The Public's View of Increasing Violence toward Healthcare Staff

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Abstract

Aim: We investigated the public's view of increasing violence in the healthcare sector, their opinions on violence, the underlying causes of violence, and the possible ways of preventing violence.

Materials and Methods: This study was conducted between November 2012 and February 2013 in central Gaziantep, Turkey. We conducted a face-to-face survey with 1600 respondents who closely resembled the general structure of the population.

Results: The most common causes underlying violent behavior were failure of the healthcare staff to perform their tasks properly (15.9%) and prolonged waiting times (15%). In total, 20.3% of the respondents considered violence as a method of securing rights. The issue that disturbed the respondents most (28%) was being unable to find someone who would listen to them, whereas 13.3% believed that the doctor should be beaten or killed when a patient died.

Conclusion: A large proportion of those surveyed viewed violence toward healthcare professionals as a method of securing rights. *(JAEM 2015; 14: 19-25)*

Key words: Healthcare staff, violence, public's view, media, education

Introduction

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, 2). With a relatively higher number of staff, health centers are among some of the most common workplaces where violence occurs (3). Moreover, violence in a health center may take the form of a verbal or behavioral threat to the healthcare staff or physical or sexual assault by the patients' relatives or other individuals (4-6). According to the 2002 report of the International Labor Organization, work-related violence in the health sector accounts for 25% of all violent incidents. It has been observed that healthcare providers are victims of assault 16 times more often than those working in other sectors (6). A majority of the victims of violence are general practitioners (67.6%) and nurses (58.4%) (7), and acts of violence in the health sector are primarily observed in emergency departments (8-10). Among the factors increasing the risk of violence are 24-h non-stop service; stressed family members; prolonged waiting times (11, 12); too many examinations and tests (8); personality traits of patients (13, 14), nurses (15-17), other healthcare staff, and patients' relatives (18, 19); relatively low number of personnel to address an intensive workload; working in a very crowded environment; lack of education in addressing violence; inadequate number of security personnel; and lack of any restrictions on violence in health center regulations (5). Although society generally disapproves of acts of violence, it does not do much to alleviate the suffering of the healthcare staff exposed to acute violence and offers relatively little support (18%) for their suffering (20). Moreover, all such acts of violence against doctors are sometimes appreciated by a small segment of society (5).

A literature review shows that studies covering violence toward healthcare staff have generally been conducted with respect to healthcare staff, and only a very limited number of studies assessing the public's impression of healthcare staff are available. In light of these findings, this study evaluated the public's view of increased violence in the healthcare sector, their opinions on violence, the underlying causes of violence, and the potential actions for preventing it. In this respect, we aimed to identify the potential actions that could be taken to reduce and eliminate violence in this sector.

Materials and Methods

Purpose and significance of the study

Population and sampling

We conducted this study between November 2012 and February 2013 at the Department of Emergency Medicine, Faculty of Med-

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icine, Gaziantep University, central Gaziantep, Turkey. Approval from the Medical Ethics Committee of the Faculty of Medicine, Gaziantep University, was obtained prior to the study (ethical committee decision no: 05.07.2012/286 Date: 05.07.2012), and the ethical standards of the Helsinki Declaration were adopted.

The study included respondents aged 18-65 years, domiciled in Gaziantep, who were neither healthcare staff nor in the process of health-related education (faculty of medicine, vocational health high schools, or nursing schools). We did not record their identification details, and we informed all respondents of the study details at the beginning. We obtained voluntary written informed consent from all respondents.

We drafted a multiple-choice questionnaire form comprising 33 questions that covered society's violence toward healthcare staff, the underlying causes of violence on the part of the society, the respondents' dissatisfaction, demands, complaints related to the dissatisfaction of patients and their relatives, and whether violence is a method of securing rights. We also recorded data regarding the respondents age, gender, occupation, and level of education. A short explanation (*This questionnaire is being conducted to determine how our society perceives and interprets the recently increased acts of violence toward healthcare staff. The respondents' identification details shall not be recorded. Filling in the questionnaire form is completely voluntary. The results will be published after an analysis*) was given. In addition, the following text was added at the top of the questionnaire form for the respondents, briefly disclosing the purpose of the study and describing violence: violence in a health center may take the form of a verbal or behavioral threat to the healthcare staff or physical or sexual assault by the patients' relatives or other individuals.

Before beginning the study, we obtained the demographic characteristics (age, gender, profession, education) of the population in central Gaziantep from the Gaziantep Branch of the Turkish Statistical Institute. We used power analysis to determine the maximum and minimum number of respondents according to the sociocultural and demographical characteristics.

Inclusion criteria:

1. Residence in Gaziantep
2. Aged 18-65 years
3. Volunteering
4. Not a healthcare worker
5. Not in the process of receiving health-related education (faculty of medicine, vocational health high schools, nursing schools)
6. Clearly understands the purpose and content of the questions in the questionnaire

Exclusion criteria:

1. Not returning the questionnaire form in a timely manner
2. Questionnaire form not completed
3. Questionnaire form ruined (e.g., by scribbling)
4. Hesitation to complete the questionnaire for any reason
5. Failure to return the questionnaire
6. Respondents stating that they "did not understand or perceive" the questions in the questionnaire form.

A total of 1600 volunteer respondents met the above criteria and participated in this study.

Data-gathering Tools

We organized a one-day seminar for candidate interviewers who would make site visits to brief the participants on the purpose and significance of the study, the questionnaire developed for the study, and questionnaire management. We initially conducted a sample survey with 30 respondents to identify any shortcomings of the questionnaire. We restructured any questions that the respondents found difficult to comprehend, so that they became understandable, and reorganized the questionnaire form.

We escorted the interviewers to the designated areas. Care was taken to ensure that the questionnaire forms were not handed out to individuals who were neighbors, worked in the same workplace, or met frequently on a daily basis. We conducted the study via site visiting (workplace, home, or another place) and interviewing. During the interview, the respondents were handed a written form containing the questions and the interviewer asked them to complete the form by answering these questions. In the case of illiterate respondents, the interviewers completed the questionnaire forms on the basis of the answers received, without manipulating the answers. We collected the questionnaire forms from the respondents no later than within a week of delivering them. We then excluded all those forms that met the above-mentioned exclusion criteria and analyzed the remaining forms.

Statistical analysis

We used Statistical Package for Social Sciences (SPSS Inc., Chicago, IL, USA) 17.0 to analyze the collected data, employing mean and percentage distributions as descriptive statistics. We used cross tables to compare non-quantitative data and tested the results at a significance level of 95%. We compared intergroup relationships using chi-square and Yates's corrected chi-square tests and considered $p<0.05$ as statistically significant.

Results

A total of 54.9% of the respondents were male and 45.1% were female. The mean age of the respondents was 36.4 years (age range: 16-72 years). Of the respondents, 49.9% (n=798) had a healthcare worker among their close relatives; 17.6% (n=282) had a history of chronic disease; 31.3% (n=5001) smoked; 23.3% (n=373) used alcohol; 1.8% (n=29) used drugs; and 0.4% (n=6) had a habit of gambling. A total of 5.3% (n=85) of the respondents had previously received prison sentences for committing acts of violence; 4.4% (n=70) had been indicted and acquitted of a violent crime; 54% (n=864) declared that they were unaware of the penalties they would face for committing violent acts; 33.8% (n=541) were aware of the penalties; and 12.2% (n=195) stated that they did not need to know the penalty they would face. Furthermore, 35.1% (n=562) of the respondents had engaged in violence toward healthcare staff as the relative of a patient, whereas 17.6% (n=262) had performed violent acts while they were patients themselves. Only 1.1% (n=18) of the respondents had apologized, even when most had considered themselves to be at fault in the quarrel with healthcare staff. The respondents were most violent toward doctors (28.2%), nurses (17.8%), and caregivers (4.2%). They displayed violent behavior at public hospitals (30.7%), university hospitals (13.2%), private hospitals, and other health centers (such as mothers' health clinics and medical centers; n=6). Of the respondents, 44.3% (n=708) stated that they had engaged in verbal

abuse, 3.9% (n=62) had threatened, and 2.3% (n=36) had engaged in beating. Whereas 47.3% of the respondents had not engaged in any violence, 38.5% had been violent on at least 1 occasion, and 2% had been violent on more than 5 occasions. Only 2.8% (n=45) of the healthcare staff who had been subjected to violence had filed complaints against their attackers (Table 1).

A total of 16.6% (n=265) of the respondents declared that they had been subjected to verbal abuse (15.8%) or physical (0.6%), sexual (n=2), or psychological (n=1) violence by healthcare staff, primarily doctors (8.4%) and nurses (6.3%). Furthermore, no feedback was received in 83.5% of the complaints filed with the hospital administration concerning the healthcare staff.

The rate of respondents who accepted violence as a method of claiming their rights was 20.3%. Although a great majority of respondents who thought that they had been victimized chose the "complaints mechanism" to claim their rights, 9.6% stated that they had attempted to obtain their rights directly from the healthcare staff. According to the respondents, the 3 most common underlying causes of violence were failure of the healthcare staff to perform their jobs properly (15.9%), prolonged waiting times (15%), and provocative remarks made by the media and politicians (23.3%). The 3 issues that most frequently disturbed and upset the respondents at health centers were being unable to find someone who would listen to them (28%), failure to be sufficiently informed with respect to the patient they were accompanying (21.9%), and very crowded hospital settings (11.6%). In most cases, patients and their relatives found it difficult to find doctors (42.3%) who would listen to them (Table 2).

Furthermore, 13.3% of the respondents partly or completely believed that the intervening doctor should be beaten or killed when a patient died. A total of 67.4% of the respondents were disturbed after receiving news that healthcare staff had been subjected to violence, with 14.3% being directly or indirectly pleased. The most important deterrents with respect to stopping the respondents from wanting to commit violence were the police (35.6%), security cameras (22.1%), and private security guards (19.8%) at hospitals. The respondents identified the factors of a sufficient number of comfortable waiting spaces (23.4%) and the reception given to patients by staff at the emergency entrance (27.2%) as those that would most help them to relax while waiting at health centers. A substantial number (45.6%) of respondents stated that they had initially tried to control their anger by "trying to calm themselves down." Failing to do so, the respondents acted violently toward healthcare staff, either by shouting at or insulting them (40.4%) or using a nearby object to attack them (12%) (Table 2). The respondents were primarily violent toward healthcare staff in the emergency department (16.1%), department of general internal diseases (9.8%), department of general surgery (7.4%), department of pediatrics (5.1%), and department of psychiatry (5%) (Table 2).

A general examination of the respondents who engaged in violence or who were inclined to do so revealed a statistically significant correlation ($p<0.001$) between respondents who, till date, had acted violently toward healthcare staff and those who were aged 24-30 years, male, non-university graduates, and had substance addiction (alcohol or drugs). There was no statistically significant difference ($p>0.05$) between being aware or unaware of the penalties that they would face by being violent toward healthcare staff. Those with no relatives in the healthcare sector committed more acts of violence ($p<0.05$). There was no significant difference ($p>0.05$) between age

Table 1. Sociodemographic characteristics of the respondents

	n	%
Sex		
Male	878	54.9
Female	722	45.1
Age distribution		
16-23	209	13.1
24-30	435	27.2
31-38	384	24.0
39-45	271	16.9
46-54	198	12.4
>55	103	6.4
Jobs		
Civil servant	395	24.7
Tradesman	215	13.4
Student	163	10.2
Housewife	148	9.3
Self-employed	303	18.9
Others	376	23.5
Education		
Primary School	296	18.5
High School	532	33.3
Higher Education	8	0.5
University	734	45.9
Not schooled	30	1.9
Types of violence committed		
Verbal	785	49.1
Physical	50	3.1
Sexual	2	0.1
Psychological	6	0.4
Not committed	757	47.3
Healthcare staff subjected to violence		
Doctor	451	28.2
Nurse	284	17.8
Student	10	0.6
Caregiver	67	4.2
Hospital administrator	25	1.6
Security staff	6	0.4
Not committed violence	757	47.3
Number of violent acts committed		
None	757	47.3
Once	616	38.5
Between 2 and 5 times	195	12.2
More than 5 times	32	2.0
Respondents' ideas about doctors		
They have poor knowledge	93	5.8
They do not adequately listen to patients and patients' relatives	676	42.3
They don't work hard	145	9.1
They work hard	381	23.8
They earn much	157	9.8
I have no idea	148	9.3

Table 2. Cause of violence, methods used in violence, and respondents' view of violence

	n	%
Is violence a method of claiming rights?		
Completely agree	24	1.5
Party agree	300	18.8
Completely disagree	1276	79.7
Cause of violence toward healthcare staff		
Lack of education of perpetrators	149	9.3
Perpetrators mistreated	166	10.4
Perpetrators claiming their rights	34	2.1
Failure of the healthcare staff to perform their tasks	255	15.9
Being kept waiting for prolonged hours	240	15.0
Healthcare staff very busy	111	6.9
Lack of sufficient number of beds	69	4.3
Patients and patients' relatives very impatient	30	1.9
News, broadcasts, and movies encouraging	217	13.6
violence in the media		
Politicians' remarks against healthcare staff	155	9.7
Improper transfers between hospitals	104	6.5
Social perception that the healthcare staff earns high salaries	70	4.4
Methods used for violence		
Shouting/verbally insulting	646	40.4
Spitting on the other person	13	0.8
Using sticks	16	1.0
Using sharp objects such as knives	2	0.1
Using guns	2	0.1
Using whatever one can find	192	12.0
Trying to calm down	729	45.6
Method of claiming rights of respondents feeling mistreated		
Filing a complaint with the administration	816	51.0
Filing a complaint with the public attorney	388	24.3
Filing a complaint with SABIM*	242	15.1
Personally claiming rights from the mistreating person	154	9.6
Most important causes of respondents being upset/getting angry at the hospital		
Not being listened to	448	28.0
Being uninformed about my patient	350	21.9
Prolonged treatments	141	8.8
Hospital settings being very crowded	185	11.6
No vacant beds for my patient	121	7.6
Patient not recovering	81	5.1
Healthcare staff shouting at us	120	7.5
Inadequate comfort at the hospital	154	9.6
Beating or killing of doctors for non-surviving patients		
Completely disagree	1388	86.8
Partly agree	203	12.7
Completely agree	9	0.6
Responses for beating or killing of healthcare staff		
I would be pleased	17	1.1
They deserve it	63	3.9
This is the treatment they understand	53	3.3
You should suffer a bit too	96	6.0
What a pity	383	23.9
No one deserves this	696	43.5
I don't care	292	18.3
Factors preventing the desire to commit violence toward healthcare staff		
Police on duty at the hospital	570	35.6
Security staff at the hospital	317	19.8
Too many staff working	80	5.0
A security camera	354	22.1
None of these would prevent me if I wanted to commit violence	279	17.4
Factors relaxing respondents at health centers		
Comfortable waiting rooms	374	23.4
Spacious examination rooms	197	12.3
Sufficient number of and clean restrooms	122	7.6
Quick tests and analyses	434	27.1
Sufficient number of parking lots	38	2.4
Reception of our patient by the staff at the emergency entrance	435	27.2

*Ministry of Healt Communication Center

and engaging in physical violence. There was a positive correlation ($p<0.001$) between respondents being physically violent and being a male, non-university graduate, and having substance addiction. There was a positive correlation ($p<0.001$) between respondents agreeing that being violent is a method of claiming rights and being aged 24-30 years, a male, a non-university graduate, and having substance addiction. There was no significant correlation ($p>0.05$) between being aware and unaware of the penal liabilities among respondents claiming their rights using their own methods. The rate of respondents with relatives in the healthcare sector was relatively low ($p<0.05$) among those claiming their rights using their own methods.

The correlation between beating or killing doctors when a patient died and alcohol and drug addiction was statistically significant ($x^2=137.0$; $p<0.001$). Respondents with such addiction resorted to violence using more aggressive methods (sticks, sharp objects, and guns), with non-addict respondents being capable of calming themselves down more easily ($x^2=169.9$; $p<0.001$). Respondents who agreed that being violent was a method of claiming rights had behaved in that way on more than 1 occasion ($x^2=287.4$; $p<0.001$). Respondents who agreed that committing violence was a method of claiming rights preferred verbal threats and physical and sexual violence ($x^2=62.0$; $p<0.001$). Pleasure from the desire to kill the doctors increased as the number of acts of violence increased ($x^2=276.8$; $p<0.001$). Respondents who had committed more than 2 acts of previous violence preferred to use physical instruments (sticks, knives, and firearms) ($x^2=515.2$; $p=0.001$). Having been previously punished for any acts of violence did not prevent the respondents from resorting to violence again ($x^2=40.2$; $p<0.001$). Respondents who felt that

they were unable to find anyone who would listen to them, that the patients were not well cared for, that they waited for long hours, that they could not find any dedicated bed vacancies for the patients they accompanied, that the healthcare staff shouted at them, and that the patients were somehow still suffering had a greater desire to see the doctor killed or took greater pleasure if such an incident occurred (x^2=46.8; p=0.02). Moreover, 26.1% of the respondents who reported having not engaged in any violence stated that they would like to see the doctor beaten or killed when a patient died.

Discussion

Approximately half of the respondents had used at least one form of violence against healthcare staff at a certain time in their lives, mainly men and respondents aged 24-30 years. Although 90.4% of the respondents had initially communicated their problems to various centers [hospital administration, public attorney, or the Ministry of Health Communications Center (SABIM)], a significant number of these respondents tried to claim their rights themselves, including by killing the healthcare staff. Only 4.4% of the respondents who had quarrels with the healthcare staff filed complaints with an authority (hospital administration, public attorney, or SABIM) before becoming violent. Although a great majority of women who believed that they had been mistreated stated that they had initially tried to avoid violence, it is remarkable that 1 in 10 of all respondents, including women, thought that they should claim their rights themselves. Although this finding may suggest that a person is inclined to be aggressive, it can also be explained by the distrust of the individuals toward the organization they filed their complaint with or by them receiving little feedback from the organization with respect to their complaints. A very low percentage (2.8%) of the healthcare staff who had been a frequent victim of violence filed complaints against the perpetrators of this violence. We believe that this low percentage is because the healthcare staff accepted this violence or because the judicial process is too slow.

The rate (49.1%) of verbal abuse directed toward healthcare staff was lower than that found in many previous studies. For example, Winstanley et al. (21) reported a rate of 68%, Ilhan et al. (22) reported a rate of 80%, and other studies conducted in Turkey (23) reported the rate to vary between 53.7% and 60%. A study conducted in Europe (24) revealed similar findings. One of the most important reasons why respondents choose verbal abuse is the very minor, or a lack of, penalties they incur.

In our study, the respondents used at least one form of violence toward healthcare staff, primarily doctors (28.2%) and nurses (17.8%). Boz et al. (25) observed these rates to be 40% for doctors and 28% for nurses. Another study reported that nurses suffered more (82%-96%) violence (26), whereas a separate study showed that the primary victims of violence were doctors (74.9%) (27).

In the present study, the respondents were most frequently violent toward emergency department staff (30.6%) and in public hospitals (58.2%). Ilhan et al. (22) reported that violence occurred most frequently (56.3%) in emergency departments and public hospitals (55.5%). Ayranci et al. (7) observed a rate of violence of 63.1% both in emergency departments and in public hospitals. In England, emergency department staff members are also the most frequent victims of violence (28). We believe that the reason why violence occurs most commonly in emergency departments and public hospitals is because of a busy workload, the fact that every patient considers his or her situation to be more urgent than anyone else's (even non-urgent patients are admitted to the emergency department), lack of personnel in emergency departments, and insufficient time allocated for the patient by the doctors.

Our respondents stated that failure of the healthcare staff to perform their tasks properly, prolonged waiting times at hospitals, media coverage, broadcasts and movies encouraging violence, and politicians' remarks criticizing healthcare staff were the most common causes of violence. Ilhan et al. (22) found that prolonged waiting times (62.7%) was the main cause of violence, whereas Boz et al. (25) found that alcohol and drug addiction (36%) was the biggest cause. In our study, the rate of respondents considering violence as a method of claiming rights was 20.3%, which is similar to that reported by Ilhan et al. (22) (20%). These levels are alarmingly high for healthcare staff.

In our study, the rate of respondents who were not completely unaware of the penalties they could face for committing violence against healthcare staff or respondents who did not consider it necessary to be aware of the penalties was 66.2%. This finding suggests that the respondents believed that any violent behavior would incur only minor penalties or none at all. In the present study, approximately one-sixth of the respondents reported that they had been subjected to violence from healthcare staff, primarily doctors and nurses. No similar results were found in researches.

The primary issues disturbing and upsetting the respondents at health centers were being unable to find someone who would listen to them and failure to be sufficiently informed about the patients whom they accompanied. This finding, although due to excessive workload, shows that healthcare staff experience communication problems with patients and their relatives. We found that the respondents were violent as a relative of a patient rather than as a patient. Some studies have affirmed that patients' relatives are more violent (29), whereas others have reported that patients are more violent than their relatives (8, 23, 25). The fact that 13.3% of the respondents believed that the doctor should be beaten or killed when a patient dies and that 14.3% of the respondents felt happy when they heard that a healthcare worker had been beaten or killed shows that the respondents supported violence. The literature contains no similar previous findings.

The most important deterrent against wanting to commit violence was security (police, security cameras, and private security guards) at hospitals. However, the fact that a non-negligible number of respondents (17.4%) committed acts of violence ignoring all types of security measures shows that we must take further measures.

A total of 77.7% of the respondents felt relaxed by the reception given to patients and their relatives by staff at the emergency entrance, by a sufficient number of comfortable waiting spaces, and by short service times. This finding demonstrates that increased comfort at healthcare centers could have some impact on reducing violence.

A significant number (45.6%) of respondents stated that they had not been violent and that they had initially tried to control their anger by "trying to calm themselves down." Conversely, 13.2% could not prevent themselves from engaging in violent behavior using sticks, sharp objects, guns, or whatever other object they could find. In a study conducted in Habbs (28), 60% of patients and patients' relatives engaged in violence by damaging doctors' cars, whereas 25% threw knives or other objects. Tekin reported that 40% of the healthcare staff was subject to assault by sticks, 26.7% by serum bottles,

20% by sticks, sharp objects, or guns, and 13.3% by firearms (30). In our study, only 1.1% of the respondents apologized, even when most considered themselves to be at fault in their quarrel with healthcare staff. This result emphasizes that the respondents used violence against healthcare staff as a method to claim their right and therefore did not consider it a circumstance to apologize.

The following respondents were most aggressive: those who most strongly believed that violence is a method of claiming rights, those who felt that the doctor should be beaten or killed when a patient dies, those who were most affected by the media and the remarks of politicians, those who used mostly guns, sticks, or sharp objects for violence, and those in the age group of 24-30 years. Respondents who most strongly believed that comfort and security measures would prevent them from being violent were primarily those aged 24-30 years. Hahn et al. (8) emphasized that males aged under 18 years and individuals with a low level of education were more inclined to violence, whereas Senuzun et al. (31) found that this tendency applied to men, individuals with a lower socioeconomic status, and alcohol and drug addicts. On the other hand, Novitsky et al. (32) found that silent individuals were more likely to be violent.

Those respondents who made the most efforts to calm themselves down when they quarreled with healthcare staff for any reason, who most strongly believed that violence is not a method of claiming rights, who were opposed to the idea that the doctor should be beaten or killed when a patient dies, and who were least affected by the media and politicians' remarks were women and university graduates. One of the most striking findings of our study was that 10.5% of the respondents who had never committed violence believed that doing so was a method of claiming rights and that 26.1% of the respondents partly/completely agreed that the doctor should be beaten or killed when a patient dies. These results show that violence toward healthcare staff has become a tremendous problem.

Study limitations

We consider the non-homogeneous nature of the respondents enrolled in our study and the restriction of the study population to Gaziantep to be the most important limitations. We believe that our findings will form the basis for drafting regulations required to prevent violence toward healthcare staff as well as for determining the public's view of healthcare staff. The most important feature of this study that distinguishes it from previous studies is that it reflects society's view of violence toward healthcare staff, whereas a great majority of previous analyses reflect healthcare staff's view of the violence aimed toward them.

Conclusion

This study found that half of the respondents had engaged in verbal abuse directed toward healthcare staff, mainly in emergency departments and in public hospitals. It is remarkable that 1 in 10 respondents believed that they should claim their rights themselves when they have been mistreated. One in 5 respondents believed that violence is a method of claiming rights, whereas half of the respondents were not sufficiently informed with respect to the penalties they could face as a consequence of violent behavior. The most disturbing issues for respondents were being unable to find someone who would listen to them and being insufficiently informed about the patient who they accompanied. Approximately 1 in 4 respondents wanted the doctor to be beaten or killed if a patient died or felt happy if they heard that this had happened. The respondents believed that violence will be reduced when security staff are present at a hospital as well as when an appropriate level of comfort and shortened waiting times are provided.

Ethics Committee Approval: Ethics committee approval was received for this study from the ethics committee of Gaziantep University Faculty of Medicine (05.07.2012/286 Date: 05.07.2012).

Informed Consent: Written informed consent was obtained from patients who participated in this study.

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