91.6
Disappointment	96	80.7
Feelings of guilt	65	54.6
Heightened emotional sensitivity	102	85.7
Impaired self-esteem	80	67.2
Self-doubt	56	47.1
Depression	40	33.6
Reduced quality of life	59	49.6
Work-related consequences		
Reduced willingness or unwillingness to care for patients	79	66.4
Job dissatisfaction	75	63.0
Poor work performance	62	52.1
Intention to change workplace	47	39.5
Resignation	29	24.4

Table 2 illustrates workplace violence has many serious consequences for healthcare workers, particularly in terms of psychological well-being. The most common reactions were anger (91.6%), heightened emotional sensitivity (85.7%), fear (81.5%), and disappointment (80.7%), indicating a high level of emotional distress. A considerable proportion of participants also reported impaired self-esteem (67.2%), feelings of guilt (54.6%), depression (33.6%), and reduced quality of life (49.6%), reflecting the long-term impact on mental health. Regarding work engagement, most participants reported reduced motivation to provide care (66.4%) and job dissatisfaction (63.0%); more than half experienced decreased work performance, and nearly 40% intended to leave their workplace, highlighting the negative effects on professional commitment and the stability of the healthcare workforce.

3.4. Preventive solutions of workplace violence against healthcare workers

Table 3. Some preventive solutions of workplace violence against healthcare workers (n = 209)

Preventive solutions	Frequency (n)	Percentage (%)
Access control at hospital entry and exit points	160	76.6
Increase the number of healthcare workers to ensure better service delivery and reduce waiting time for patients and their relatives	183	87.6
Strengthen security personnel	165	78.9
Limit visiting hours	119	56.9
Install surveillance cameras in the workplace	148	70.8
Provide clear explanations to patients and their relatives	148	70.8
Train hospital staff in skills for responding to workplace violence	154	74.0
Ensure appropriate and modern facilities and equipment	160	76.6
Promote public education and mass communication on workplace violence	126	60.3
Collaborate with local police authorities	135	64.6

Increasing the number of healthcare workers was the most frequently proposed measure, reported by 87.6% of participants. This was followed by strengthening security personnel (78.9%). Notably, 76.6% of healthcare workers suggested implementing access control at hospital entry and exit points and providing appropriate, modern facilities and equipment. Several other measures were reported at lower proportions but were still proposed by more than half of the participants, including workplace surveillance, providing clear explanations to patients and their relatives, and collaborating with local police authorities. Limiting visiting hours was the least frequently proposed measure. See Table 3.

IV. DISCUSSION

Our study found a median age of 30 years, reflecting a relatively young healthcare workforce, consistent with several studies conducted in Türkiye, Jordan, and Iran [2]. Younger age may be associated with a higher risk of experiencing workplace violence because of limited professional experience and less well-developed skills in handling challenging situations [2]. This finding underscores the need for soft-skills training, psychological support, and the development of a safe working environment, particularly for younger staff. Although 89.5% of healthcare workers considered the hospital's security system to be adequately maintained, only 67.0% actually felt safe while at work. This gap clearly suggests that physical security, although necessary, is not sufficient to foster an internal sense of safety among healthcare workers. Feelings of insecurity may still persist, arising from direct or indirect experiences of violence involving not only patients and their relatives but even colleagues. This indicates that the sense of safety is a complex psychosocial construct and is consistent with previous literature emphasizing that meaningful improvements in perceived safety require a combination of physical protection, psychological support, a positive organizational culture, and transparent feedback mechanisms following each incident [3].

The causes of violence against healthcare workers identified in our study are generally consistent with the international literature [2,7]. Prominent factors such as prolonged waiting

times, psychological distress among patients and their relatives, staff shortages, and ineffective communication continue to be recognized as major contributors [6]. These findings not only reflect the operational characteristics of a healthcare system under pressure from overcrowding, but also highlight gaps in expectation management, health communication, and training in response skills. Other factors, such as cultural differences, mental disorders, substance misuse, and lack of training, may also contribute to an increased risk of conflict, particularly in environments characterized by frequent interpersonal contact and the absence of effective violence-prevention mechanisms [6]. Differences in prevalence across studies may be attributable to contextual factors, organizational capacity, as well as the degree to which violent behavior is tolerated within each community. Overall, the causes identified in our study indicate that workplace violence is a multidimensional issue arising from the intersection of systemic, individual, and broader social environmental factors, thereby requiring an interdisciplinary approach to prevention and intervention.

Of the 209 healthcare workers who participated in the study, 119 had experienced workplace violence. Violence had profound consequences for both psychological well-being and professional commitment, with both similarities to and differences from previous studies. Psychologically, the high prevalence of negative reactions such as anger (91.6%), stress (85.7%), fear (81.5%), and disappointment (80.7%) in the present study indicates a substantial level of emotional distress, consistent with previous findings [6,8]. Manifestations such as loss of self-esteem, feelings of guilt, and depression were reported at lower rates but remain noteworthy, as they suggest prolonged adverse effects on mental health. From a professional perspective, more than 60% of healthcare workers reported reduced job satisfaction and decreased motivation to care for patients; a considerable proportion also wished to change workplaces or had already resigned. These figures reinforce the view that workplace violence not only reduces work performance but also erodes professional commitment [6,8]. Differences across studies may reflect the degree of transparency in incident reporting: in institutions without effective reporting systems, the psychological and behavioral consequences may be underestimated. The high rates observed in our study may indirectly suggest that when healthcare workers feel heard and protected, they are more willing to disclose their experiences, thereby providing a more accurate and reliable picture of the negative impact of workplace violence.

The preventive measures most strongly prioritized by healthcare workers included increasing staffing levels, strengthening security personnel, controlling hospital entry and exit, improving facilities, providing training in violence-response skills, and enhancing communication and explanation of procedures for patients. These preferences indicate a focus on three major domains: improving human resources, strengthening on-site security, and enhancing communication capacity. Compared with the study by Al Anazi, the level of support for these measures was markedly higher, particularly for more coercive measures such as collaboration with the police, suggesting both the seriousness of the problem and a lack of confidence in the institution's internal capacity for self-regulation [9]. This emphasis on such measures may be explained by the context of overcrowding, high patient volume, limited waiting space, and insufficient internal response mechanisms, which are common characteristics of many public healthcare facilities. The strong support for training and communication interventions also reflects clear awareness of the role of communication skills and transparent information in managing expectations, which were identified in this study as important sources of conflict. The pattern of preferred preventive measures identified in our study is not only consistent with international evidence regarding the core pillars of workplace violence prevention – staffing, training, and security [2,3,9] – but also highlights a clear need for more direct and systematic interventions tailored to organizational characteristics and occupational risk levels.

V. CONCLUSION

Workplace violence against healthcare workers was primarily associated with prolonged waiting times, increased stress among patients,

staff shortages, and suspicions of preferential treatment in service delivery. The consequences of such violence had clear adverse effects on mental health, work performance, and professional commitment. Priority measures included increasing staffing levels, ensuring security, providing skills training, and improving communication. Healthcare institutions should foster a safe, transparent, and responsive working environment, while integrating workplace violence prevention into quality management policies, staff training, and the protection of the healthcare workforce.

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