ORIGINAL RESEARCH

Bagcilar Med Bull
DOI: 10.4274/BMB.galenos.2025.63308

Legal Dimensions of Violence in Healthcare: An Evaluation Based on White Code Data

Sağlık Hizmetlerinde Şiddetin Hukuki Boyutları: Beyaz Kod Verilerine Dayalı Bir Değerlendirme

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Abstract

Objective: This study aims to examine violence against healthcare workers from a legal perspective by analyzing the types of violence, the characteristics of perpetrators, and the service areas where incidents occur, as well as by evaluating the operational mechanisms within the current legislative framework.

Method: A total of 427 white code reports filed at University of Health Sciences Turkey, Prof. Dr. Cemil Taşcıoğlu City Hospital were retrospectively analyzed. Data were examined in terms of service units, types of violence, victim and perpetrator profiles, and access to legal assistance following reported incidents.

Results: According to the findings, 56.67% of violent incidents occurred in emergency departments. Verbal violence constituted 85.48% of cases, while physical violence accounted for 4.92%. The majority of perpetrators were patients' relatives. Among the victims, 50.03% were physicians and 35.14% were nurses or other healthcare professionals. Only 59.71% of healthcare workers who filed a white code report received legal assistance.

Conclusion: The relatively low rate of legal support utilization suggests that healthcare workers may refrain from engaging in legal or bureaucratic procedures due to limited awareness or administrative burden. Communication-related factors, particularly inappropriate language and terminology used by patients or their relatives, were identified as major contributors to violent incidents. The study concludes that strengthening the effectiveness of legal regulations, implementing public awareness initiatives, and introducing structural reforms aimed at ensuring safe working environments are essential for combating violence in the healthcare sector.

Keywords: Health law, healthcare professionals' rights, violence in healthcare, white code, workplace violence

Öz

Amaç: Bu çalışma, sağlık çalışanlarına yönelik şiddet olgusunu hukuki açıdan incelemeyi; şiddet türlerini, failleri ve olayların meydana geldiği hizmet alanlarını analiz etmeyi ve mevcut yasal çerçevede işleyiş mekanizmalarını değerlendirmeyi amaçlamaktadır.

Yöntem: Sağlık Bilimleri Üniversitesi, Prof. Dr. Cemil Taşcıoğlu Şehir Hastanesi'nde açılan toplam 427 beyaz kod bildirimi retrospektif olarak incelenmiştir. Veriler; olayların gerçekleştiği birimler, şiddet türleri, mağdur ve fail profilleri ile hukuki destek alma durumları açısından değerlendirilmiştir.

Bulgular: Bulgulara göre, şiddet olaylarının %56,67'si acil servislerde gerçekleşmiştir. Olayların %85,48'i sözlü, %4,92'si ise fiziksel şiddet niteliğindedir. Faillerin çoğunluğunu hasta yakınları oluştururken, mağdurların %50,03'ü hekim, %35,14'ü ise hemşire veya diğer sağlık çalışanlarıdır. Beyaz kod bildirimi yapanların yalnızca %59,71'inin hukuki destek aldığı tespit edilmiştir.

Sonuç: Hukuki destek alma oranının görece düşük olması, sağlık çalışanlarının farkındalık eksikliği veya idari ve bürokratik yükler nedeniyle yasal süreçlere katılmaktan kaçınabileceğini düşündürmektedir. İletişime bağlı faktörlerin, özellikle hastalar veya yakınları tarafından kullanılan uygunsuz dil ve terminolojinin, şiddetin temel nedenleri arasında yer aldığı belirlenmiştir. Bu bağlamda, yasal düzenlemelerin etkinliğinin artırılması, kamuoyu farkındalığını güçlendirecek stratejilerin uygulanması ve sağlık çalışanları için güvenli çalışma ortamlarını hedefleyen yapısal reformların hayata geçirilmesi büyük önem taşımaktadır.

Anahtar kelimeler: Beyaz kod, işyeri şiddeti, sağlık çalışanlarının hakları, sağlık hizmetlerinde şiddet, sağlık hukuku

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Received: 04.11.2025 **Accepted:** 23.12.2025 **Epub:** 09.01.2026

Cite this article as: Eray E, Sert G. Legal dimensions of violence in healthcare: an evaluation based on white code dat. Bagcilar Med Bull. [Epub Ahead of Print]

Introduction

Violence, which has permeated every aspect of human life since ancient times, continues to manifest at both individual and societal levels. The World Health Organization (WHO) defines violence as "the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (1). Based on the nature of actions and their interaction with individual characteristics, interpersonal relationships, and socio-cultural factors, WHO categorizes violence into three groups: Self-directed violence, interpersonal violence, and collective violence. Based on the form of violence applied, five major types are identified: Physical, sexual, psychological, economic, and cyber. Among these, physical violence is the most common and the most visible form (2).

Violence against healthcare professionals holds a particularly significant place within this framework. In healthcare settings, violence not only causes individual victimization but also directly disrupts the functioning of health systems, undermines patient safety, and reduces the overall quality of healthcare services. The World Medical Association has described violence against healthcare workers as "a global emergency that undermines the foundations of healthcare systems and severely compromises patient health" (3). According to the literature, between 8% and 38% of healthcare professionals worldwide experience violence at least once during their careers (4). In Turkey, however, this rate is significantly higher, ranging from 49% to 91% (5). Most of the violence against healthcare professionals is perpetrated by patients or their relatives (6). Furthermore, studies indicate that verbal threats and psychological violence are reported more frequently than physical assaults (7). Studies have reported that most incidents of violence occur in psychiatric units and emergency departments, with nurses and physicians the most frequently targeted groups (8,9).

The causes of violence in healthcare settings are multifaceted and complex (3). One of the primary contributing factors is the inherently high-stress environment of healthcare services (10). Additional causes include poor communication between healthcare providers and patients, elevated stress levels, deficiencies in the judicial system, insufficient security measures, and inadequate enforcement of regulations designed to protect healthcare workers (11).

In Turkey, several initiatives have been undertaken in recent years to address healthcare settings, both within academic and bureaucratic circles. Various preventive and intervention strategies have been proposed to combat this problem. Accordingly, amendments have been introduced to the Basic Law on Health Services, the Turkish Penal Code, and the Code of Criminal Procedure. Furthermore, specialized units within the Ministry of Health (MoH) have been established to tackle violence, alongside enhanced security protocols, the implementation of emergency code systems, and the provision of legal support for victims of violence. The MoH has also created a reporting and recording system for incidents of violence against healthcare personnel. To facilitate this process, a centralized "White Code" call center was established, accessible via telephone or the internet. This system allows healthcare professionals to report and monitor incidents of violence, ensuring that such cases are addressed more promptly and effectively. The procedures for filing a White Code report have been outlined in the Regulation on Legal Assistance and in the White Code Implementation. The White Code program operates 24/7 and is supported by the national hotline "113 White Code Call Center," which provides healthcare workers with continuous access to reporting and legal assistance (12). This constant access enables healthcare professionals to promptly report incidents of violence and receive necessary support, thereby enhancing their safety. Moreover, it plays a critical role in monitoring episodes of violence against healthcare workers and ensuring timely intervention when required.

Despite preventive policies, daily occurrences of violence in healthcare settings persist. Over time, the concepts of "health" and "violence" have increasingly become intertwined in society's collective perception, and as a result, violence in healthcare has persisted as a pressing social problem. This study aims to examine the legal dimensions of violence in healthcare by analysing White Code reports and assessing the functioning and accessibility of legal support mechanisms within the existing legislative framework. Furthermore, the study seeks to assess the extent to which the current legal framework protects healthcare professionals and to offer recommendations for addressing the legal and structural challenges encountered in combating violence in healthcare.

Materials and Methods

In this study, a total of 427 "White Code" incidents that occurred between January 2023 and August 2024 at

University of Health Sciences Turkey, Prof. Dr. Cemil Taşcıoğlu City Hospital in İstanbul were examined. For the retrospective analysis of these incidents, ethical approval was obtained from the Ethics Committee of the Faculty of Medicine, Marmara University (approval no: 09.2024.1380, dated: 19 June 2025). This study does not require patient informed consent.

Under the White Code system, incidents of violence against healthcare professionals by patients or their relatives—cases for which both judicial and administrative procedures had been initiated—were analyzed. With the permission of the hospital administration, official documents pertaining to these events, including incident reports prepared by healthcare personnel, security officers, and patient rights representatives, as well as event notification forms and formal complaints, were reviewed.

Information on substance abuse, psychiatric illness, or prior traumatic experiences was obtained exclusively from official incident reports, security records, and statements documented at the time of the event. No clinical psychiatric assessment was performed as part of this study.

Cases in which essential information about either the healthcare worker who was subjected to violence or the perpetrator(s) was incomplete were excluded from the dataset. The data obtained were recorded in Microsoft Excel for the variables specified below. The variables extracted from the documents included: Date of incident, age range, gender, perpetrator of violence, type of violence, title of the healthcare professional exposed to violence, department where the incident occurred, causes of violence, and communication-related factors between the healthcare provider and the patient. For descriptive analyses, the age of individuals perpetrating violence was reclassified into four groups (18-29, 30-44, 45-64, and ≥65 years) in line with commonly used epidemiological age groupings to facilitate clearer interpretation and consistency across age-based comparisons.

The determination of the causes of violence and communication-related factors was based on a structured interpretative review of official White Code documentation. This process involved the systematic examination of incident reports prepared by healthcare professionals, security personnel, and patient rights representatives; formal event notification forms and written statements recorded at the time of the incident.

Communication-related causes were categorized according to predefined criteria derived from recurrent patterns identified in the reports. “Insufficient information” was recorded when the documentation explicitly indicated that patients or their relatives had not been adequately informed about diagnostic procedures, treatment processes, waiting times, or administrative regulations.

The communication style of the healthcare professional was coded as a contributing factor only when the reports explicitly referred to behaviors such as abrupt, dismissive, or non-empathic language; failure to provide explanations in an understandable manner; or a perceived lack of active listening during patient-provider interactions.

To ensure consistency and minimize subjective bias, classifications were based solely on documented statements and not inferred beyond information explicitly recorded in official documents.

Statistical Analysis

For statistical analysis, the dataset was transferred to SPSS version 22.0 (Statistical Package for the Social Sciences). Categorical variables were presented as frequencies (number and percentage), whereas were summarized using descriptive statistics (mean, standard deviation, median, interquartile range). In addition to descriptive statistics, bivariate analyses were conducted to explore potential associations between selected variables. The chi-square (χ^2) test was applied to examine the relationship between receiving legal assistance and (i) type of violence, (ii) professional title of the healthcare worker, and (iii) gender of the perpetrator. A p-value of <0.05 was considered statistically significant.

Results

Among the 427 White Code reports examined in this study, 59.71% (n=255) received legal assistance, while 40.29% (n=172) did not receive legal assistance. This finding suggests that healthcare professionals may have reservations about initiating legal proceedings. No statistically significant association was observed between the type of violence and the likelihood of receiving legal assistance (χ^2=1.84, df=2, p=0.399). In contrast, a statistically significant association was observed between healthcare workers’ professional title and receipt of legal assistance (χ^2=6.72, df=1, p=0.010), indicating that physicians were more likely than other healthcare professionals to receive legal support.

To further elucidate the factors associated with access to legal assistance following incidents of violence, chi-square analyses were conducted to examine the relationships between this access and selected violence-related and

professional characteristics of healthcare workers. The results of these analyses are presented in Table 1.

As shown in Table 1, no statistically significant association was identified between the type of violence experienced and the likelihood of receiving legal assistance, indicating that access to legal support did not differ according to whether the incident involved verbal, physical, or other forms of violence.

In contrast, a statistically significant relationship was observed between the professional title of the healthcare worker and the receipt of legal assistance. Physicians were more likely to benefit from legal support than other healthcare professionals, suggesting that professional role may be decisive in navigating or accessing post-incident legal mechanisms.

Additionally, the analysis revealed no significant association between perpetrator gender and provision of legal assistance, indicating that legal follow-up processes were not influenced by this factor. Overall, these findings underscore the prominence of occupational status, rather than incident characteristics, in determining access to legal support within the existing White Code framework.

Demographic Characteristics of Perpetrators of Violence

Among perpetrators, 60% were men and 40% were women. When age was reclassified into standardized epidemiological categories (18-29, 30-44, 45-64, and ≥65 years), the highest proportion of perpetrators was observed in the ≥65-year age group, whereas the lowest proportion was observed in the 30-44-year age group (Figure 1).

The age distribution suggests that violent incidents against healthcare workers are predominantly perpetrated by individuals aged 30-44, who constitute the largest proportion of perpetrators. This pattern indicates that violence is most frequently associated with the economically and socially active population, who are more likely to engage directly with healthcare services, either as patients or as relatives of patients.

The substantial proportion observed in the 18-29 age group highlights the role of younger adults, potentially reflecting a reduced capacity for emotional regulation and heightened reactivity in stressful healthcare environments.

Although the proportion decreases in older age groups, the non-negligible contribution of individuals aged 45-64 underscores that violent behavior in healthcare settings is not confined to younger cohorts. In contrast, a relatively small proportion observed among individuals aged 65 years or older suggests a declining tendency toward aggressive behavior with advancing age.

Overall, the age-related pattern indicates that violence in healthcare is primarily driven by working-age adults, emphasizing the need for targeted communication and de-escalation strategies tailored to this demographic.

Violence Types and Perpetrator Profiles

Among the cases, verbal violence accounted for the largest proportion (85.48%). Physical violence accounts for 4.92% of incidents, while the remaining cases involve psychological abuse or threatening behaviors (Figure 2).

A breakdown of the perpetrators reveals that patients are responsible for 42.82% of the incidents, while their relatives account for 55.37%. The remaining 1.79% of violent acts are committed by other individuals.

Titles of Healthcare Workers Subject to Violence

Among victims of violence, physicians constitute the largest group, accounting for 50.03%. Non-physician healthcare

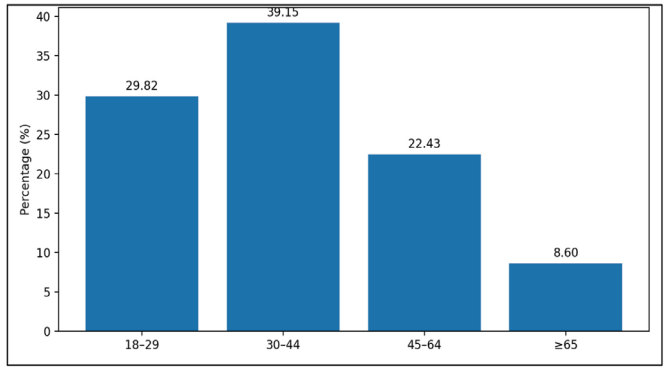

Figure 1. Distribution of individuals perpetrating violence against healthcare workers by age group (18-29, 30-44, 45-64, ≥65 years) (%)

Table 1. Association between violence-related variables and receipt of legal assistance

Variable	Chi-square (χ^2)	df	p-value
Type of violence × Legal assistance	1.84	2	0.399
Professional title × Legal assistance	6.72	1	0.010
Gender of perpetrator × Legal assistance	0.56	1	0.454

staff, such as nurses and midwives, represent 35.14% of the victims. Contract workers and administrative personnel each account for 6.98% of cases (Figure 3).

These statistics suggest that professional groups with direct patient contact are at significantly higher risk of experiencing violence.

Units Where Violence Occurs

The vast majority of violent incidents (56.67%) occur in emergency departments. This is followed by outpatient clinics (23.42%), inpatient wards and services (12.88%), imaging and examination units (5.15%), and other units (1.87%) (Figure 4).

Most incidents (98.82%) were reported to the employee safety unit. Only 1.17% were reported via the 113 White Code Call System.

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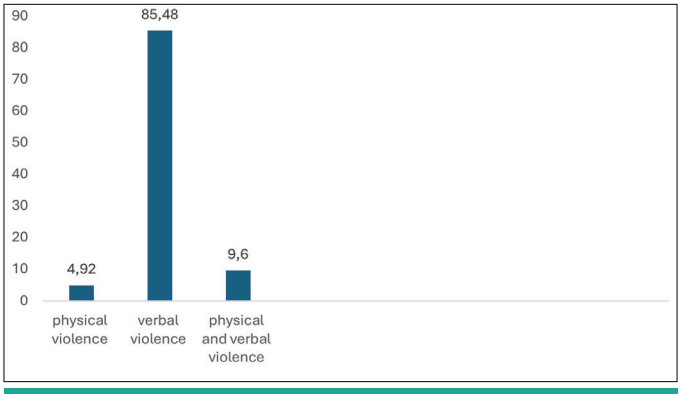

Figure 2. Distribution of violence against healthcare workers by type (%)

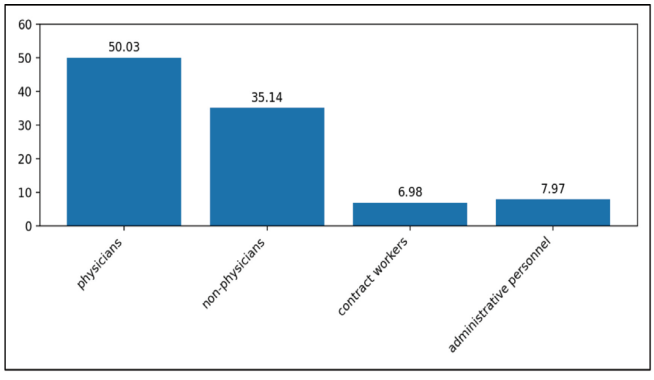

Figure 3. Distribution of healthcare workers exposed to violence by professional title (%)

Causes of Violence

The evaluation of the causes of violence revealed that some perpetrators were reported to have a history of alcohol or substance abuse (1.5%), psychiatric illness (0.5%), and past trauma (0.5%). Additionally, dissatisfaction with treatment emerged as a significant reason for the violence.

Communication-based Causes

In 95.65% of the violent incidents, the language and terminology used by the patient or their relatives were identified as contributing factors. Furthermore, insufficient information (3.04%) and the communication style of the healthcare professional (1.3%) were identified as influential. These findings suggest that communication style is a key determinant of violence in healthcare settings (Figure 5).

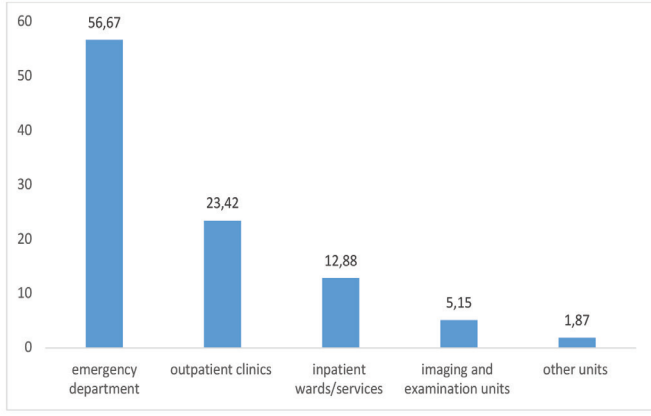

Figure 4. Units where incidents of violence occurred (%)

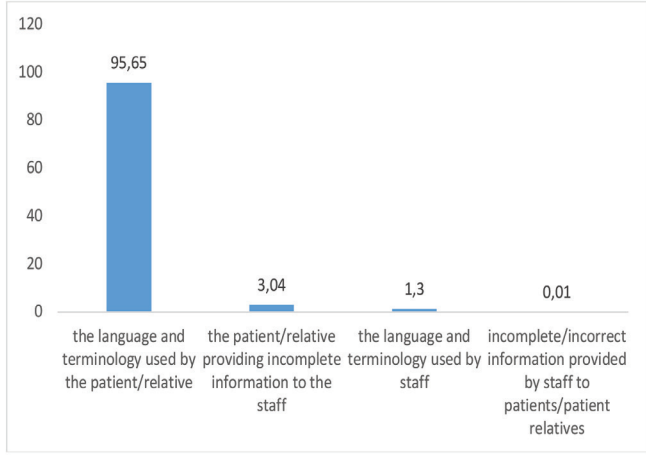

Figure 5. Reasons related to patient-healthcare provider communication (%)

Discussion

The discussion of the present findings is strictly limited to the variables documented in the White Code reports and the retrospective data presented in the results section. All interpretations were derived solely from officially recorded incident reports and legally documented information. No inferences were made regarding unmeasured social, cultural, psychological, or institutional factors beyond the scope of the available data.

Violence against healthcare workers constitutes a complex phenomenon that extends beyond isolated physical acts and reflects broader structural, legal, and communicative deficiencies within healthcare systems (12-21). Rather than representing sporadic individual behavior, violence in healthcare settings emerges from the interaction of high-stress clinical environments, institutional constraints, and inadequacies in patient-provider communication (11). The present study contributes to this discussion by examining White Code reports through a legal and operational lens, thereby offering empirical evidence on how violence manifests and how legal mechanisms function in practice.

The concentration of violent incidents observed in emergency departments in this study is consistent with prior research and can be explained by the intrinsic characteristics of these units, including overcrowding, time pressure, uncertainty about clinical outcomes, and heightened emotional stress among patients and their relatives (10,13,17,18,20). Emergency departments operate under crisis-oriented conditions, increasing the likelihood of conflict escalation, particularly when expectations for rapid diagnosis and treatment are not met. The predominance of verbal violence further supports the notion that violence in healthcare frequently originates from communicative breakdowns rather than physical aggression alone (7,13).

A notable finding of the study is that patient relatives constitute the primary group of perpetrators. This result is in line with previous studies conducted in Turkey and internationally, which indicate that companions often play a central role in violent incidents due to anxiety, fear, and frustration experienced on the patient's behalf (6,14). This dynamic underscores the need for institutional communication strategies that explicitly address patients' relatives, including structured information-sharing processes and clearly defined boundaries for interaction.

The distribution of victims by profession further reinforces the exposure risk associated with direct patient contact. Physicians and nurses, who occupy central roles in diagnosis, treatment, and clinical decision-making, were disproportionately affected, consistent with earlier findings in the literature (14,15). This pattern suggests that violence is closely linked to perceived authority and responsibility rather than to professional hierarchy alone. Importantly, the presence of violence against non-physician staff indicates that exposure is systemic rather than profession-specific, affecting the healthcare workforce as a whole.

From a legal and institutional perspective, one of the most critical findings of this study is that a substantial proportion of White Code applications did not result in legal assistance. Similar concerns regarding underutilization of legal mechanisms have been reported in previous national studies (12,13). The absence of a significant association between the type of violence and access to legal support suggests that procedural barriers or lack of awareness, rather than incident severity, may determine whether healthcare workers pursue legal pathways. In contrast, the association between professional title and legal assistance implies that institutional familiarity with legal mechanisms may influence engagement with post-incident processes.

Interpretations in this section are strictly based on communication-related expressions explicitly documented in the White Code incident reports. No assumptions were made regarding unrecorded intentions, attitudes, or broader communication patterns beyond the available data. Communication-related factors emerged as the primary triggers of violent incidents. The high prevalence of inappropriate language and hostile expressions expressed by patients or their relatives indicates that violence is often precipitated by discourse rather than by clinical outcomes alone (15,16,18,19). Although the communication style of healthcare professionals was identified less frequently, this finding should not be interpreted as diminishing the importance of professional communication skills. Instead, it suggests that violence prevention strategies must extend beyond individual-level training and address broader societal attitudes toward healthcare services.

The identification of substance use, psychiatric conditions, and prior traumatic experiences among a subset of perpetrators is consistent with earlier findings emphasizing individual risk factors for aggressive behavior (8,9). These results highlight the need for risk-sensitive institutional protocols, including early recognition of high-risk individuals and the implementation of de-escalation and security measures in vulnerable units.

Overall, the findings demonstrate that violence in healthcare cannot be effectively addressed through punitive legal measures alone (19-21). Although legal frameworks such as the White Code system are indispensable, their impact remains limited without institutional enforcement, procedural clarity, and active awareness among healthcare professionals (12). A sustainable solution requires an integrated approach that combines legal protection, organizational reform, communication strategies, and public awareness initiatives. In this respect, violence against healthcare workers should be recognized as a systemic challenge requiring coordinated action at legal, institutional, and societal levels rather than fragmented interventions.

Accordingly, the findings should be interpreted within the methodological and data-related limitations of this retrospective analysis and should not be generalized beyond the scope of the White Code reporting system.

Recommendations

This study aimed to analyze the types of violence experienced by healthcare workers, the healthcare units where such incidents occurred, the perpetrators' profiles, and the functioning of legal procedures following these incidents to evaluate the effectiveness of the current legal framework in addressing this phenomenon. The findings reveal that healthcare workers are frequently exposed to violence, particularly in emergency departments, and that most incidents are perpetrated by patients' relatives. The high incidence of violence in emergency departments is associated with overcrowding, excessive workload, time pressure, and frequent crises. Intense interactions between staff and patients (or their relatives), coupled with tension arising from waiting times, render healthcare workers in these units more vulnerable to violence.

Our results indicate that physicians account for 50.03% of victims of violence, while nurses and other healthcare workers account for 35.14%. This demonstrates that because healthcare delivery is team-based, all professionals involved are exposed to similar risks. That only 59.71% of the examined "Whide Code" applications resulted in the provision of legal support suggests that victims may refrain from completing official paperwork or visiting administrative units or courts, and that there may be issues related to awareness. Bringing acts of violence before the judiciary and holding perpetrators accountable are only possible through an effective reporting mechanism and the provision of professional legal assistance. However, the data indicate that this process does not always function effectively, and that healthcare workers are sometimes reluctant to exercise their legal rights.

Our findings demonstrate that combating violence in healthcare should not rely solely on criminal sanctions. In addition, public awareness campaigns, programs aimed at strengthening patient-healthcare worker communication, and psychosocial support mechanisms for employees need to be implemented. Furthermore, to ensure effective monitoring of violent incidents in healthcare settings, it is essential to expand the "Whide Code" system into a more comprehensive structure that systematically records each case and makes the legal process transparent and traceable. The data obtained in our study demonstrate that incidents of violence against healthcare workers pose a serious threat to the healthcare system as a whole and represent a structural problem rather than isolated incidents. Violence, particularly concentrated in emergency departments and other units, leads not only to disruptions in service delivery but also to reduced professional motivation among healthcare personnel. Studies have shown that all healthcare workers, particularly physicians and nurses, are exposed to this threat. Addressing incidents of violence requires not only punitive measures but also the adoption of preventive and protective strategies that take into account the structural problems of the healthcare system, prioritize effective communication, and promote public awareness.

Policy Implications

From a policy and hospital-management perspective, the findings of this study underline the necessity of translating legal regulations into actionable institutional practices. Hospital administrations should establish clearly defined internal protocols to ensure immediate legal guidance following White Code notifications and to actively inform healthcare workers about their legal rights and available support mechanisms. Regular in-service training programs focusing on effective communication, conflict de-escalation, and patient-relative interactions should be institutionalized, particularly in high-risk units such as emergency departments. In addition, strengthening coordination between hospital management, employee safety units, and legal departments may enhance the continuity and effectiveness of post-incident procedures. These feasible, implementable steps at the institutional level may significantly contribute to reducing violence against healthcare workers and improving the practical implementation of existing legal frameworks.

Study Limitations

A key limitation of this study is that legal processes following violent incidents were not followed through to final judicial outcomes. Therefore, the effectiveness of legislation was evaluated in terms of accessibility and procedural implementation rather than legal deterrence or conviction rates.

Conclusion

In conclusion, our study highlights both the individual and institutional dimensions of violence in healthcare, emphasizing that an effective legal framework can succeed in preventing violence only when supported by systemic reforms. In this regard, combating violence in healthcare should not be approached solely through legislative measures but rather through a holistic strategy encompassing education, ethics, communication, and public policy.

The findings of this study demonstrate that violence against healthcare workers remains a persistent and multifaceted problem, particularly in emergency departments and among professionals with direct patient contact. While legal mechanisms such as the White Code system provide an essential framework for institutional response, limitations in awareness, accessibility, and follow-through reduce their practical impact. Addressing violence in healthcare therefore requires not only legislative provisions but also effective implementation, strengthened communication strategies, and sustained institutional commitment. A violence-free healthcare environment can only be achieved through a coordinated approach that integrates legal safeguards, education, and public awareness.

Ethics

Ethics Committee Approval: Ethical approval was obtained from the Ethics Committee of the Faculty of Medicine, Marmara University (approval no: 09.2024.1380, dated: 19 June 2025).

Informed Consent: This study does not require patient informed consent.

Footnotes

Authorship Contributions

Surgical and Medical Practices: E.E., G.S., Concept: E.E., G.S., Design: E.E., G.S., Data Collection or Processing: E.E., Analysis or Interpretation: E.E., G.S., Literature Search: E.E., G.S., Writing: E.E.

Conflict of Interest: No conflict of interest was declared by the authors.

Financial Disclosure: The authors declared that this study received no financial support.

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