



## Ethical and Professional Frameworks for Addressing Violence Against Health Care Workers: A Health Security Perspective

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### Abstract

**Background:** Violence against health care workers has become a pervasive and escalating global concern, encompassing behaviors ranging from verbal aggression to physical assault. Such violence disrupts clinical care, inflicts psychological harm, contributes to burnout, and threatens the stability of health systems. The article highlights how nurses and frontline clinicians experience disproportionate exposure to these risks due to their roles and continuous patient contact.

**Aim:** This paper aims to examine the ethical tensions, professional responsibilities, and organizational frameworks necessary for managing violence toward health care workers, emphasizing ethical reasoning, clinical culture, and institutional accountability.

**Methods:** A structured ethical analysis was conducted drawing on professional guidelines, clinical experience, and institutional practices. The paper synthesizes ethical principles—beneficence, nonmaleficence, autonomy, justice—alongside operational strategies such as de-escalation, team-based responses, trauma-informed care, and leadership accountability. It reviews contextual factors influencing clinician responses, including urgency of care, patient decision-making capacity, threat severity, and institutional culture.

**Results:** The analysis shows that ethical management requires balancing patient rights with staff safety, applying proportional responses based on clinical urgency and threat level, and ensuring equity in institutional responses. Trauma-informed approaches reduce escalation, while structured de-escalation training and behavioral response teams enhance safety and consistency. Leadership engagement emerges as critical for policy enforcement, cultural change, and staff support.

**Conclusion:** Violence in health care settings is a multifactorial challenge demanding coordinated ethical, clinical, and organizational action. Integrating trauma-informed practice, de-escalation skill-building, and leadership accountability strengthens safety, preserves dignity, and promotes equitable and sustainable clinical environments.

**Keywords:** violence; health care workers; ethics; de-escalation; trauma-informed care; workplace safety; clinical culture; leadership accountability.

### Introduction

Violence directed at health care workers has emerged as a persistent and escalating challenge within contemporary health systems. This violence encompasses a wide spectrum of behaviors, ranging from verbal abuse, threats, and discriminatory remarks to overt physical assaults occurring in clinical settings. Current evidence indicates that as many as 38% of health care workers have been subjected to physical violence during the course of their professional duties, underscoring the magnitude of this occupational hazard [1][2][3][4]. Among affected groups, nurses experience a disproportionate burden, largely due to the nature of their roles, which involve prolonged patient contact, frontline clinical decision-making, and

frequent exposure to emotionally charged situations. Such experiences not only compromise personal safety but also contribute to psychological distress, burnout, reduced job satisfaction, and workforce attrition, thereby threatening the overall stability and effectiveness of health care delivery systems. In response to the growing prevalence of violence in health care environments, leading professional organizations have articulated formal positions that emphasize the urgency of collective and systematic action. The American Medical Association and the American Nurses Association have each published policy statements advocating for coordinated, institution-wide strategies to prevent and manage violence across hospitals, integrated health systems,

and independent clinical practices [5,6]. These calls reflect a recognition that isolated or reactive measures are insufficient and that ethical, organizational, and security considerations must be addressed in a unified manner. Such guidance highlights the responsibility of health care institutions to safeguard workers while maintaining equitable and compassionate patient care.

Violent behavior by patients or visitors introduces complex ethical tensions into clinical practice. Health care workers must often balance their duty to provide care, respect patient autonomy, and uphold professional beneficence against the imperative to protect themselves, colleagues, and other patients from harm. Individual responses to these situations vary and are shaped by multiple factors, including professional role, institutional culture, available security resources, prior experiences with violence, and personal ethical frameworks. Understanding these influences is essential for developing ethical responses that are both practical and principled. Accordingly, ethical management of violence in health care settings requires a structured approach that integrates moral reasoning with operational safeguards. Addressing this issue involves recognizing violence as a systemic risk, clarifying professional obligations, and implementing organizational strategies that support prevention, de-escalation, and accountability. By examining the ethical challenges posed by violent behavior and the factors shaping health care worker responses, a foundation can be established for developing comprehensive, ethically sound frameworks to manage violence within hospitals and other care environments [1][4][5].

### **Ethical Tensions**

The increasing prevalence of violence within hospital environments generates significant ethical tension by placing fundamental professional values in direct conflict. Clinicians are expected to uphold principles such as beneficence, respect for patient autonomy, justice, and non-maleficence, while simultaneously ensuring personal safety and the safety of colleagues, patients, and visitors. When violent or threatening behavior occurs, these ethical commitments may no longer align seamlessly. The obligation to provide compassionate and unbiased care can conflict with the duty to prevent harm, particularly when a patient's actions pose an immediate or foreseeable risk. As a result, clinicians are often required to make rapid judgments about which ethical values should take precedence in situations marked by uncertainty and potential danger [7]. These circumstances challenge traditional conceptions of professional responsibility. Tolerating or minimizing violence in the name of patient-centered care may undermine the moral obligation to protect health care workers from harm, while overly restrictive or punitive responses may compromise respect for patient dignity and equity. Ethical tension is further intensified by disparities in power, vulnerability, and

accountability between patients and health care professionals, especially when violence is associated with mental illness, cognitive impairment, substance use, or social stressors. Clinicians must therefore consider not only the intent and capacity of the individual involved but also the broader institutional responsibilities to provide a safe working environment. Resolving these tensions requires deliberate ethical reflection rather than reactive decision-making. Clinicians and institutions must determine how to balance competing values in a manner that is fair, consistent, and transparent. Developing structured ethical frameworks and response plans allows for more equitable resolution of these conflicts, supports moral integrity among health care workers, and reinforces the principle that safety and ethical care are not mutually exclusive but interdependent goals within modern health systems [7].

### **Fig. 1: Ethical values in response to violent patients. Role of Clinical Urgency**

Clinical urgency plays a central role in determining ethically appropriate responses to violence in health care settings. When a patient's condition is immediately life-threatening, clinicians carry a strong ethical obligation to attempt the delivery of essential medical interventions while simultaneously minimizing risk to themselves and others. In such circumstances, beneficence and non-maleficence demand that efforts be made to preserve life, but these efforts must be balanced against the professional duty to maintain a safe care environment. Emergency responses may therefore require coordinated teamwork, security involvement, or modified clinical approaches that allow treatment to proceed without exposing health care workers to unreasonable danger. In contrast, when a patient is clinically stable and does not face imminent harm, the ethical balance shifts. Adult patients who are capable of understanding their actions and who choose to engage in violent behavior may ethically be required to accept the consequences of that behavior. These consequences can include delayed care, modification of treatment plans, or, in extreme cases, the temporary withdrawal of non-emergent services. Such actions do not represent abandonment but rather reflect a proportional response that prioritizes safety and accountability. Recognizing clinical urgency as a

dynamic factor allows clinicians to differentiate between situations that demand immediate intervention despite risk and those in which delaying care is ethically permissible to protect health care workers and uphold institutional safety standards [7][8].

### **Role of Patient Decision-Making Capacity**

Patient decision-making capacity is a critical determinant in shaping ethical responses to violent behavior in clinical settings. When patients possess intact capacity, clinicians are ethically justified in engaging them through communication, negotiation, and boundary-setting. In these situations, care can be offered conditionally, with the expectation that the patient modifies violent or threatening behavior in order to receive treatment. This approach respects patient autonomy while reinforcing the principle that access to care is accompanied by responsibility for one's conduct. It also affirms the moral agency of the patient and supports de-escalation through dialogue rather than coercion. By contrast, when a patient lacks decision-making capacity, such as in cases of severe intoxication, delirium, or acute psychiatric decompensation, the ethical framework shifts toward substituted judgment and best-interest standards. In these circumstances, violent behavior cannot be understood as a fully autonomous choice, and clinicians may ethically employ measures such as chemical sedation or physical restraint to facilitate life-saving or essential care. These interventions are justified not as punishment but as necessary tools to prevent harm and enable treatment. Cases involving partial or fluctuating impairment of capacity require nuanced, individualized assessment. Clinicians must carefully evaluate the degree of impairment, reassess capacity over time, and tailor responses that proportionally balance patient rights, therapeutic necessity, and the safety of health care workers [7].

### **Severity of Threat to Workplace Safety**

The ethical obligation of clinicians to provide compassionate and equitable care exists alongside an equally important duty to preserve workplace safety. As violence toward health care workers increases, the protection of staff from physical harm, psychological trauma, and professional burnout has become a core ethical and institutional priority [7]. While clinicians are often motivated to continue care despite difficult or hostile patient behaviors, there are circumstances in which maintaining a safe clinical environment must take precedence over a patient's nonurgent clinical interests. A failure to address threats to safety risks normalizing violence and undermining the sustainability of the health care workforce. Violence in health care settings does not present as a single uniform phenomenon but rather along a broad spectrum of severity. Ethical responses should therefore be proportionate and responsive to the level of threat posed. Acts of physical violence, credible threats, or behavior that places staff or other patients at immediate risk may ethically justify the suspension

or discontinuation of nonessential clinical services. In such cases, limiting care is not an act of punishment but a necessary step to prevent harm and preserve institutional safety. Conversely, less severe behaviors, such as repeated verbal hostility or nonphysical intimidation, may warrant graduated responses that emphasize de-escalation, boundary setting, and clear communication of behavioral expectations. Importantly, consequences imposed in response to violent behavior should be framed as safety measures rather than retributive actions. The goal is not to penalize patients but to establish and reinforce standards of conduct that allow care to be delivered in a secure environment. By aligning the intensity of the response with the severity of the threat, health care institutions can uphold ethical obligations to both patients and staff. This proportional approach supports a culture of safety, reinforces professional boundaries, and acknowledges that clinician well-being is an essential prerequisite for the delivery of high-quality care [7][8].

### **Violence and Health Care Equity**

Violence directed at health care workers carries significant implications for equity, inclusion, and workforce sustainability. Exposure to aggressive or threatening behavior can be deeply distressing, contributing to emotional exhaustion, moral distress, and increased rates of burnout and staff attrition. These effects are not distributed evenly across the workforce. Racism, sexism, and other forms of patient bias often shape violent encounters, disproportionately targeting clinicians from historically marginalized groups and undermining institutional efforts to promote diversity, equity, and inclusion. When such behaviors go unaddressed, affected staff may experience isolation and a diminished sense of institutional support. Effective and visible institutional responses to violence play a critical role in mitigating these harms. When health care workers perceive that leadership and colleagues actively prioritize their safety and dignity, the risk of alienation is reduced, even following distressing incidents. Clear policies, consistent enforcement, and public affirmation of zero tolerance for discriminatory or violent conduct signal that the well-being of staff is valued. These measures not only protect individuals but also strengthen trust within care teams and reinforce organizational commitments to equity. Equity considerations must also extend to patient care. Clinicians are not immune to implicit bias, and perceptions of threat may be influenced by a patient's race, ethnicity, socioeconomic status, or mental health history. Such biases can affect how quickly violence is identified, how severely it is judged, and how aggressively it is managed [8][9]. Ethical management of patient violence therefore requires ongoing reflection, training, and accountability to ensure that responses are proportionate, evidence-based, and free from discriminatory assumptions. Balancing staff safety with equitable treatment demands vigilance,

institutional support, and a commitment to fairness for both patients and health care workers.

### **From Ethics to Clinical Culture**

The ethical management of violent patient behavior does not occur in isolation from clinical culture. Individual clinician style and the hierarchical structure of health care institutions strongly shape how ethical principles are interpreted and enacted in practice. These cultural factors influence whether violence is minimized, normalized, addressed constructively, or escalated in ways that may unintentionally compromise safety, trust, or equity within the care environment. Clinicians who favor a collaborative style often emphasize flexibility, patient autonomy, and responsiveness to individual needs. This approach is grounded in ethical commitments to respect, beneficence, and patient-centered care. In the context of violent behavior, however, such clinicians may tolerate hostility or aggression in an effort to preserve the therapeutic relationship or avoid exacerbating patient distress. While well intentioned, this nonresponsive posture risks undermining workplace safety by signaling that violent behavior will be absorbed rather than addressed. Over time, such tolerance can contribute to moral injury among staff, normalize unsafe conditions, and erode collective expectations for professional conduct. Ethical practice in this context requires collaborative clinicians to balance responsiveness to patient needs with an explicit duty to protect colleagues from harm and to affirm that safety is a shared, nonnegotiable value. By contrast, clinicians with a more authoritarian or rule-oriented style may prioritize institutional order, boundary enforcement, and the rapid imposition of consequences in response to violence. This approach can provide clarity and immediate protection, particularly in situations of escalating threat. However, when applied rigidly or without attention to context, it may intensify a patient's sense of powerlessness or marginalization, which can further fuel aggressive behavior. Excessive reliance on punitive measures risks shifting the clinical encounter from care delivery to control, thereby undermining ethical commitments to dignity and proportionality. Clinicians who favor this style benefit from structured training in de-escalation, trauma-informed communication, and reflective practice to ensure that enforcement of safety measures does not inadvertently perpetuate harm [10].

Ethical competence therefore requires clinicians to recognize the limitations of their preferred styles and to actively mitigate associated risks. Effective responses to patient violence often emerge not from adherence to a single approach but from adaptive integration of empathy, boundary setting, and situational judgment. Institutional support for ongoing ethics education and interprofessional dialogue can help clinicians refine these skills and respond consistently across care settings. Clinical culture is further shaped by entrenched hierarchies

within health care organizations. Physicians, by virtue of role authority and reduced bedside exposure, may experience patient violence less frequently or with lower personal risk than nurses and allied health professionals. This disparity can influence perceptions of severity and urgency, leading to greater tolerance of behaviors that frontline staff experience as threatening or demoralizing. Similarly, nurses with longer tenure or greater institutional influence may have more capacity to advocate for safety measures than newer staff who spend more time in direct patient contact and possess less organizational power. These structural inequities can result in uneven protection and inconsistent ethical responses to violence. An ethical commitment to workplace safety must therefore be institutional rather than individual. Organizations bear responsibility for ensuring that all staff, regardless of role or status, have equitable access to protection, support, and recourse when violence occurs. This includes clear reporting pathways, consistent enforcement of behavioral standards, and leadership practices that validate the experiences of those most exposed to risk. When institutions fail to address hierarchical disparities, they risk perpetuating cultures in which violence is unevenly distributed and ethically rationalized. Moving from ethical principles to a resilient clinical culture requires alignment between values, behaviors, and structures. Respect for patient autonomy must coexist with respect for clinician safety. Compassion must be paired with accountability. Only through deliberate cultural and institutional commitment can ethical responses to patient violence become consistent, equitable, and sustainable across the health care system [10].

### **Ethical Management of Violence in Hospitals**

The ethical management of violent behavior within hospital settings requires a comprehensive approach that operates simultaneously at the level of individual clinical encounters and at the level of health care systems. Violence in hospitals is rarely an isolated event; rather, it emerges from the interaction of patient vulnerabilities, clinician stressors, environmental pressures, and institutional cultures. Ethical responses must therefore extend beyond the immediate management of an aggressive episode to include coordinated organizational strategies that promote safety, dignity, and fairness for both patients and health care workers. Achieving this balance necessitates the engagement of a broad range of stakeholders, including patients, frontline clinicians, nursing and allied health staff, hospital administrators, behavioral health specialists, security personnel, and legal representatives. Clinical ethicists play a critical role in this process by helping teams identify and navigate ethical tensions, clarify institutional values, and design response frameworks that are morally defensible, practical, and consistent across settings. At the system level, ethical management emphasizes preparedness rather than reaction alone. Institutions have a duty to establish clear policies that articulate

acceptable behavior, define graduated responses to violence, and outline mechanisms for staff support and accountability. These policies should be informed by ethical principles such as respect for persons, nonmaleficence, proportionality, and justice. Ethical consultation can assist institutions in aligning these principles with operational realities, ensuring that responses to violence neither default to punitive exclusion nor normalize harm to staff. Structured education in de-escalation techniques, team-based responses to escalating behavior, and leadership accountability further reinforces an ethical culture in which safety is understood as a shared responsibility rather than an individual burden [10].

Trauma-informed care represents a central ethical framework within this broader approach. Trauma-informed care is grounded in the recognition that past trauma frequently shapes patient behavior and that health care environments themselves can retraumatize individuals, even when care is delivered with benevolent intent [10]. This model reframes violent or disruptive behavior not as inherent patient pathology but as a possible adaptive response to perceived threat, loss of control, or prior experiences of harm. By encouraging clinicians to remain attentive and curious about patients' life histories and emotional states, trauma-informed care seeks to reduce reflexive judgments and mitigate the influence of implicit bias on clinical decision-making. Such an approach supports ethical commitments to respect and fairness by promoting understanding without excusing harm. Importantly, trauma-informed care acknowledges that clinicians are also affected by trauma. Exposure to violence, repeated threats, and institutional silence can contribute to moral distress, burnout, and disengagement among health care workers [11][12]. An ethical system response therefore includes mechanisms to support staff who experience or witness violence, such as debriefings, counseling resources, and visible leadership advocacy. When clinicians perceive that their well-being is valued and protected, they are better positioned to provide compassionate, measured care, even in challenging circumstances. This reciprocal recognition of vulnerability strengthens trust within clinical teams and reinforces a culture of mutual respect.

In practice, trauma-informed care can function as both a preventive and responsive strategy. By assessing environmental triggers, communication breakdowns, and unmet patient needs, teams may identify modifiable factors that precipitate aggression. For example, overcrowding, lack of privacy, abrupt changes in care plans, or inconsistent messaging can heighten patient distress and loss of perceived control. Addressing these factors proactively can reduce the likelihood of violent incidents. When violence does occur, a trauma-informed response emphasizes clear communication of nonviolent expectations, validation of emotions without endorsement of harmful behavior, and collaborative exploration of triggers once

immediate safety is restored. This approach preserves accountability while minimizing escalation. Ethically managing violence in hospitals thus requires integration of individual clinical judgment with institutional commitment to trauma-informed principles. Such integration ensures that responses to violence uphold patient dignity, protect health care workers, and sustain public trust in health care institutions. By embedding ethical reflection, interdisciplinary collaboration, and trauma awareness into policy and practice, hospitals can move beyond reactive containment toward a more just and resilient clinical environment [11][12].

### **De-escalation Skills Building**

At the individual level, de-escalation skills building represents a core ethical and practical strategy for protecting health care workers while maintaining therapeutic relationships with patients who exhibit escalating or violent behavior. Nurses and other frontline clinicians are often the first to encounter agitation, distress, or aggression, and they therefore require structured training that equips them to respond effectively before emotional intensity progresses to physical harm. De-escalation communication focuses on recognizing early warning signs of agitation, responding with calm and respectful language, and reducing perceived threats within the clinical interaction. When applied consistently, such communication can interrupt the progression from heightened emotion to overt violence and can preserve trust even during conflictual encounters. Preventive de-escalation strategies are particularly important in busy clinical environments where stressors are frequent and unavoidable. Visible institutional behavioral expectations can help set clear boundaries and normalize nonviolent conduct as a shared responsibility rather than a personal demand imposed by individual clinicians. Simple environmental interventions, such as offering stress-relief objects or access to calming audiovisual materials, may further reduce agitation by supporting patient self-regulation during periods of waiting, uncertainty, or discomfort. These measures signal respect and attentiveness to patient needs while simultaneously promoting safety, thereby aligning ethical commitments to beneficence and nonmaleficence [13][14].

When preventive efforts are insufficient and the risk of violence increases, responsive de-escalation strategies become ethically necessary. Coordinated team responses, including brief huddles, allow clinicians to share information, establish consistent messaging, and reduce the likelihood of mixed signals that may further provoke distress. Environmental controls, such as closing doors to limit exposure or creating physical distance, can be implemented proportionately to the perceived threat. Prompt engagement of trained security personnel when violence appears imminent is not a failure of care but an extension of the clinician's duty to protect themselves, colleagues, and other patients [13].

Ethical de-escalation training emphasizes that such actions are preventive and protective rather than punitive. De-escalation competence should not be limited to select roles within the institution. All employees within the health care system benefit from foundational education in role-appropriate communication and de-escalation techniques, as violence can affect staff across clinical and nonclinical domains [14][15][16]. Standardized training promotes shared language, predictable responses, and collective confidence, reducing the burden placed on individual workers to manage volatile situations alone. This institutional investment also reinforces the ethical principle of justice by ensuring equitable access to safety resources regardless of professional status.

Beyond individual skill development, ethical de-escalation requires collective responsibility through active bystander engagement. Health care teams trained to intervene early, support colleagues under threat, and address concerning behavior collaboratively contribute to a safer and more respectful workplace culture. Brief debriefings following difficult encounters allow teams to process events, identify unmet needs, and connect affected individuals with appropriate support. Such practices acknowledge the emotional impact of violence on health care workers and strengthen institutional responses that extend beyond the immediate incident. Through sustained commitment to de-escalation skills building, health care organizations can reduce harm, preserve therapeutic alliances, and uphold ethical obligations to safety and care [15].

### **Team Responses**

Team-based responses are increasingly recognized as an essential component of the ethical and effective management of patient aggression and violence within health care settings. Many institutions have established behavioral response teams composed of clinicians with advanced expertise in mental health, crisis intervention, and conflict management. These teams are designed to intervene early in situations where agitation, distress, or hostility threatens to escalate, providing real-time guidance that supports bedside clinicians while prioritizing safety for patients and staff alike. Their presence helps distribute responsibility for managing violence across the system rather than placing the burden solely on individual nurses or physicians. Beyond immediate clinical decision-making, behavioral response teams play a strategic role in shaping institutional approaches to workplace violence. By drawing on repeated exposure to high-risk scenarios, these teams can identify patterns, environmental triggers, and systemic gaps that contribute to aggression. This broader perspective allows them to inform policy development and organizational planning in ways that are grounded in clinical reality. For example, teams may advise against rigid zero-tolerance policies that fail to account for mental illness, cognitive impairment, or acute distress, as such policies can unintentionally escalate conflict

rather than resolve it. Instead, they can support proportionate, ethically justified responses that balance compassion with safety. Behavioral response teams also contribute to critical discussions around the use of behavioral health contracts, including their potential benefits and moral limitations. While such contracts may clarify expectations and boundaries, they can also risk coercion or inequity if applied without sensitivity to patient capacity or context. Teams with mental health expertise are well positioned to guide clinicians and administrators in navigating these tensions responsibly. In addition, these teams often serve as advocates for preventive institutional investments, including de-escalation training, antibiotic education, and environmental safety measures such as controlled access points or metal detectors [17]. Through these activities, team responses extend beyond crisis management to become a cornerstone of a comprehensive, ethically grounded strategy for reducing violence toward health care workers.

### **Leadership Accountability**

Leadership accountability is a defining element of ethical violence management in hospitals and health systems. While individual clinician training and specialized team responses are necessary, they are insufficient without visible and sustained commitment from institutional leadership. Leaders set the tone for how violence is understood, addressed, and prioritized, and their engagement signals whether workplace safety is treated as a core organizational value or as an individual problem to be managed in isolation. Active leadership involvement reinforces the message that violence toward health care workers is unacceptable and that staff well-being is integral to high-quality patient care. Accountable leadership is particularly important in complex clinical situations where competing ethical obligations intersect. Decisions about restricting care, involving security, or modifying the care environment often require experience, authority, and coordination across departments. Leaders can provide the managerial latitude and ethical guidance needed to support clinicians facing these challenges, ensuring that responses are consistent, fair, and aligned with institutional values. This includes allocating resources for behavior response teams, supporting reporting mechanisms, and protecting staff from retaliation when safety concerns are raised [16][17].

Leadership accountability must also be closely linked to diversity, equity, inclusion, and belonging initiatives. Evidence suggests that workplace violence disproportionately affects certain groups of health care workers, including nurses, early-career staff, and individuals from historically marginalized backgrounds. Without intentional leadership attention, these disparities may persist or worsen. Integrating equity-focused training alongside violence prevention efforts helps ensure that institutional responses do not reproduce bias or

unequal protection. Leaders who actively engage with affected staff groups, acknowledge harm, and implement targeted supports contribute to a culture of trust and psychological safety. Ultimately, leadership accountability transforms ethical commitments into operational realities. By aligning policies, resources, and organizational culture, leaders play a decisive role in creating health care environments where safety, respect, and ethical responsibility toward both patients and workers are upheld consistently across all levels of care [16][17].

### Conclusion:

Violence toward health care workers presents an urgent ethical and operational challenge that requires far more than reactive incident management. As demonstrated throughout the article, sustainable solutions must arise from the alignment of ethical principles, clinical judgment, and organizational responsibility. Ethical care cannot be separated from staff safety: maintaining a secure environment is a prerequisite for compassionate, equitable, and effective care. Clinicians frequently face competing demands—protecting themselves and their colleagues while upholding patient dignity and autonomy—and these tensions demand structured, principled decision-making rather than fragmented or ad hoc responses. Institutional commitment is therefore essential. Trauma-informed care shifts the focus from punitive reactions to understanding behavior within broader contexts of vulnerability, while de-escalation training equips staff with skills to intervene early and prevent escalation. Behavioral response teams further distribute responsibility and ensure consistency across settings. Leadership accountability remains the cornerstone of a resilient system, shaping culture, ensuring equitable protection, and upholding zero tolerance for violence. Ultimately, addressing violence in health care requires a cultural transformation that places safety, ethical integrity, and mutual respect at the center of organizational identity. By fostering environments where both patients and providers feel safe and valued, health systems can better ensure high-quality, just, and sustainable care delivery.

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