

Violence Against Junior Medical Doctors, Triggers and Problems of Under-Reporting

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ABSTRACT

Background: The prevalence of workplace violence has reached about two-thirds of healthcare workers being exposed, and this problem is rising globally. It varies across different geographical regions, with different triggering factors. **Objective:** To identify the triggers of violence against healthcare workers in Iraqi health facilities. **Methods:** A sample of 1,079 Iraqi junior doctors from 18 secondary hospitals was surveyed between August 2021 and January 2022 using a semi-structured questionnaire to determine the reasons behind this problem. **Results:** The main triggers reported by the respondents were a shortage of medicines (16.9%), aggressive attitudes of patients' relatives (15.4%), patient death (10.4%), and workload (7.8%). Other factors included poor hospital security and inadequate protective measures. An important issue raised was the high proportion of underreporting violent incidents, with reasons including feelings of shame, the perception that such attacks are part of the usual daily routine, and a belief that reporting will not improve their work environment. Some respondents also felt that reporting would result in their blame or punishment. **Conclusion:** Shortages of supplies and poor healthcare services play a major role in provoking violence. As a future course of action, improving healthcare quality, staff training, the implementation of strict legislation, and the establishment of guidelines to encourage reporting could help reduce violence in healthcare settings.

Keywords: Health Care Workers; Junior Doctors; Triggers; Violence

INTRODUCTION

It has been estimated that Healthcare Workers (HCWs), especially nursing staff, are at the highest risk of violence, as they are four times more likely to be injured at their workplace compared to other professions. This may be due to the fact that they often deal with individuals in stressful conditions (Reddy *et al.*, 2019). Workplace Violence (WPV) is defined by the International Labour Organisation (ILO) as "any action, incident, or behaviour that departs from reasonable conduct in which a person is threatened, harmed, or injured in the course of, or as a direct result of, his or her work" ("International Labour Organisation", 2003). The World Medical Association (2020) declared violence against healthcare personnel to be at an emergency level, severely undermining the foundations of health systems and critically affecting patient care. This concern is also emphasised in the 73rd World Health Assembly's agenda on the COVID-19 pandemic response and in the World Health Organisation's guidelines on preventing violence against health workers (WHO, 2021).

However, most published studies focus on the prevalence of the problem and overlook the fundamental causes behind it. The prevalence of WPV by patients and their companions against HCWs is high, especially in Asian and North American countries, particularly in emergency settings, and among nurses and physicians (Eshah *et al.*, 2024). The global prevalence exceeds 69%, though it varies greatly depending on the country, occupation/speciality, study location, practice settings, work schedules, and definitions of violence (Liu *et al.*, 2019; Pai *et al.*, 2024).

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A fundamental problem in accurately estimating the prevalence of WPV is the underreporting of incidents. Reporting is key to addressing violence, as it reveals when, where, and how incidents occur. Some studies have shown that 60% of violence is not reported (Larkin, 2021). This issue is further exacerbated in conflict zones such as Afghanistan, Palestine, Syria, Yemen, Libya, and Iraq (Haar *et al.*, 2018; Omar, 2020; Yousuf *et al.*, 2021). The problem worsened during the COVID-19 pandemic (Abed, Abdul-Hassan & Abdulwahid, 2021; Bou-Karroum *et al.*, 2018; Elnakib *et al.*, 2021; Lafta *et al.*, 2021; Rashed, 2014; Rodríguez-Bolaños *et al.*, 2020).

Positioned on the front line, nurses engage continuously with patients and families, placing them in a pivotal role to manage expectations, provide psychosocial support, and defuse tensions before junior physicians' brief, high-stakes encounters. When nursing teams are overburdened, under-resourced, or insufficiently trained in conflict resolution, this critical communicative interface deteriorates, leaving junior doctors exposed to unmediated family anger, which heightens the risk of escalation to violence (Alnofaiey *et al.*, 2022; Torabi *et al.*, 2025).

The common reasons for violence include patients' and their companions' dissatisfaction, miscommunication, long working hours, and a poor work environment. Additionally, weak administration, infrastructural issues—especially differences in services between private and public hospitals—and hostile media are among the triggering factors (Kumari *et al.*, 2020; Li *et al.*, 2020; Liu *et al.*, 2019; Reddy *et al.*, 2019). While modern medical care is reaching advanced levels, a negative public perception of nurses and doctors is leading to an increase in litigation. A review study from Peshawar, Pakistan, reported the predominant factors for WPV to be communication failure (71%), unrealistic expectations (61%), management failure (55%), and human error (51%) (Khan *et al.*, 2021; Koukia, 2013). Traditionally, in most eastern communities, medical professionals have been treated with respect in the past, but, with the recent economic recession, financially based violence is greatly increasing.

In Iraq, the most probable reported reasons include those related to the perpetrators, such as lack of education, recklessness, ignorance, nervousness, dissatisfaction, bad behaviour, and the patient's death. On the other hand, some mentioned reasons that are related to the HCWs or the health system, such as doctors' dereliction, carelessness, inexperienced doctors, and inadequate nursing services. In addition, the absence of strict laws for the punishment of perpetrators represents a commonly encountered factor (Al-Shimari, Lafta & Hagopian, 2024; Lafta *et al.*, 2025). This study aimed to investigate the triggers of violence against healthcare workers among a sample of junior medical doctors from some Iraqi health facilities.

METHODOLOGY

Study Design and Setting

This cross-sectional study was conducted between August 2021 and January 2022 in 18 secondary hospitals located in the Baghdad (capital) and Karbala (southern Iraq) governorates. The selected hospitals included 14 from Baghdad (out of 22) and 4 from Karbala (out of 8), chosen through simple random sampling.

Inclusion Criteria

The study included all junior doctors (house officers, senior house officers, and registrars) who were available at the time of the study and willing to participate. These doctors were required to have direct patient contact during their daily work, which made them more likely to encounter violent attacks in their professional environment.

Exclusion Criteria

Senior specialised doctors who had limited patient contact were excluded from the study, as their experiences may not have been relevant to the research on violent incidents in patient care.

Data Collection

Data were collected using a semi-structured, self-administered questionnaire consisting of both closed-ended and open-ended questions (Al-Shaban, Al-Otaibi & Alqahtani, 2021; Deniz & Yüksel, 2020; Kibunja *et al.*, 2021; Viottini *et al.*, 2020). The questionnaire was distributed anonymously to the participants, ensuring

confidentiality. The participants were instructed to report the most probable triggers of violent attacks against them, based on their prior experiences.

Data Analysis

The data were analysed using the Statistical Package for Social Sciences (SPSS) version 26. Descriptive statistics, including means, percentages, and standard deviations, were used to summarise continuous variables. The chi-square test was applied to examine associations, with a significance level set at a cut-off point of ≤ 0.05 .

Ethical Consideration

The research obtained ethical exemption from the Ministry of Higher Education and Scientific Research University of Warith Al-Anbiyaa College, Iraq of Nursing Ethical Approval Committee, with reference number 7 on 1st January 2021.

RESULTS

The questionnaire was distributed to 1100 junior doctors and completed by 1079 respondents, giving a response rate of 98%. The mean age of the participants was 30.0 ± 5.72 years with an almost equal sex distribution (Table 1).

Table 1: Demographic Characteristics of the Sample-Iraqi Junior Doctors (n=1079)

Variable	Group	Frequency	Percentage
Age (years)	Mean $\pm$ SD	30.0	5.72
Gender	Males	512	47.5
	Females	567	52.5
Age group (years)	< 30	548	51.80
	30-39	432	40.83
	40-49	61	5.77
	50 +	17	1.60
Marital state	Single	522	48.47
	Married	533	49.49
	Divorced/Widow	22	2.04
Residence	Baghdad	760	78.84
	Karbala	123	12.76
	Others	81	8.40
Type of job	House officers	231	21.7
	Senior house officers	464	43.6
	Registrars	370	34.7
Experience (years)	1-4	437	42.6
	4-9	466	45.4
	10+	123	12
Total		1079	100

About three quarters of the sampled junior medical doctors (80.0%) reported being exposed to violence during their work, with the mean time of exposure being 4.07 ± 6.584 . Males and females experienced almost equal rates of exposure to violence. Junior doctors with experience less than five years showed the highest rate of exposure (78.1-81.3%), and the difference was highly significant when compared to those with longer experience (10 years and more). Single and divorced doctors reported higher rates of exposure in comparison to their married colleagues. Verbal violence formed more than four fifths (80%) of the violent attacks, while only 8% were exposed to physical violence (Figure 1). Some determinants showed no significant impact, such as gender, residence and job category.

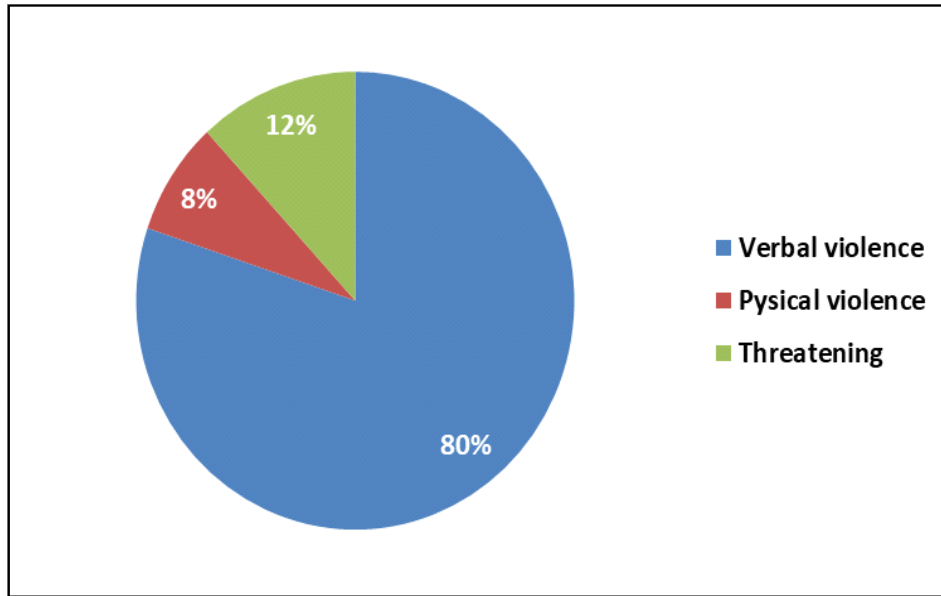


Figure 1: Type of Violence Among Iraqi Junior Doctors (n=1079)

With respect to the reasons behind violent incidents; the participants attributed it to shortage of medicines or services (16.9%) aggressive attitude of the patient's relatives (15.4%), patient death (10.4%), workload (7.8%) and unknown reasons (11.0%). In addition, misunderstanding, unmet patient expectation, and clients' characteristics such as low education, low ethics, hysterical/addict patients, and trouble making patients, were implicated as reasons related to the persons. Other factors included poor hospital security and poor protective measures (Figure 2).

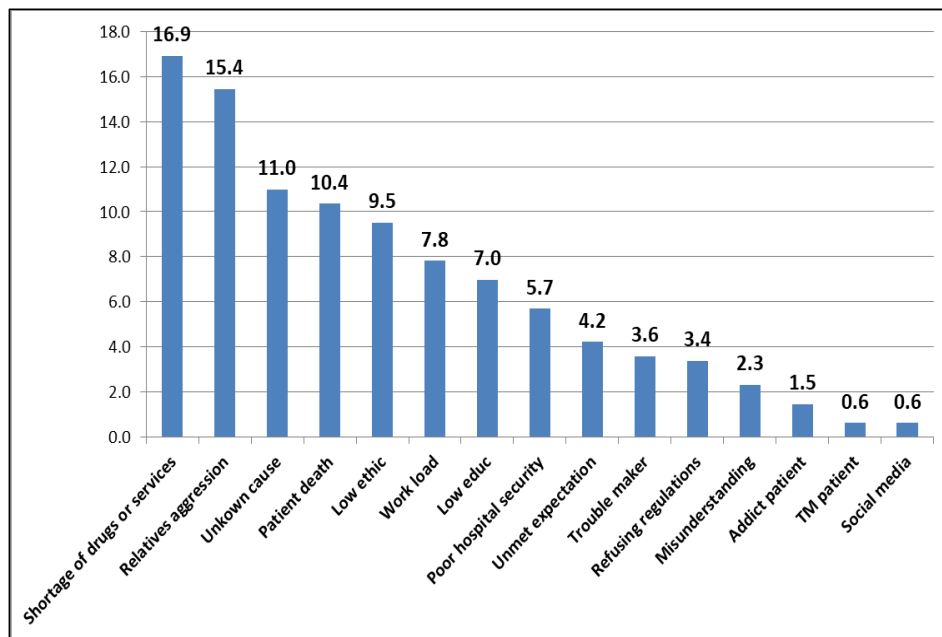


Figure 2: Triggers of Violence Among Iraqi Junior Doctors (n=473)

In addition, the results showed that reporting violent incidents was performed by only one quarter of the participants (223, 27.4%), with highly significant differences for both gender and age groups. Males and older age groups showed higher willingness to report violent attacks (34.1% vs. 21.4%, $p < 0.001$ in favour of males,

and 31.9% vs. 23.5%, $p=0.008$ in favour of older age groups). More in-depth analysis of the reasons behind not reporting violent incidents showed that 63.1% of the participants thought that “reporting is useless”, 6.8% think that “the incident was not important to report”, 11.5% did not report because reporting is “a time-consuming procedure”, 5.8% were feeling ashamed, and 1.5% were afraid of the consequences (perpetrators' revenge).

Further questions that explored the aftermath of violent incidents indicated a high prevalence of unsupportive measures of the local authorities following violent attacks. Significantly higher intentions to change the workplace, leave medical practice, or even leave the country were found among those with frequent exposure to WPV in comparison to those not exposed (Table 2).

Table 2: Association of last 3 Years Exposure to Violence with Victims' Perspectives

Variable	Group	Last 3-year exposure		p-value
		Exposed	Not exposed	
Thinking of changing workplace	Yes	239 (87.9%)	33 (69.5%)	<0.001
Thinking of changing job	Yes	233 (84.4%)	43 (70.7%)	<0.001
Thinking of leaving the country	Yes	441 (84.5%)	81 (63.3%)	<0.001
Family members left Iraq due to violence	Yes	308 (81.1%)	72 (69.7%)	<0.001
Know colleagues left Iraq due to violence	Yes	630 (79.4%)	163 (54.8%)	<0.001
Witnessed workplace violence	Yes	653 (77.7%)	187 (55.6%)	<0.001
Violence negatively affects work	Yes	60 (75.0%)	20 (77.9%)	<0.001
Health facility supports HCWs against violence	Yes	179 (74.0%)	63 (74.8%)	0.804
Local authorities (health, justice or police) are supporting you	Yes	142 (28.3%)	103 (21.3%)	0.01
Feel safe at work	Yes	106 (59.9%)	71 (77.1%)	<0.001
Future perspectives	Looks better	72 (9.7%)	39 (15.6%)	<0.001
	Stay the same	377 (50.7%)	88 (39.7%)	
	Will get worse	295 (35.2%)	123 (49.2%)	

Note: Degree of freedom (df) = 1

Suggestions for preventive measures mentioned by the participants (not tabulated) emphasised the importance of implementing laws (17.34%), educating the public (6.99%), punishing perpetrators (6.43%), limiting the number of patients' companions in the EDs (4.75%), and adopting measures to counter the negative role of social media in provoking WPV (4.06%).

DISCUSSION

Delivering healthcare is often a stressful job, as it typically involves working with people who are experiencing distressing conditions and suboptimal cognition, emotions, or arousal. For these reasons, aggression has been considered a usual, expected, and accepted practice. Some healthcare workers, especially nurses, perceive WPV as an inevitable part of their daily routine in healthcare work (Lafta *et al.*, 2025). People working in healthcare are at high risk of experiencing workplace aggression, second only to those working in protection and security services (Geoffrion *et al.*, 2020). Identifying the triggers of WPV opens the door for developing steps and procedures to address this issue. A recent qualitative study in China found that understaffing, lack of supplies, and insufficient care services were the main causes of increased violent attacks during the COVID-19 pandemic (Yin *et al.*, 2024). In the USA, a focus group discussion summarized the triggers of WPV as environmental or institutional causes, such as workload concerns that increase stress, safety deficits in the physical environment, and a non-responsive system that amplifies healthcare workers' vulnerability to abuse at work. Additionally, some cultural factors include the absence of consequences for low-level aggression (Purcell *et al.*, 2017).

The triggers of WPV varied in different geographical areas; they include communication failure, lack of medicines and equipment, shortage of HCWs, long waiting time, perceived sub-standard care, aggression following patients' deaths or unexpected outcomes, and a general lack of awareness and education of the society (Al-Mousawi & Lafta, 2024; ALBashtawy & Aljezawi, 2016; Khan *et al.*, 2021; Shaikh *et al.*, 2020; Viottini *et*

et al., 2020; Yenealem *et al.*, 2019; Yin *et al.*, 2024). The triggers reported by a study in Saudi Arabia were lack of education (56%), long waiting time (56%), culture and personality (55%), staff shortage (52%), overcrowding (48%), workload (42%), and lack of security (41%) (Alsalem *et al.*, 2018).

During the COVID-19 pandemic, other triggers were added, such as fear, panic, misinformation about the pandemic and inability to visit critically ill relatives (Alsuliman, Mouki & Mohamad, 2021; Arafa *et al.*, 2022; Cai *et al.*, 2021; Dopelt *et al.*, 2022; Gupta & Sahoo, 2020; Kumar & Nayar, 2021; Lafta *et al.*, 2021; Mello, Greene & Sharfstein, 2020; Yin *et al.*, 2024). A survey in China pointed out a group of triggers during the pandemic, such as strong relationship-orientated violence, mismatched healthcare resources and services mismatched and violence caused by ineffective patient-physician communication, while a review of violent incidents from lower-middle-income countries reported additional contributors to the already existing psychological distress caused by COVID-19, such as working extra hours, inadequate Personal Protective Equipment (PPE), a shortage of medical equipment like ventilators and the continuous fear of the high risk of getting infected and spreading it to their families (Yin *et al.*, 2024; Zhao *et al.*, 2015). Many tragic news of attacks against nurses during the epidemics obligated the WHO and many governments to call for additional support for the ‘white army’ (Wirth *et al.*, 2021; Yin *et al.*, 2024).

It was revealed by the present study that the main reported reasons for WPV were lack of medicines, poor services and dissatisfaction, relatives’ aggression, patients’ death, workload and low people awareness. Exploring these reasons could put forward the guidelines for future planning to improve the health care system in Iraq. Public education is a vital task that should be conducted by the full participation of the community as a whole, with health professionals being the guide to light the fuse and provoke the essential steps in controlling WPV. The findings of this study partially reflected the gap between the expected quality of care by the patients and the health care services they actually received. The dissatisfaction (including dissatisfaction with the treatment outcomes, staff attitudes, facilities, and cost) was one of the reported reasons. Given these results, improving the patient’s satisfaction with services and care could be one of the promising venues to prevent or, at least, de-escalate WPV against HCWs (Cai *et al.*, 2019; Hargreaves & Wax, 2024).

Another attitude that might exacerbate WPV is under-reporting of violent incidents, which results in underestimation of the true extent of the problem on the one hand and encourages the offender to commit more violence on the other hand. Poor reporting or under-reporting seen in the present study was a widely noticed phenomenon that was also reported in several previously published studies in the regional countries (ALBashtawy & Aljezawi, 2016; Alsmael, Gorab & AlQahtani, 2020; Emam *et al.*, 2018; Hamdan & Abu Hamra, 2015; Özdamar Ünal, Işcan & Ünal, 2022) and internationally (Abdellah & Salama, 2017; Al-Turki, Afify & AlAteeq, 2016; Bhatti, 2020; Liu *et al.*, 2019; Sisawo, Ouédraogo & Huang, 2017).

About two-thirds of the junior medical doctors in this study believed that "it is useless to report, as no action would be taken." Others were afraid of the consequences, such as being blamed by hospital management, facing potential retaliation from offenders or their relatives, or feeling ashamed to report. Other studies have noted that the reasons for underreporting range from healthcare workers believing that WPV is a "normal, routinely expected behavior by clients" to workers becoming disillusioned, feeling that reporting offers no benefits. Additionally, some were afraid of the consequences of reporting (Emam *et al.*, 2018; Özdamar Ünal, Işcan & Ünal, 2022). Healthcare managers who are committed to ensuring safe working environments may achieve this by adopting incident-reporting procedures that protect vulnerable groups from harm and ensure strong managerial support. Liu and colleagues concluded that the main reasons for underreporting include time-consuming reporting procedures, inadequate supervisory support, fear of reprisal or being blamed by hospital administration, and the belief that reporting violent incidents will not lead to positive change (Arnetz *et al.*, 2015; Hemati-Esmaili *et al.*, 2018; Liu *et al.*, 2019).

Limitation

As in other cross-sectional studies, the main limitation was the recall bias, however, dilution of the effect of this bias; was done through enquiring about the respondents’ opinions from their experience during the last three years.

CONCLUSION

The findings of the present study indicated that poor healthcare services and a shortage of supplies play a major role in provoking violence. Additionally, aggressive attitudes from patients' relatives, patient death, and heavy workloads also contribute to the rising incidents of violence against healthcare workers. As a future scope, improving healthcare services and staff training, in addition to the application of strict legislation and modelling guidelines to encourage reporting, could help lessen violence in healthcare premises. Moreover, enhancing hospital security and implementing protective measures will be crucial in mitigating such incidents. A comprehensive approach involving healthcare policy reform, better resource allocation, and fostering a supportive environment for reporting violent occurrences could lead to a safer and more effective healthcare setting for both workers and patients.

Conflict of Interest

There is no conflict of interest to report in this study.

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