

Violence in Public Healthcare Institutions: A Multilevel Analysis from Patient, Physician and Manager Perspectives *

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Abstract

Violence in healthcare is a multidimensional problem shaped at the intersection of individual, institutional and structural dynamics. In the health management literature, the phenomenon of violence is predominantly examined through single-level analyses, while studies that simultaneously investigate the perspectives of different actors remain limited. Drawing on interviews with thirty patients and their relatives, thirty physicians and ten senior managers, this study examines the causes of violence in healthcare institutions and proposes solutions for Turkish public health system. The study analyses the findings obtained through semi-structured interviews using a multilevel analytical framework across micro, meso and macro levels. At the micro level, interpersonal communication problems, unmet expectations, inadequate information provision and negative interaction experiences are identified as key factors that increase the potential for violence between service providers and recipients. At the meso level, institutional and organisational factors become more visible, with administrative problems, insufficient institutional coordination, infrastructural constraints and delays in healthcare delivery deepening tensions within healthcare institutions. At the macro level, systemic pressures such as high patient volumes, heavy workloads and low health literacy are regarded as structural factors that fuel violence. Accordingly, improving interpersonal communication, strengthening institutional functioning and addressing structural problems related to health policy are identified as the primary areas for solution.

Keywords: *Violence in Healthcare, Health Policy, Multilevel Analysis, Public Hospitals in Türkiye.*

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1. INTRODUCTION

Violence in the healthcare sector is one of the most critical issues directly affecting the quality-of-service delivery and the functioning of the health system in the public sector. In particular, tensions and conflicts between patients and healthcare professionals both disrupt the delivery of health services and negatively affect the working environment within healthcare institutions. Although studies on violence in healthcare are generally confined to the axes of adverse patient behaviour and violence experienced by healthcare workers, this study argues that the phenomenon of violence should be addressed as a consequence of healthcare service delivery processes, institutional structures and, more broadly, health policies. For this reason, the study comprehensively evaluates the experiences of actors participating in health service use, delivery and policy implementation at different levels in order to identify the causes of violence in healthcare and possible solutions.

It is well established that interactions in healthcare institutions frequently occur in an emotionally intense environment between service providers and recipients. These interactions are delivered to citizens within the organisational frameworks provided by healthcare institutions and are further shaped by the decisions and practices of senior policymakers. Accordingly, violence in healthcare services can be considered a field that requires evaluation beyond being merely a product of the behaviours and responses of patients and physicians. The analyses aim to demonstrate that the factors leading to violence in healthcare delivery and services emerge through the interrelationship of actors across different levels.

The empirical investigation aims to contribute a multilevel analysis of the causes of violence and potential solutions by drawing on the perspectives of patients and their relatives, physicians and healthcare administrators. Examining violence in healthcare at micro, meso and macro levels, this study draws on the multilevel analytical framework of the socio-ecological approach. It therefore focuses on interpersonal interactions at the micro level, institutional factors at the meso level and broader system-related elements at the macro level.

The study makes a twofold contribution. First, it provides an integrated perspective that simultaneously evaluates the experiences and perceptions of different actors within the setting where healthcare services are delivered. Second, it aims to contribute to the development of more effective preventive strategies by comprehensively examining whether violence in healthcare arises from the interaction of processes occurring at different dimensions. Although these levels are analytically distinct, the perceptions of actors participating in processes related to the health system allow problems to be examined from different angles. In this respect, the paper intends to contribute both to the literature and to health policies in Türkiye by offering a holistic analysis that does not reduce violence in healthcare solely to individual behaviours but also takes organisational and systemic dynamics into account.

2. THEORETICAL AND CONCEPTUAL FRAMEWORK

Violence in healthcare services is one of the most significant problems directly affecting both healthcare workers and patients and the functioning of the health system, worldwide. Studies show that healthcare professionals are among the occupational groups most highly exposed to violence in fields characterised by intense human interaction and high service circulation (Liu et al., 2019; O'Brien et al., 2024). The phenomenon of violence encompasses various forms of behaviour including physical aggression, verbal harassment and threats, and not only causes serious psychological distress among healthcare workers but also leads to structural problems in the functioning of the health system (Gillespie et al., 2010). Accordingly, comprehensively understanding violence in healthcare requires an approach that evaluates individual interactions alongside organisational factors.

A significant portion of studies in the literature focuses on the interpersonal dynamics arising from interactions between healthcare workers and patients. Healthcare services frequently occur in environments characterised by uncertainty, stress and urgency, and these conditions increase the likelihood of misunderstanding and the tendency toward violence. Communication problems are among the primary factors triggering tension in healthcare service delivery and frequently give rise to a process built on misunderstandings (International Labour Organization et al., 2002).

Inadequate information regarding medical procedures, failure to provide clear and comprehensible information about the treatment process, negative attitudes and behaviours of healthcare workers are identified as the primary causes of violence towards healthcare workers as perceived by patients (Terkeş et al., 2021). At this point, the information asymmetry that exists between patients and physicians emerges as an important structural element that deepens differences in expectations and perceptions, often without either party being fully aware. Patients' limited knowledge of diagnosis, treatment and institutional processes can lay the groundwork for the emergence of a conflict environment (Temel & Aydın, 2018).

Related to this, patients' expectations of healthcare services also constitute an important area of discussion. Expectations regarding the swift, effective and high-quality delivery of services in the healthcare sector are considerable (World Health Organization, 2000). When these expectations are not met, dissatisfaction and disappointment may arise. Terkeş et al. (2021) found that patients and their relatives often identified delays in service processes, access problems and the perception of inadequate service as factors that increase tension between patients and healthcare workers. Moreover, when emotional stress arising from illness is added to these tensions, the perception of inadequacy information intensifies anxiety and can lead to more severe reactions (Kocaman, 2010).

Institutional and organisational factors constitute another important dimension in the emergence of violence in healthcare. Healthcare services are conducted within certain administrative processes and resource capacity limitations and are directly affected by the quality of these structures. In this context,

institutional governance problems, disruptions in service delivery and resource inadequacies can negatively affect the functioning of healthcare institutions (Arnetz et al., 2018; O'Brien et al., 2024). While these disruptions increase the burden on healthcare workers, they simultaneously create dissatisfaction for patients. Consequently, institutional conditions may give rise to an environment in which problems between healthcare providers and recipients are more likely to arise (Tengilimlioglu et al., 2008).

The working conditions of healthcare workers are also an important factor in this context. Heavy workloads, high patient flow and long working hours increase stress levels among healthcare workers and may limit the time available for effective communication with patients. This indirectly reduces the quality of interpersonal interactions and increases the risk of conflict. Studies show that workplace violence is associated with burnout and job dissatisfaction (Nart, 2014). For this reason, violence in healthcare should be considered not only as an external risk but also as an outcome of organisational tensions and working conditions.

Another issue that stands out at the institutional level is the management and reporting of violent incidents. Research shows that a significant proportion of violent incidents in healthcare go unreported for various individual and organisational reasons. Healthcare workers often view violence as part of the profession and may refrain from reporting such incidents with the belief that reporting processes will not produce effective outcomes. Lack of managerial support and inadequacy of feedback mechanisms are also among the factors that limit reporting behaviour (Arnetz et al., 2015; Günaydın & Kutlu, 2012). This makes it difficult to reveal the true extent of violence and prevents institutions from developing preventive strategies.

Further factors shaping violence in healthcare are systemic and political factors. Health systems operate under structural constraints such as increasing service demand, high patient volumes and long waiting times. These conditions create pressures beyond the control of both patients and healthcare workers and can negatively affect the quality of interactions between the parties (Lim et al., 2022; O'Brien et al., 2024). In addition, low levels of health literacy can also increase these tensions by preventing individuals from accurately assessing healthcare processes (Nutbeam, 2008).

Furthermore, the way in which health policies are implemented plays a determining role in the emergence of violence. The existence and functioning of institutional mechanisms aimed at preventing violence directly affect how such incidents arise and are managed in the health system (Occupational Safety and Health Administration, 2016). For this reason, structural characteristics and policy choices should be considered as systemic elements that create the conditions for violence in healthcare.

When the literature is evaluated together, violence in healthcare is seen to be a multilevel phenomenon shaped by the interaction of interpersonal relations, institutional conditions and systemic dynamics. Although communication problems between patients and their relatives and healthcare

workers, disruptions in institutional functioning and structural pressures related to the health system represent different levels of analysis, these are not entirely independent and isolated processes. Problems and solution proposals emerging at one level are often shaped through interaction and permeability between different layers.

Accordingly, the socio-ecological model provides an important analytical framework for explaining the multilevel structure of violence in healthcare (Krug et al., 2002; McLeroy et al., 1988). The model argues that individual behaviours are influenced not only by interpersonal relations but also by organisational structure, institutional environment and the broader systemic and policy context (Bronfenbrenner, 1979). This model allows for the assessment that violence in healthcare develops at the intersection of multilevel social and institutional dynamics beyond interactions arising from aggressive behaviours (Dahlberg & Krug, 2002). In this study, violence in healthcare is examined within the framework of interpersonal relations at the micro level, organisational processes at the meso level and systemic and policy-based factors at the macro level.

Understanding the causes and consequences of violence in healthcare requires a holistic analytical approach in which these different levels are examined together. While most studies in the literature tend to examine violence at a single level (e.g., Al-Bitar et al., 2025; İpek & Özlük, 2023; Morphet et al., 2019), this study brings together the perspectives of different actors (patients, relatives, physicians and managers) to examine violence in healthcare within the framework of the interaction of individual, organisational and systemic factors. In this respect, the study aims to offer a more holistic evaluation as an alternative to fragmented approaches in the literature and to contribute to health management and health policy literature with solution proposals for preventing violence in public healthcare settings.

2.1. Research Questions

How do patients and their relatives, physicians and managers evaluate the causes of violence in healthcare?

How do patients and their relatives, physicians and managers evaluate solution proposals for preventing violence in healthcare?

How are the causes of violence in healthcare and solution proposals positioned at micro, meso and macro levels?

3. METHOD

This study examines the underlying factors and proposed solutions to violence in healthcare services within the framework of a qualitative research design drawing on the perspectives of different actors. Case study is a method that allows for an in-depth examination of a bounded system and its particular conditions by enabling an understanding of the complex structure of a specific situation

(Creswell, 2013; Stake, 1995; Yin, 2014). The complex and context-dependent nature of the healthcare sector and the interactional and multidimensional nature of violent incidents in healthcare led to the selection of an exploratory case study design as the appropriate method for this study. This approach allows for an in-depth examination of violence in healthcare through the experiences and interactions of different actors within a specific institutional context.

The research phenomenon is defined as the structural, institutional and interpersonal factors contributing to violence potential in healthcare delivery. The unit of analysis consists of the problem areas and solution strategies expressed by patients, physicians and managers. The classification of data at micro, meso and macro levels was also carried out in line with the multilevel analytical logic of the socio-ecological approach.

The fieldwork was conducted in Türkiye in the emergency and outpatient departments of a public hospital and in the institutions where senior local managers work. The hospital units were included in the study through purposive sampling as they are units with high patient volumes and therefore a higher likelihood of violent incidents. Interviews with senior managers were also purposively included in the sample in order to approach the subject from an administrative and system-level perspective.

The sample consisted of three participant groups: patients and their relatives who had experienced conflict and applied to the Patient Rights Unit, physicians working in emergency and outpatient departments who had experienced conflict with patients or their relatives and senior managers involved in healthcare administration. In total, interviews were conducted with 70 participants: 30 patients or patient relatives, 30 physicians and 10 senior managers. The inclusion of different actor groups strengthened the study by increasing the depth and diversity of the data.

The interview questions were prepared based on the socio-ecological model and the relevant literature on workplace violence in healthcare. Rather than using one standard tool, we developed three separate guides for patients/relatives, physicians and managers. This allowed us to capture how each group experiences the healthcare system from their own position. Each set of questions covered two areas: what participants saw as triggers of violence and their opinions on possible solutions. The questions were broad and open-ended. This let participants speak about whatever felt most relevant to them and the differences between groups emerged naturally from their answers. Three experts also checked the questions: one person with experience as both a physician and a healthcare manager and two academics.

Interviews lasted between 10–30 minutes and were conducted with patients and their relatives at the Patient Rights Unit, with physicians at the emergency departments or outpatient clinics where they work and with managers by visiting the institutions where they are employed. Prior to the

interviews, a voluntary consent declaration was obtained from each participant and the audio recordings taken during the interviews were subsequently transcribed.

The interviews consisted of two parts: the first focused on the formation process of violence and the problem areas that cause it, while the second addressed recommendations for resolving violent incidents. The data collection process was concluded in accordance with the principle of data saturation, as is widely used in qualitative research. The depth of interpretations was also strengthened by collecting data from different actor groups. When the themes derived from participant responses began to recur, it was determined that the necessary number of interviews and sufficient data had been reached (Guest et al., 2006). Throughout this process, the researchers were careful not to direct the experiences of participants, and during data analysis and presentation, attention was paid to ensuring that themes and quotations were derived directly from participant statements.

The data were examined through thematic analysis, the most commonly used method in exploratory case analysis. Interviews were first transcribed and the notes taken were systematically coded. During the analysis, the data were read several times to gain familiarity with the content. Initial open codes were generated directly from the data and subsequently categorised by grouping them under broader themes. Continuous comparisons between themes and codes were made throughout these iterative processes to ensure analytical consistency (Braun & Clarke, 2006; Saunders et al., 2023). In the analysis process, the findings are organised by participant group rather than by analytical level; the socio-ecological framework is applied interpretively to assess at which levels each group positions violence in healthcare. The study therefore employs both inductive coding and theoretically guided thematic classification.

4. FINDINGS

Adopting the multilevel analytical framework of the socio-ecological model, this research aims to comparatively demonstrate at which levels violence in healthcare is experienced and interpreted by different actors. Although the analytical framework consists of micro, meso and macro levels, each participant group is seen to assign different weights to these levels. For this reason, the findings are structured not only thematically but also in a way that shows at which level actors position violence in healthcare.

4.1. Patient and Relative Perspectives on Violence in Healthcare

This section presents findings on problem areas and solution proposals from the perspectives of patients and their relatives. These findings focus primarily on problems experienced in settings where direct services are received and highlight the interpersonal dynamics arising from communication deficiencies, unmet expectations and inadequate information provision.

Table 1. Drivers of Healthcare Violence and Proposed Solutions: Patient and Relative Perspectives

Level	Dimensions	Themes	Codes
Micro Level (Interpersonal & Individual)	Problem Areas	Access to healthcare services	Inability to receive medical examination
		Unmet service expectations	Expectations not being met
		Physician feedback and communication problems	Lack of solution proposals
	Solution Proposals	Communication and empathy expectations	Experiencing negative attitudes and behaviours
			Physicians establishing empathy with patients
			Patients being listened to and understood
Meso Level (Institutional & Organisational)	Problem Areas	Addressing information deficiencies	Healthcare workers being friendly and understanding
			Patients being informed in advance about services not available at the institution
	Solution Proposals	Access to healthcare services	Delays in procedures and processes
		Information provision problems	Lack of information provision
		Communication and empathy expectations	Healthcare workers receiving training on patient communication
		Addressing information deficiencies	Providing explanatory information about institutional procedures and application processes
			Guiding patients throughout institutional processes
		Improving institutional functioning and organisation	Ensuring standardisation in intra-institutional activities
		Social support and services for vulnerable groups	Availability of authorised units to which patients can submit their requests
			Developing facilitative practices for elderly patients
			Providing administrative and healthcare conveniences for patients with disabilities
Macro Level (Systemic & Policy)	Solution Proposals	Improving institutional functioning and organisation	Taking action regarding personnel with complaints filed against them
			Supervising employees who fail to fulfil their duties
		Social support and services for vulnerable groups	Ensuring responsibilities are fulfilled in healthcare service delivery
			Regulating patient density and service delivery
			Providing social service support for patients living alone or in need of support

Source: Authors' own work

Patients and their relatives identify access to healthcare services, unmet expectations, difficulty accessing information and communication problems with physicians as the primary problem areas. Among the factors that fuel a conflict and violence environment, timely access to services, delays in processes and dissatisfaction with service delivery stand out most prominently. Similarly, when examining views on situations that contribute to feelings of helplessness and frustration within the health system, comments such as "I don't know which door to knock on" are encountered.

One of the main themes prominent in patient views is the lack of information. Participants emphasise that they are inadequately informed about treatment processes, procedures and institutional functioning. Similarly, patients evaluate physicians not only on the basis of the success of treatment processes but also through physicians' attitudes toward patients, their respectful behaviour, their responsiveness to questions and their manner of expression. These findings are consistent with the existing literature, which explains that insufficient information and poor communication are closely linked to conflict and dissatisfaction in healthcare interactions (Temel & Aydın, 2018; Terkeş et al., 2021).

Participant statements illustrate how this communication and information deficiency fuels a violence environment. A patient describes the process as follows: "I said, doctor... I am trying to explain my own problem... I have pain... I didn't even get the chance to say I'm coming to you for this reason."

Another participant conveys the dissatisfaction created by not being informed about processes in advance with these words: "The hospital management or the hospital staff should have warned me from the beginning... I am paying money here. I am getting examined. Time lost. Financial loss. I have wasted my energy. Then you tell me that this service is not available here... The report is cancelled. But there is no refund... (It is said that) the report is cancelled, go and start from scratch somewhere else." These statements indicate that in healthcare services, not only the treatment outcome but also the manner of communication during the service delivery process shapes conflict dynamics.

The solutions proposed by patients and their relatives focus largely on improving guidance and making institutional functioning clearer and more comprehensible. Expectations directed at healthcare workers also focus on interpersonal dimensions, at the micro level, such as maintaining more effective communication, showing empathy and listening to patients. In addition, among the proposals that can be evaluated at the meso level, strengthening institutional guidance, clarifying procedural information and making service delivery processes more structured stand out. Furthermore, participants' proposals regarding the ability of vulnerable groups such as the elderly and disabled individuals to access healthcare services without difficulty, evaluated at the meso level, indicate that there are significant expectations regarding the inclusiveness dimension of service delivery.

When views on violence in healthcare are examined from a multidimensional perspective, it is seen that patients and their relatives frame the problems they experience predominantly at the micro

level, while positioning their expectations for solutions mostly at the meso level. From the perspective of the socio-ecological approach, this difference suggests that although patients interpret violence as arising from individuals, face to face interactions, they find its solution primarily to institutional level improvements rather than interpersonal changes. In this context, participants are seen to experience systemic and institutional problems primarily through individual interactions. On the other hand, waiting times, confusion in processes and negligence are perceived not as direct policy criticisms but as structural problems encountered in service delivery. This may cause service users to interpret violence through direct interactions and concrete service experiences rather than evaluating it within a systemic awareness or a broader structural context.

4.2. Physician Perspectives on Violence in Healthcare

This section identifies problem areas derived from physician data and reports solution strategies for these problems. The views of physicians offer a broader and more holistic perspective that points not only to interpersonal tensions but also to institutional inefficiencies and systemic pressures that trigger potential violence.

Table 2. Drivers of Healthcare Violence and Proposed Solutions: Physician Perspectives

Level	Dimensions	Themes	Codes	
Micro Level (Interpersonal & Individual)	Problem Areas	Patient behaviours and expectation dynamics	Patient demands, requests and expectations Communication problems	
		Health system and policy structure	Patient expectation pressure	
		Socio-cultural and psychological factors	Disrespectful attitudes Disease psychology Lack of empathy Cultural environment effect Prejudice	
			Solution Proposals	Extra-procedural solutions Applying requested treatment Recommending additional tests Accepting patients without appointments Informal solutions
	Tolerance-based behaviours			Empathy Informing
	Using communication channels	Keeping meetings short Giving warnings Remaining silent		
		Avoidance		
		Problem Areas	Patient behaviours and expectation dynamics	Unit level patient density
	Solution Proposals		Institutional functioning and organisational capacity	Administrative problems Infrastructure deficiencies

Level	Dimensions	Themes	Codes
Macro Level (Systemic & Policy)	Problem Areas	Factors arising from the nature of the service	Delays in procedures and processes
			Branch-specific working conditions
			Long treatment process
			Unexpected process obstacles
		External factors	Registration and insurance problems
		Avoidance	Directing to complaint mechanisms
		Individual regulation of procedures	Adapting the appointment system
			Adapting work processes
		Seeking support	Internal/external referral
		Health system and policy structure	Patient volume
			Procedural incompatibility
			Short consultation time
			Lack of inter-institutional coordination
		External factors	Problems occurring before the institution

Source: Authors' own work

Among the three participant groups examined, physicians stand out as the group that evaluates violence in healthcare in the most multilevel manner. Physicians consider patient behaviours, institutional deficiencies, systemic constraints, socio-economic dynamics and factors related to service delivery among the primary problem areas of violence. In this respect, the views of physicians demonstrate, in line with what the socio-ecological model anticipates, that violence in healthcare should be addressed not merely as an interpersonal interaction problem arising in the clinical environment but as a multilevel process shaped by the interaction of interpersonal, organisational and systemic factors.

Physicians identified communication problems, patient expectations and demands, disrespectful attitudes and behaviours and psychological factors arising from the disease process as the primary micro-level elements that trigger violence. The convergence of emotional intensity specific to healthcare institutions, increasing patient load and unmet expectations creates an important basis that increases the risk of violence in patient–physician interactions. These findings are consistent with the literature showing that high expectations and demands, emotional stress and communication breakdowns can increase aggressive attitudes toward healthcare workers (O'Brien et al., 2024; Saines, 1999;).

At the meso level, physicians emphasised institutional inadequacies such as administrative problems, infrastructure gaps and delays in institutional processes. At the macro level, they draw attention to structural service pressures such as short consultation times, inter-institutional coordination problems and policy-based constraints. One physician describes current working conditions with this statement: "An appointment opens every seven minutes... On top of that we see far more additional patients." This demonstrates that healthcare workers are trying to deliver services under time pressure and that this pressure might affect the quality of service provided to patients.

Physician views show that disruptions in institutional functioning directly contribute a conflict environment. One physician drew particular attention to irregularities in the appointment and patient flow system, using the expression: "Very, very serious problems are experienced with those who come without appointments." Similarly, another participant noted that the ineffective functioning of the referral mechanism creates congestion in tertiary hospitals, observing: "It should not be this easy to walk through a specialist's door... All the patients whose problems should be resolved at the primary care level pile up at the door." These statements show that the lack of organisational coordination and capacity problems in service delivery processes increase the likelihood of interpersonal tension.

Regarding coping strategies for dealing with these problems, physician statements show that conflict processes are often managed through practical methods developed at the individual level. Physicians state that they resort to methods such as adopting tolerance-based approaches (for example, producing informal outcomes, providing flexibility in processes), developing communication strategies (informing and building empathy), avoidance behaviours (shortened meeting durations, remaining silent) and seeking support. In particular, it is observed that rather than waiting for structural and institutional systemic solutions to be developed in the face of high workloads, they sometimes manage the process by acting outside formal procedures. These findings are consistent with studies showing that in situations where strong institutional support mechanisms are limited, healthcare workers develop context-adapted individual strategies to manage the tendency toward violence (Günaydın & Kutlu, 2012).

Although physicians express views on all three micro, meso and macro levels, their assessments are seen to concentrate largely at the micro and meso levels. In this respect, physicians stand out as frontline actors who face violence arising from patient-physician interaction at the micro level while simultaneously attempting to manage institutional and systemic pressures at the meso and macro levels within daily service delivery. Physicians position violence at the intersection of interactional and organisational dynamics, and because they directly experience both interpersonal conflicts and institutional constraints, they are able to offer significant solution proposals in these areas. On the other hand, while acknowledging the importance of macro-level factors related to health policies, they tend to evaluate these problems primarily through their effects on workload, patient volume, short consultation times and service delivery.

4.3. Managerial Perspectives on Violence in Healthcare

This section addresses problem areas and solution proposals related to the potential for violence in healthcare from the perspectives of managers. The findings emphasise the need for organisational development and policy-level interventions, focusing on institutional structure and systemic-level constraints.

Table 3. Drivers of Healthcare Violence and Proposed Solutions: Manager Perspectives

Level	Dimension	Theme	Code
Micro Level (Interpersonal & Individual)	Problem Areas	Professional inadequacies of personnel and behavioural factors	Negative attitudes and behaviours
	Solution Proposals	Interpersonal relations	Developing service awareness Improving communication quality
Meso Level (Institutional & Organisational)	Problem Areas	Professional inadequacies of personnel and behavioural factors	Lack of professional knowledge and experience
			Deficiency in guidance
			Lack of information provision
		Internal management and organisational structure	Lack of institutionalisation
			Physical infrastructure inadequacy
	Solution Proposals	Healthcare institution management	Lack of intra-institutional coordination
			Organisational deficiency
			Non-reporting of violent incidents
			Centralisation of institutional practices
			Strengthening preventive structures such as the Patient Rights Unit
Macro Level (Systemic & Policy)	Problem Areas	Interpersonal relations	Increasing entry and security controls
			Developing guidance and advisory services
		Patient behaviour and expectation dynamics	Communication and anger management training
			Lack of health literacy
		Solution Proposals	Health policies
	Patient volume		
	Workload and work pressure		
	Continuity of policy-driven structural problems		
	Insufficient legal sanctions		
			Interpersonal relations
Improvement of system-driven problems			
Strengthening social services			
			Deterrent legal sanctions
			Sanctions directed at employees
			Increasing health literacy
			Public awareness-raising

Source: Authors' own work

When examining the responses from managers, it is seen that the causes of violence and solution proposals are evaluated predominantly from an institutional and structural perspective. The problem areas that managers regard as primary at the meso level are shaped around lack of institutionalisation, failures in reporting violent incidents and weak coordination. A manager who drew particular attention to the training activities conducted regarding problem areas related to personnel competence expressed this as follows:

"If you look at the standards, we provide all the necessary training, in-service training both online and face-to-face within the framework of all the ministry's standards... Especially for those working in the emergency department, we continuously provide in-service training on topics such as interpersonal communication, anger management and crisis management. Under normal circumstances, we are doing what is required. But whether the result is effective or not depends on the individual."

At the macro level, managers drew attention to systemic pressures, focusing on themes such as policy-driven structural problems, insufficiency of the deterrent effect of laws and high patient volume. They also noted that these problems point to incompatibilities between institutional capacity and the manner in which health policies are implemented. For example, even though deterrent penalties have been put into practice, the fact that violent incidents are not always reported by healthcare institutions may cause these incidents to remain partially invisible in the eyes of senior health policymakers. As similarly noted in the research by Arnetz et al. (2015), these findings show that violent incidents in healthcare services are frequently not reported and can become normalised over time. The views of managers show that violence is conceptualised as an administrative problem arising not only from individual behaviours but also from systemic incompatibilities and institutional reporting deficiencies.

Manager views draw particular attention to the incompatibility between health policies and service capacity. One manager emphasised the effect of structural pressures on healthcare workers with the following statement: "The health system has a great impact on this too. Why? Long appointment waiting times are a factor here... The workload in healthcare is very heavy."

When examining solution approaches, manager themes concentrate on policy-level reforms, expansion of legal measures, increasing health literacy and broadening the scope and boundaries of the social support system in the healthcare field. At the institutional level, centralisation of practices, increasing the effectiveness of prevention units, improving security measures and increasing guidance services were recommended. It is also seen that managers put forward some proposals related to interpersonal dynamics and relations such as providing training on communication skills and increasing public awareness.

Within the scope of solution proposals, attention was drawn to health literacy and the problems of the hierarchical healthcare system, with one manager observing: "Our people need to become more informed, make full use of the primary care system and then come here." Another manager commented:

"There is no health literacy among the public... we are suffering from this. What does the patient do? They say let me stop by the hospital on the way and get my issue sorted, or they leave their issue - a report or medication, for example - to the last day, and then come and say let this be resolved."

However, managers also state that punitive sanctions alone will not be sufficient. One manager commented that "We solve everything with punishment... here too, the person says, so what if it is violence? I'll spend three days in detention and be released" that legal sanctions will remain limited without social awareness and cultural transformation, recommending that legal regulations be evaluated with a more comprehensive perspective. In general, the manager perspective reveals that violence in healthcare cannot be explained solely through individual behaviours or punitive sanctions but must be addressed together with institutional oversight, service capacity, systemic pressures, social awareness and policy implementation processes.

5. DISCUSSION

This study draws on the perspectives of actors who are directly or indirectly involved in violent incidents in healthcare and examines the causes of these incidents and solution proposals within a multilevel framework. The findings of the study show that violence in healthcare is not a singular event arising solely from interpersonal interactions but emerges as a multilevel and relational process shaped by organisational and systemic conditions. Nevertheless, while patients and their relatives express views that focus more on the services, they directly receive, physicians place greater emphasis on tensions arising from institutional problems and managers place greater emphasis on structural and systemic matters.

The findings also reveal a clear differentiation among the participant groups examined. While patients and their relatives make statements that can largely be evaluated at the micro level and partially at the meso level, physicians expressed views at all levels, primarily the micro and meso levels. Managers, while also touching on all levels, placed more emphasis on macro-level policy, capacity and systemic functioning problems than the other two groups. However, within their own responses, macro and meso-level concerns were equally represented. This balance is not surprising since managers are the actors responsible for translating macro policy decisions into meso level institutional practices. Overall, these different perspectives are not opposed to one another but are rather complementary in revealing the multilevel structure of violence in healthcare. This pattern is also consistent with prior literature that addresses violence as a multi-component phenomenon involving communication breakdowns, organisational constraints, unmet expectations and structural-political pressures (Krug et al., 2002; O'Brien et al., 2024).

When examining the findings classified at the micro level, violence in healthcare is seen to be closely associated with elements such as communication breakdowns, unmet expectations and emotional stress triggered in a violence environment. Patients and their relatives in particular argue that

inadequate information provision, negative communication styles and lack of empathy are of critical importance in the formation of a violence environment. As expressed in the studies of Temel & Aydın (2018), information asymmetry and problems in communication channels can undermine trust and contribute to dissatisfaction between patients and healthcare professionals. Furthermore, it can be stated on the basis of the findings that the environments in which healthcare services are delivered are prone to misunderstanding and conflict due to uncertainty, sensitivity and emotional intensity (Saines, 1999).

One of the noteworthy findings of this study is that patients and their relatives interpret violence primarily not as a structural problem but through the service experiences they directly encounter and individual interactions. Although a significant portion of the problems that fuel violence is systemic and organisational in nature, these problems become visible for patients primarily during the interpersonal interactions they encounter in healthcare institutions. For this reason, violence at the micro level is often experienced by patients not as the result of incorrect or inadequate systemic policies but through communication problems, waiting times, guidance deficiencies and unmet expectations during service delivery. This demonstrates that patients interpret violence in healthcare through the concrete problems they encounter in the direct service-receiving process rather than within a broader structural context.

The meso-level findings reveal how institutional structure and organisational functioning affect violence dynamics. Physicians and managers emphasise that coordination deficiencies, infrastructure inadequacies, process-related delays, institutional capacity problems and administrative disruptions are important factors that trigger violence in healthcare. Most of these findings are consistent with previous studies highlighting the role of inadequate infrastructure and resourcing, delays in procedures, poor organizational support in contributing the risk of violence (O'Brien et al., 2024). In this context, the meso level can be considered a transitional space between the interpersonal tensions observed at the micro level and the systemic pressures at the macro level. The views of physicians are particularly important from this perspective. Physicians are positioned at the intersection between patients and the institution, directly experiencing both interpersonal conflicts and attempting to deliver services under institutional constraints and systemic pressures. Physicians' assessments regarding inadequacies in processes and procedures, time pressure, workload and institutional capacity problems reflect themes associated with burnout, stress and excessive workload (e.g., Maslach & Jackson, 1981; Nart, 2014). For this reason, physician narratives are significant in demonstrating that violence in healthcare is not limited to the patient-physician interaction alone but that this interaction is shaped by organisational constraints and systemic pressures.

In this context, the strategies developed by physicians as street-level bureaucrats (Lipsky, 1980) demonstrate that not only formal procedures but also informal adaptations developed in daily practice play an important role in healthcare service delivery. Participants' recourse to methods such as producing extra-procedural solutions, providing flexibility in processes, remaining silent or adapting the appointment system according to circumstances reveals that healthcare workers develop practical coping

mechanisms to manage violent incidents under intense institutional and systemic pressures. This demonstrates that violence in healthcare is related not only to individual behaviours but also to the ways in which workers cope with organisational constraints.

It is also noteworthy that physicians resort to informal coping strategies such as adopting a more tolerant approach, managing interaction processes through certain adjustments in communication, acting outside formal procedures or developing avoidance behaviours. These findings demonstrate that formal institutional mechanisms are not always sufficient for managing violent incidents and that service providers are compelled to produce their own solutions in daily practice. As addressed by Fernandes et al. (2002), this suggests that violence in healthcare institutions is often managed reactively rather than prevented proactively, partly because preventive measures are not fully implemented. Consequently, healthcare workers should be evaluated not merely as passive victims of violence but also as frontline actors who develop flexible and informal adaptations to sustain service delivery under intense organisational and systemic pressures.

When macro-level findings are evaluated, systemic factors are seen to play an important role in shaping the conditions that give rise to violence in healthcare. Senior managers particularly emphasise the importance of high patient volumes, increasing workloads, insufficient deterrent effect of laws, low health literacy and policy-driven structural problems. These findings show similarities with the literature that views violence in healthcare as a consequence of systemic imbalances between demand and capacity (O'Brien et al., 2024) and policy-based pressures on service delivery (Krug et al., 2002). From this perspective, manager views demonstrate that violence in healthcare cannot be explained solely through individual behaviours or clinical-level conflicts but must be addressed together with health system capacity and structural problems, concepts that align with the broader literature on policy implementation (Hill & Hupe, 2009) and public governance (Osborne, 2010).

Furthermore, the solution proposals emphasised by managers also support the multidimensional nature of violence in healthcare. Managers state that increasing punitive sanctions alone will not be sufficient; developing health literacy, strengthening social support mechanisms, increasing institutional oversight, improving security and guidance services and aligning health policies with implementation capacity are also necessary. This reveals that while legal sanctions are important in combating violence in healthcare, they are not sufficient on their own and need to be supported by institutional, social and administrative interventions.

The primary contribution of this study is that the findings obtained from three different actor groups are evaluated not independently but within a structure that dynamically interacts across micro, meso and macro levels. When participant narratives are evaluated together, it is seen that patients focus on communication deficiencies, being misunderstood and access problems; physicians focus on workload, time pressure and institutional functioning problems; and managers focus on health policies,

system capacity, coordination and governance problems. This differentiation demonstrates that violence in healthcare is a multilevel and relational process shaped by the transformation of systemic pressures into organisational constraints and these constraints into interpersonal conflicts, experienced at different levels according to actors' positions within the health system, rather than being a singular event. For this reason, the study offers an actor-centred and socio-ecological mode of interpretation that does not reduce violence in healthcare to individual behaviours.

Another important finding of the study is the significance of accessibility and inclusiveness in the healthcare environment for violence discussions in healthcare. Patients point out that inequalities in service delivery, perceptions of exclusion and the difficulties experienced by vulnerable groups, particularly the elderly, disabled individuals and those in need of social support, can intensify the conflict environment. This finding demonstrates that the discussion of violence in healthcare should not be confined solely to efficiency, communication or security measures but should also be evaluated together with the principles of equity, accessibility and inclusiveness in the health system.

In general, the findings show that reducing violence in the healthcare sector is not possible through single-level interventions and that a multidimensional prevention and intervention approach is needed. While overcoming communication barriers at the individual level is important, it alone does not appear sufficient for comprehensive institutional reform aimed at reducing violence in healthcare. For this reason, a holistic approach in which individual, organisational and policy-based dimensions are addressed simultaneously is required in combating violence in healthcare. Such an approach will make it possible not only to intervene after violence occurs but also to proactively address the systemic constraints, institutional disruptions and interpersonal tensions that drive violence.

6. CONCLUSION

This study examined the phenomenon of violence in public healthcare institutions by investigating the problems that give rise to violence and the factors that contribute to the escalation of these problems into violence. It also evaluates the effectiveness of policies aimed at preventing violence in healthcare in Türkiye and the relationship between the causes of violence and ongoing health policies.

The findings demonstrate that violence in healthcare does not arise solely from individual behaviours occurring in interpersonal relations but is shaped together with organisational and systemic conditions. Violence in healthcare services emerges not as an isolated and singular event but most often as the result of accumulated tensions. Communication breakdowns, unmet expectations of service recipients, inadequacies in organisational capacity and service delivery and systemic pressures that intensify over time can escalate violence. For this reason, preventive strategies should focus not only on the visible violent incident but also on improving the conditions that lay the groundwork for violence to emerge.

One of the most important findings of this study is that violence in healthcare is perceived and experienced differently by different actors depending on their positions within the health system. While patients evaluate violence more through direct service experiences and interpersonal interactions, physicians focus on organisational pressures and service delivery processes. Managers, on the other hand, address violence in healthcare as a structural problem area related to system capacity, governance and health policies. This demonstrates that violence in healthcare is a multidimensional phenomenon, the nature of which shifts according to where an actor stands within the health system.

Evaluated from a public policy perspective, the findings offer systemic proposals in three main areas. At the micro level, improving the quality of communication, empathy and patient participation in the healthcare service-receiving process; at the meso level, strengthening organisational capacity, coordination and service delivery processes; and at the macro level, addressing systemic problem areas such as developing the legal framework, increasing health literacy and reducing workload are necessary. In particular, improving health literacy could be addressed by some practical steps such as distributing guidance materials at hospital entrances, adding health-related content to the national education curriculum, adding educational modules to the e-Nabız platform and holding information sessions at the family health centers to assist to patients understand where and how to seek care. Evaluating and regulating these policy proposals not as independent areas but within a strategic framework will enable a more coherent, feasible and outcome-oriented process (Hill & Hupe, 2009).

The theoretical contribution of this study lies in addressing violence in healthcare within an actor-centred, multilevel and socio-ecological framework. The findings demonstrate that violence in healthcare is a relational process that most often emerges through the transformation of systemic pressures into organisational constraints and the subsequent manifestation of these constraints as interpersonal conflicts. In this respect, the study does not explain violence in healthcare solely through individual behaviours or singular events but conceptualises it at the intersection of interpersonal interactions, organisational conditions and systemic and policy-based pressures.

Finally, this study has certain limitations. As a qualitative field study conducted within a specific institutional context, the findings cannot be generalised to evaluate health policies across different countries. Nevertheless, owing to the depth of analysis and the inclusion of perspectives from different actors, the study can offer analytical inferences for improving the quality of health policies in Türkiye. Future studies may conduct comparative analyses across different healthcare institutions and national contexts and may also examine in greater detail the informal coping strategies developed by healthcare workers and the processes of organisational adaptation.

Ethics committee approval for the study was obtained from Hitit University Ethics Committee on 05/05/2025, with decision number 2025-0100.

The authors declare that the study was conducted in accordance with research and publication ethics.

The authors state that artificial intelligence tools were employed only for the purpose of language polishing.

The authors declare that there are no financial conflicts of interest involving any institution, organization, or individual associated with this article. Additionally, there are no conflicts of interest among the authors.

The first author contributed to conceptualization, interpretation and discussion of the results and drafting of the manuscript; the second author contributed to the literature review, data analysis and writing of the manuscript; the third author contributed to data collection and analysis.

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