

RESIDENTS IN DANGER: WHAT'S GOING ON TURKIYE?

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Article History	Abstract
<p>Original Research Article</p> <p>Received: 10-02-2026</p> <p>Accepted: 28-02-2026</p> <p>Published: 05-03-2026</p> <p>Copyright © 2026 The Author(s): This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CC BY-NC) which permits unrestricted use, distribution, and reproduction in any medium for non-commercial use provided the original author and source are credited.</p> <p>Citation: Basak Sezgi BEZGINSOY, Serpil DEMIRAG. (2026). RESIDENTS IN DANGER: WHAT'S GOING ON TURKIYE? UKR Journal of Medicine and Medical Research (UKRJMMR), Volume 2(2), 11-17.</p>	<p>Aim: This study was designed to examine the prevalence and characteristics of violence encountered by medical residents at Aydin Adnan Menderes University School of Medicine. It aimed to identify sociodemographic and professional variables associated with exposure to violence and to explore the potential impact of such experiences on specialty selection and career orientation. In addition, the study aimed to bring the light medical residents' views and proposed solutions concerning the prevention of violence within healthcare environments.</p> <p>Method: A cross-sectional analytical design was held between 1st of February and 31st of May 2023. The whole universe consisted 483 medical residents. Based on a 95% confidence level and a 5% margin of error, the minimum required sample size was calculated as 215. Regarding potential data loss, the target sample was increased to 267. Ultimately, 297 residents voluntarily participated in the study. Data were obtained via a structured questionnaire consisting of 50 items organized into three sections: (1) sociodemographic characteristics, (2) experiences of workplace violence, and (3) proposed preventive measures. Statistical analyses were conducted using SPSS software, and a p-value below 0.05 was considered statistically significant.</p> <p>Results: The mean age of participants was 30.1±5.3 years, and 51.5% were female. Overall, 73.1% of residents reported having been subjected to violence at some point during their medical training. Verbal violence was the most frequently reported form (73.1%), whereas 14.5% indicated exposure to physical violence. Incidents were most commonly reported in emergency departments (78.8%) and outpatient clinics (54.6%). In more than 90% of cases, the perpetrators were patients' relatives. Furthermore, 32.3% of participants indicated that the perceived risk of violence played a role in their specialty choice. Exposure to violence was significantly associated with both the intention to change specialty and the consideration of pursuing a career abroad.</p> <p>Conclusion: The findings indicate that a considerable proportion of medical residents are exposed to violence during their training, primarily in verbal form but also physically. Such experiences appear to exert a detrimental influence on professional motivation, specialty preferences, and future career plans. Addressing violence against healthcare professionals requires the effective implementation of legal frameworks, strengthening of institutional security measures, enhanced societal awareness, and the development of structured support systems within healthcare institutions.</p> <p>Keywords: Healthcare, violence, residents.</p>

Introduction

The World Health Organization defines violence as ‘the intentional use of physical force or power, whether threatened or actual, against oneself, another person, or a group or community, that results in or has a high likelihood of resulting in injury, psychological harm, death, developmental impairment, or social deprivation’ (1). The term “use of physical force or power” should be understood to encompass not only direct physical acts but also neglect and all forms of psychological, physical, and sexual abuse, as well as other intentional harmful behaviors, including suicide (2). Exposure to workplace violence across different professional groups in the healthcare sector identified nurses, as well as resident and general practitioners, as the groups most frequently subjected to violence (3).

Workplace violence is defined as any threat, harassment, or assault directed toward an employee’s safety, well-being, or health that occurs in relation to work, including during commuting to and from the workplace. Among all sectors, the healthcare setting is recognized as the area where workplace violence is most frequently encountered (4). Previous research has demonstrated that healthcare workers are up to 16 times more likely to experience violence compared with employees in other service sectors (5). Based on the types of behaviors involved, violence can be classified into several categories, including physical, verbal, psychological (emotional), sexual, economic, and cyber violence (6).

Intention of healthcare professionals to pursue employment cannot be attributed solely to exposure to violence. Additional structural and occupational factors play a substantial role in this trend, including high patient volumes and escalating workloads, lack of job security, prolonged working hours and frequent on-call duties, inadequate remuneration policies, and limited opportunities for education, research, and career advancement (7).

In Türkiye, the title of “medical doctor” is awarded after the completion of a six-year undergraduate medical education program. Physicians who obtain this title are eligible to take the exam, which is required for admission to postgraduate medical specialty training programs. This exam is administered twice a year. Physicians who achieve a qualifying score are assigned to residency positions based on their exam results and available quotas, and they subsequently commence specialty training within institutions affiliated with the Ministry of Health, medical faculties, training and research hospitals, or the Council of Forensic Medicine. A wide range of factors influence medical students’ choices of specialty. Choices were affected by individual personality traits, lifestyle

expectations, anticipated financial income of the specialty, perceived professional prestige, workload, presence of role models, personal clinical experiences, family influence, and perceived individual capacity (8).

According to the 2022 Activity Report of the Turkish Medical Association, the number of physicians obtaining certificates to work abroad has demonstrated a steady upward trend over the years, with a particularly pronounced increase over the past seven years. The report further indicates that physician migration abroad has risen twenty-four-fold over the last decade (9). These findings suggest that professional violence may negatively affect not only individual and organizational well-being, such as burnout, but also physicians’ motivation to remain in their home country. Notably, the number of physicians applying for a “Certificate of Good Standing” from the Turkish Medical Association exceeded 3,000 in 2023, highlighting how workplace violence, mobbing, and systemic challenges may contribute to migration tendencies.

High daily patient volumes and the resulting workload intensity are key contributors to systemic strain within healthcare facilities. In Türkiye, the absence of an effective referral chain at the primary care level has resulted in a large proportion of patients bypassing family physicians and presenting directly to emergency departments, thereby exacerbating overcrowding in secondary and tertiary care services. This dysfunctional referral system can be defined as a factor that increases demand on emergency units, as many cases that could be managed at the primary care level are instead seen in higher-level facilities, reducing service efficiency and increasing pressure on healthcare staff. Deficiency in other healthcare workers’ number is also a reason for excessive work hours, therefore it maybe a reason for violence exposure. Daily number of patients was associated with a higher frequency of exposure to violence.

Several studies have demonstrated that medical residents, who constitute a fundamental component of healthcare delivery, frequently work under suboptimal conditions characterized by understaffing and extended working hours. They are expected both to achieve competency in their specialty training and to manage the diagnostic and therapeutic processes of a high volume of patients. While striving to perform their professional duties effectively, they are often exposed to adverse conditions, including violence from patients and their relatives. Such incidents may lead to professional anxiety, reduced job satisfaction, specialty change, and, in extreme cases, fatal outcomes (10). Face to face healthcare delivered by nurses and residents in Türkiye, especially in university hospitals. Nurses work in 8-hour-shifts while residents work at least 9-10 hours/daily, sometimes extend to 24 hours continuously.

Similar to numerous healthcare systems worldwide, the Turkish healthcare system faces a growing challenge related to workplace violence directed at healthcare professionals. In a nationwide study conducted in 2019 with a representative sample from across Türkiye, the prevalence of violence against healthcare workers was found to be notably high, with a percentage of 40.7 physical violence and 94.6% verbal harassment (11). In another nationwide study, 44.7% of healthcare professionals indicated that they had experienced workplace violence within the previous 12 months, while the lifetime prevalence was reported as 52.3% (12).

This study aimed to assess the prevalence and characteristics of violence experienced by residents, to identify factors associated with exposure to violence, to examine the impact of violence-related experiences during medical practice on specialty preferences, and to explore participants' suggestions regarding measures that could be implemented to prevent violence in healthcare settings.

Materials and Method

A cross-sectional analytical design was held between 1st of February and 31st of May 2023. The whole universe consisted 483 medical residents. Based on a 95% confidence level and a 5% margin of error, the minimum required sample size was calculated as 215. Regarding potential data loss, the target sample was increased to 267. Ultimately, 297 residents voluntarily participated in the study. The questionnaire was applied face-to-face to volunteer residents at Aydın Adnan Menderes University

School of Medicine. The questionnaire included a total of 50 items, comprising both open-ended and closed-ended questions. Data were obtained via a structured questionnaire consisting of 50 items organized into three sections: (1) sociodemographic characteristics, (2) experiences of workplace violence, and (3) proposed preventive measures. Statistical analyses were conducted using SPSS software, a value of $p < 0.05$ was considered statistically significant in the data obtained. All departments were visited, and the questionnaire was administered in person. All necessary permissions were obtained from the Ethical Committee.

Results

When the associations between exposure to violence and intentions to change specialty or country of practice were examined, 14.8% of participants who had experienced workplace violence reported an intention to change their specialty. No statistical significance was observed between the intention to change specialty and exposure to violence at any time, exposure to violence before the current specialty, or exposure to physical violence at any point ($p > 0.100$).

In contrast, residents who reported exposure to violence in their current specialty were significantly more likely to consider changing their specialty, and this difference was statistically significant ($p = 0.016$). Violence exposure and specialty change willing association is presented in Table 1.

Table 1. Association Between Exposure to Violence and Intention to Change Specialty

Variables		Intention to Change Specialty			Statistics
		No	Yes	Total	
Exposure to Violence	No	72 (%88,9)	9 (%11,1)	81	X ² =0,404 P=0,525
	Yes	184 (%85,2)	32 (%14,8)	216	
Exposure to Violence Before Current Specialty	No	116 (%87,9)	16 (%12,1)	132	X ² =0,340 P=0,560
	Yes	140 (%84,8)	25 (%15,2)	165	
Exposure to Violence in Current Specialty	No	103 (%91,2)	10 (%8,8)	113	X ² =5,791 P=0,016
	Yes	85 (%78,7)	23 (%21,3)	108	
Exposure to Physical Violence	No	221 (%87)	33 (%13)	254	X ² =0,559 P=0,455
	Yes	35 (%81,4)	8 (%18,6)	43	

Among participants who had experienced workplace violence at any time, 65.3% reported an intention to work abroad, whereas 42.0% of those without exposure to workplace violence expressed such an intention. Exposure to violence in

healthcare at any time, before the current specialty, or during the current specialty was associated with a higher intention to work abroad, and these associations were statistically significant ($p < 0.001$, $p < 0.001$ and $p = 0.033$, respectively).

No statistically significance was observed between exposure to physical violence and the intention to work abroad ($p=0.697$) (Table 2).

Table 2: Association Between Exposure to Violence and Intention to Work Abroad

Variable		Intention to Work Abroad			Statistics
		No	Yes	Total	
Lifetime Exposure to Violence	No	47 (%58)	34 (%42)	81	X²=13,216 P<0,001
	Yes	75 (%34,7)	141 (%65,3)	216	
Exposure to Violence Before Current Specialty	No	68 (%51,5)	64 (%48,5)	132	X²=10,695 P=0,001
	Yes	54 (%32,7)	111 (%67,3)	165	
Exposure to Violence in Current Specialty	No	48 (%42,5)	65 (%57,5)	113	X²=4,562 P=0,033
	Yes	31 (%28,7)	77 (%71,3)	108	
Exposure to Physical Violence	No	106 (%41,7)	148 (%58,3)	254	X²=0,152 P=0,697
	Yes	16 (%37,2)	27 (%62,8)	43	

Physicians who had been exposed to violence at any point had a mean age of 30.3 ± 4.7 years, whereas the mean age of those who had not experienced violence was 29.6 ± 6.6 years. This difference was statistically significant.

The mean duration of employment in the healthcare sector among physicians who had experienced violence was 60.5 ± 55.7 months, compared to 57.2 ± 82 months among those who had not been exposed to violence. This difference was also statistically significant.

Participants who had experienced violence prior to current specialty were, on average, older, reported a lower current mean daily patient volume, and had longer overall duration of employment in the healthcare sector as well as longer experience in general practice. All observed differences were statistically significant.

In contrast, physicians who reported exposure to violence during their current specialty had a significantly higher present-day average daily patient load, a longer cumulative duration of employment in the healthcare sector, and a longer period of specialty practice. These differences were also statistically significant.

Discussion

In our study, higher exposure to healthcare violence was found to be positively associated with longer duration of practice as a general practitioner, a higher average number of patients seen per day, and increasing participant age.

A substantial proportion of existing studies on violence in healthcare have focused on heterogeneous study

populations, including healthcare workers at different professional levels, general practitioners, specialist physicians, and medical students. Working as a general practitioner was associated with a statistically significance in the likelihood of experiencing violence. Consistent with the literature, general practitioners often serving as the first point of contact within the healthcare system are reported to face violence more frequently (13, 14).

Approximately three-quarters of our medical residents revealed violence exposure at some point in their work lives. This high number is consistent with previous studies indicating that violence against healthcare workers is widespread and occurs at concerning levels (15, 16). The international literature similarly suggests that violence is more common in clinical settings marked by high workload, irregular working hours, and frequent contact with patients' relatives, including residency training environments (17-20).

In this study, verbal violence was the most commonly reported form of aggression. Nearly all physicians who had experienced any type of violence reported exposure to verbal violence, consistent with findings from national and international studies (21, 22).

Age demonstrated a borderline significant association with exposure to violence. Findings in the literature regarding the impact of age on violence risk are inconsistent (16, 23). This variability suggests that age should be interpreted alongside factors such as professional experience, work setting, and communication skills.

Male physicians reported a significantly higher lifetime exposure to physical violence compared to female physicians. Groups with direct and intensive patient contact, such as residents, may encounter this risk more frequently. The continued high prevalence of physical violence in settings involving close physical interaction may help explain this pattern (11, 24, 25).

Moreover, surgeons' prolonged operative hours contribute to professional fatigue and burnout, further undermining workforce sustainability. Excessive workloads and insufficient differentiation between urgent and non-urgent care are documented contributors to operational stress and reduced quality of care within emergency settings, highlighting the need for structural reforms that strengthen primary care capacity and effectively implement organized referral pathways.

In our study, approximately 60% of residents who had been exposed to violence reported considering working abroad. Previous research similarly emphasizes that exposure to violence significantly increases intentions to leave the workplace or migrate to another country (26, 27). Physicians' considerations of emigration are often associated with expectations of improved working conditions, greater professional recognition, a safer work environment, and enhanced quality of life. Recurrent experiences of violence may therefore be linked to professional alienation, disengagement from the healthcare system, and an increased tendency to seek opportunities abroad. Several studies have emphasized that physicians' intention to migrate is driven not only by economic factors but also by the pursuit of a safe and respectful working environment (28, 29). This underscores that policies aimed at preventing violence are strategically important not only for the healthcare system itself but also for sustaining the national physician workforce.

The increasing fragmentation of medical specialties has led to a reduction in the availability of certain subspecialists, which in turn has made it progressively more difficult for patients to secure timely appointments with these clinicians. Research on barriers to subspecialty care highlights that limited subspecialist availability and prolonged waiting times are major impediments to accessing specialist services, with difficulty in scheduling often cited as a significant challenge in healthcare systems facing subspecialist shortages. Accessing healthcare difficulties may result delay in diagnosis and treatment. Therefore, especially for patients with serious or rapidly progressing conditions, this difficulty may cause serious conditions.

Conclusion

In conclusion, this study demonstrates that violence in healthcare remains a widespread and systemic problem, disproportionately affecting less experienced physicians and undermining their professional motivation. Independent of specialty, exposure to violence contributes to burnout and may prompt intentions to leave the profession or work abroad. Our results indicate that violence in healthcare should be considered not only an individual or institutional issue but also a public and national concern with potential implications for brain drain. Accordingly, anti-violence policies should be structured not solely around deterrence, but also around strengthening physicians' professional belonging and commitment to their country. In particular, consultations conducted under time constraints may foster a perception among patients of not being adequately heard or understood, potentially contributing to heightened aggression.

Participants most frequently recommended the revision and strengthening of legal sanctions to prevent violence. Participants' potential solutions included the revision and strengthening of legal sanctions against violence toward healthcare institutions. Regarding physician-oriented support mechanisms, participants emphasized the necessity of:

- Professional support structures,
- Administrative and legal assistance mechanisms,
- Public awareness initiatives aimed at improving the professional reputation and societal standing of physicians.

In terms of administrative reforms, participants highlighted that physicians should be promoted to live a more active and participatory role especially in planning healthcare services and administration of healthcare policies.

Overall, these findings emphasize the need for comprehensive, system-level strategies to prevent violence in healthcare settings, addressing not only physician-related regulatory dimensions but also broader structural, institutional, and societal factors.

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Conflicts Of Interest

No conflict of interest was declared by the author

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