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REVIEW

Workplace Violence in the Health Sector: Focus on the Argentinean context

Violencia Laboral en el Sector de la Salud: Enfoque en el contexto argentino

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ABSTRACT

Workplace violence is classified according to the focus of analysis: type of aggression (physical, psychological, and sexual) and according to the perpetrator (internal violence, if it is a member of the organization and external when it is a user or his/her companions). The impact on the worker's health is severe; the psychological damage is the first to be registered, with all the progressive symptoms of stress: cognitive disorders - loss of immediate memory, dispersion of attention and concentration, permanent state of alertness, self-reproach, anguish, depression, exhaustion, sensation of unreality, fantasies of annihilation, fragmentation of identity, sleep disorders and conflict with affective relationships and bonds of belonging. The studies analyzed show that the effects of aggression are varied and will depend on the frequency and severity of the episodes and the vulnerability caused by the number of episodes, which cause deterioration in the quality of care, suffering, and illness of those involved, thus affecting not only the personnel involved but also having repercussions on their families and the environment outside the workplace. Therefore, it is essential to investigate and analyze the factors involved in the different situations that arise and thus be able to intervene promptly. Statistics show that violence is more frequent the younger the staff is and more frequent in the case of women. It is also evident that not only age and sex are the factors that have the most significant impact on acts of violence, but other variants, such as nationality, place of work, and position held, influence the moment of being victims of aggression in the work environment.

Keywords: Workplace Violence; Health Sector; Psychological Harm; Argentina.

RESUMEN

La violencia laboral se clasifica según el foco de análisis: tipo de agresión (física, psicológica y sexual) y según el autor (violencia interna, si es un miembro de la organización, y externa cuando es un usuario o sus compañeros). El impacto sobre la salud del trabajador es grave; el daño psicológico es el primero que se registra, con todos los síntomas progresivos del estrés: trastornos cognitivos -pérdida de la memoria inmediata-, dispersión de la atención y la concentración, estado de alerta permanente, autorreproches, angustia, depresión, agotamiento, sensación de irrealidad, fantasías de aniquilación, fragmentación de la identidad, trastornos del sueño y conflicto con las relaciones afectivas y los vínculos de pertenencia. Los estudios analizados muestran que los efectos de la agresión son variados y dependerán de la frecuencia y gravedad de los episodios y de la vulnerabilidad causada por el número de episodios, que provocan deterioro en la calidad de la atención, sufrimiento y enfermedad de los implicados, afectando así no sólo al personal implicado, sino también repercutiendo en sus familias y en el entorno extra-laboral. Por ello, es fundamental investigar y analizar los factores que intervienen en las diferentes situaciones que se presentan y así poder intervenir oportunamente. Las estadísticas muestran que la violencia es más frecuente cuanto más joven es el personal y más frecuente en el caso de las mujeres. También es evidente que no sólo la edad y el sexo son los factores que más influyen en los actos de violencia, sino que otras variantes, como la nacionalidad, el lugar de trabajo y el cargo que se ocupa, influyen en el momento de ser víctimas de agresiones en el entorno

laboral.

Palabras clave: Violencia Laboral; Sector Sanitario; Daño Psicológico; Argentina.

INTRODUCTION

The "Framework Guidelines for Addressing Workplace Violence in the Health Sector" report developed by the International Labor Organization (ILO), the International Council of Nurses and the World Health Organization and Public Services International indicates that workplace violence affects the dignity of millions of workers, both in core and peripheral countries, and deepens inequality, discrimination, and stigmatization within the workplace with consequences that are evident outside the workplace. The health sector accounts for a quarter of all violence in the workplace and affects almost half of all healthcare workers.[1]

This incidence rate of violence in our sector, where there is an increasing percentage of female workers, reminds us that in our country, the Law for the Integral Protection of Women (Law 26485) contemplates the obligation of health institutions to file a report when they become aware of acts of violence.[2]

The ILO defines violence in the workplace as "any unreasonable action, incident or behavior by which a person is assaulted, threatened, humiliated or injured by another person in the exercise of his or her professional activity or as a direct consequence thereof".[3]

Soares highlights three aspects present in the definitions of harassment:[4]

1. the persistent and recurrent nature of the action;
2. the damage and devastating effects on the person who is the victim of harassment;
3. the definition is focused on the effects it has on the victim and not on the aggressor's intentions.

Likewise, workplace violence is classified according to the focus of analysis: type of aggression (physical, psychological, and sexual) and according to the perpetrator (internal violence, if it is a member of the organization and external when it is a user or his/her companions).[5,6]

Workplace violence is a recurrent and sustained situation that, in the case of mobbing or moral or psychological harassment, has the differential characteristic (concerning physical violence) of not leaving external signs visible marks, except for the progressive socioemotional and psychophysical deterioration of the victim.

The ILO emphasizes that violence in the workplace has been increasing in the number of registered cases, reaching worrying levels in the frequency of violent behavior and in the devastating consequences that impact the victims, their family environment, and the groups to which they belong.[7]

The impact on the worker's health is severe; the psychological damage is the first to be registered, with all the progressive symptoms of stress: cognitive disorders - loss of immediate memory, dispersion of attention and concentration, permanent state of alertness, self-reproach, anguish, depression, exhaustion, sensation of unreality, fantasies of annihilation, fragmentation of identity, sleep disorders and conflict with affective relationships and bonds of belonging. At the physical level, the deterioration is correlative and usually triggers psychosomatic disorders (gastrointestinal, hypertension or arterial hypotension, cardiac, endocrinological, musculoskeletal, dermatological, tension headaches, sexual disorders, and others) and immunological and oncological pathologies.[7]

This fact is of utmost importance for both women and men; in the case of the former, their situation is aggravated by an additional form of gender violence. There is a social construction of the role of the sexes, which negatively connotes the feminine condition consolidated in cultural patterns of submission of women that, in the course of history, has produced the naturalization of such violence. These patterns of victimization are also reproduced in organizations, particularly in the workplace.

It is important to emphasize that violence in the workplace will affect not only the victim but also the whole group, reducing its capacity to work, which is why the whole group must confront the situation.

DEVELOPMENT

Psychobiology of violence

Human violence is present in many situations in our lives and has been present in all societies and all historical periods since the beginning of humanity. It occurs at various levels, ranging from the most individual, such as violence between two individuals, to the most group violence, such as in wars between nations.[8]

Impulsive aggression is generally an immediate response to an environmental stimulus. This type of violence may reflect emotional hypersensitivity and exaggerated threat perception, which may be linked to an imbalance between top-down cortical inhibitory controls and bottom-up limbic drives. The classic paradigm, involving the prefrontal cortex and limbic areas such as the amygdala, states that activity in subcortical limbic structures such as the amygdala is modulated by an inhibitory influence from cortical structures such as the orbitofrontal prefrontal cortex (OPC). Thus, an individual unable to control his impulsive aggression will have high activity

in the amygdala area and low inhibitory activity in the COF area. In contrast, an individual who can control his impulsive aggression will have high activity in the COF. Thus, an individual with a lesion in the COF will have increased impulsive aggression.[9]

It could be said that aggression results from a complex interaction of various neurochemicals and other factors, including environmental, neuroanatomical, hormonal, genetic, and molecular factors. Moreover, they all establish a bidirectional or feedback relationship with aggressive behavior.

From this bidirectional perspective, a complex neural system and various interacting chemical substances regulate violence, which can modify the neurobiological substrates involved in it. The neural network of aggression and violence comprises several structures, including, among others, the hypothalamus, amygdala, temporal lobe, and frontal lobe. Moreover, serotonin is the neurochemical substance most closely related to aggression and violence. However, other substances such as catecholamines, GABA, glutamate, acetylcholine, nitric oxide, vasopressin, substance P, histamine, and endogenous opioids are also involved. In addition, the effect of other systems, such as the endocrine and immune systems, must be considered since both are involved in regulating these behaviors. The role of genetics in the onset of aggression and violence cannot be overlooked either, as more and more studies are highlighting the role of specific genes involved in these behaviors. To all this complex web of interacting factors, we should add the unavoidable effect of experience, including factors such as maternal gestation, the consumption of psychoactive substances, or abuse.[8]

Today, psychobiological processes are considered not only as possible causes but also as possible consequences of the behavior in question. There is also the possibility that some genes may be differentially expressed epigenetically depending on their environment. Several studies have revealed that growing up in a hostile environment and suffering abuse during childhood increases the risk of antisocial behavior in adulthood; however, not all children respond similarly to such experiences. Analyzing violence from different perspectives is necessary to provide a better understanding of the phenomenon at the sociocultural level. This understanding can provide tools for a comprehensive intervention in people who manifest such behaviors.[9,10]

In the study of aggression and violence, some authors have focused on investigating its genetic basis.

Moffitt explored the heritability of antisocial behavior and found that it ranges around 50 %, with 20 % of the variance explained by variance due to the shared environment and 30 % explained by variability, specifically personal experiences.[11]

Rhee and Waldman, in a meta-analysis that included 51 studies, obtained lower estimates, where strict heritability would explain 32 % of the total variance, non-additive genetic influences would explain 9 %, shared environmental influences 16 %, and, finally, the specific or non-shared, environment would explain 43 % of the total variance. According to these findings, the heritability of disinhibited or antisocial behavior is moderate, and the primary environmental influences are the non-shared or specific ones.[12]

Forms of labor violence

Violence in the workplace has various forms of expression: physical aggression, verbal aggression, psychological aggression, harassment at work (mobbing), sexual harassment, discrimination in access to employment, permanence at work, job promotion, and remuneration: by age, gender, ethnicity, physical appearance, disability, sexual orientation.[13]

Harassment and workplace violence can occur from a person to a group or from a group to a person. It can be vertical: from a boss to subordinates (downward) or from subordinates to their boss (upward), and horizontal, between coworker coworkers and coworker coworkers.[13]

According to the Workplace Violence Advisory Office in Argentina, there are various forms of workplace violence:[14]

- Physical aggression: Any conduct that, directly or indirectly, is aimed at causing physical harm to the worker.
- Sexual harassment: Any conduct or repeated comment with a sexual connotation based on power, not consented to by the recipient.

Psychological harassment: A situation in which a person or group of people exercise modal or verbal mistreatment, alternating or continuous, recurrent and sustained overtime on a worker seeking to destabilize him/her, isolate him/her, destroy his/her reputation, deteriorate his/her self-esteem and diminish his/her work capacity in order to degrade him/her and progressively eliminate him/her from the position he/she occupies.

It can also be classified as internal violence between personnel and authorities and external violence between workers, managers, supervisors, and those who attend the place, in this case, patients and companions.[15]

Consequences of workplace violence

The effects on victims of workplace violence are manifold, encompassing health, social behaviors, and performance in productive activity. The effects on health include physical, psychopathological, psychosomatic, and behavioral issues; these symptoms are almost always combined and require the attention of more than

one medical and psychological specialty. Socially, when mistreatment manifests itself in a person, he or she is alone and strongly affected in all his or her ties, both inside and outside the workplace. Due to the same effects, there is a decrease in their productive capacity, diminishing their abilities due to concentration and chronic illnesses.[7]

There are many harmful consequences generated by workplace violence, with different impacts on the different actors involved:[14]

- In the worker: it affects his or her psychophysical health and can produce negative consequences in his or her social relations in general and family relations in particular.
- In the organization, it produces discomfort among workers, decreased productivity, wasted capacities, economic losses, and social discredit.
- In society: it consolidates discrimination favors disbelief in institutions and justice.

Violence against medical personnel in Argentina

Workplace violence against healthcare professionals is an emerging, global, and daily phenomenon. Analyzing it can contribute to establishing prevention strategies to protect their psychophysical health. The health sector is at serious risk since violence can affect more than half of all health workers. The negative consequences of such widespread violence substantially impact the delivery of health services. They can lead to a deterioration in the quality of care provided and to decisions by workers to leave their professions.[16]

It is important to note that Law 13168 of the Province of Buenos Aires establishes in its Article 2° that labor violence is also the action of public officials and employees who, taking advantage of their hierarchical position or circumstances related to their function, engage in conduct that violates the dignity, physical, sexual, psychological and social integrity of the worker, manifesting an abuse of power carried out through threats, intimidation, intimidation, wage inequality, harassment, physical, psychological and social mistreatment.[17]

To vindicate the right of the health worker to be respected as a person and not to legitimize violence. A work culture should be developed based on the human aspect, focusing on safety and dignity, non-discrimination, tolerance, equal opportunities, equity, and cooperation. The organization should be aware of violence against health personnel and committed to combating violence in the workplace. In addition, problems should be encouraged to be shared and solved as a group.

In Argentina, awareness of the magnitude of the problem has only recently begun to emerge as a result of the reports made by the various medical associations and a survey carried out by Intramed and the Epidemiology Service of the Hospital Italiano de Buenos Aires on a base of 3,100 health professionals.[18]

In Argentina, the Observatorio Sindical de la Sanidad Argentina surveyed more than 2000 healthcare workers in public and private establishments in the provinces of Buenos Aires, Santa Fe, and La Rioja, and the result was that 36 % of healthcare workers in the country suffered physical or verbal aggression or both.[19]

According to this study, almost 55 % of physicians suffer this type of violence. These findings are compatible with those collected in other countries. In the United States, studies carried out by the Bureau of Labor Statistics (BLS) showed that between 1996 and 2000, 69 homicides were reported in health services in the United States. In 2000, the BLS statistical data showed that approximately half of the non-fatal injuries from assaults on American workers in any industry originated in health or social services. Most were in hospitals, ambulatory care centers, and social housing services. When comparing the health service affected with the other sectors of the economy, the large percentage of health care workers[20] was evident.

Not all incidents are recorded, often due to the perception among health personnel that aggressions are part of their work and fear of misinterpretation of their work performance because of these events, so the vast majority do not report these events.

This problem affects the health personnel's quality of life and mental health since the aggressions cause wear and tear on their health, depression, and sick leave. The burden and pressure will generate anxiety, emotional stress, and Burnout Syndrome, whose occurrence can trigger unwanted events in the doctor-patient relationship, compromising the patient's safety.

Medical-legal aspect of violence in the health care setting

Legal aspects

In the event of physical or verbal aggression received by a member of the healthcare team, in the exercise or during the provision of healthcare services, by a third party (patient-family member), our legal system enables the initiation of various legal actions for different purposes, in order to safeguard constitutional and conventional rights (right to health, life, dignity, physical and psychological integrity, work, among others).[21]

Criminal jurisdiction

Criminal law has several functions:

- Repressive: punishes/punishes infractions committed.
- Preventive: (dissuasive) It prevents the commission of infractions so that others do not commit them

in the future.
- Penal rules contain two parts:
- It prohibits some human behavior that is defined as unlawful.
- The sanction foreseen for non-compliance with such prohibition is defined.

Crime of threats

In the exercise or on the occasion of the provision of health services, a patient/family member may announce (verbally-written-computerized) to a member of the health team a severe, possible, and future evil, with the purpose (intention - direct malice) of instilling fear, alarming or intimidating him/her. Such an action violates the individual's psychic freedom (freedom of decision and feeling of tranquility). It can, therefore, constitute the criminal offense of threats, as typified in the Penal Code, art. 149 bis. According to reiterated jurisprudence, the crime of threats is not configured when the expressions are made within the framework of a discussion (in a state of nervousness, anger, or irritation) since these do not have sufficient entity to be interpreted as an announcement of real damage (they do not seek to intimidate or instill fear among the participants of the incidence).[21]

Aggravating circumstances:

The penalty shall be increased from one to three years if:
- The threats are anonymous.
- Weapons are used to make the threats.

Who can bring the action?

This is an action that can be prosecuted ex officio. Without prejudice to the possibility of a complaint by the victim before the judge, public prosecutor, or police (art. 285 CP).[22]

Means of proof: Graphic, documentary, video, testimonials, statements, expert witnesses.

Precautionary measure: The complainant may request the judge of guarantees to grant a measure of restriction of the approach of the accused for a determined period. It is based on the obligation of the State to guarantee the victim the respect of his right to the protection of his physical and moral integrity and even of his family. It is a precautionary measure. It is a prudent and reasonable restriction by a higher interest.

Crime of injury

Within the framework of the provision of health services, the health team as a whole or individually may suffer from patients'/family members' acts that decrease bodily integrity. When such acts attempt against physical integrity (a right recognized in the Pact of San José de Costa Rica, art. 5.1) and there is an intention and will directed to cause harm, the criminal type of malicious injury can be configured, typified in our criminal code in arts. 89-90-91. Such injuries can be produced by any means and are punishable with imprisonment, which is graduated according to the type of injury in question. For the crime to be committed, the existence of real damage (a result after the action) is required.

Criminal types:[22]
- Minor injuries (art. 89 CP): covers those cases in which the agent produces damage to the body (internal injuries: organs/tissues; external injuries: cuts/burns) or to health (alteration of the balance/function of the organism that the victim had prior to the injury), comprising physical and psychic health. Note: The criminal offense is defined by exclusion when it is not provided for in another norm.
- Serious injuries (art. 90 PC): the action is included in this type when there is a permanent debilitation (prolongation in time, not perpetuity) of the health (it does not require that it be an illness), of a sense, of an organ, of a member, or speech, or when the life of the offended party has been endangered (concrete risk, not potential). Also, when the victim is rendered unfit for work for more than one month or when the face is permanently deformed. In all cases, medical evidence is required.
- Severe injuries (art. 91 PC): In this case, the loss (not the debilitation) of a sense, organ, member, word, or capacity to engender or conceive is required. When the victim's capacity to work is lost, or the mental or bodily illness caused to the victim has a definite diagnosis of incurable.

Who can bring the action?
- Minor injuries: This is a private prosecution offense. The victim himself has to denounce before the judge, public prosecutor, or Police (art. 72 CP and 285 CPP).
- Serious- severe injuries: It is an action that can be prosecuted ex officio without prejudice to the possibility that the victim himself denounces the fact or presents himself later in the ongoing investigation to assert his rights (art. 285 CPP). Therefore, the Preparatory Criminal Investigation

may be initiated by a complaint, the Public Prosecutor's Office, or the Police (art. 268 CPP).
- Likewise, public officials or employees who become aware of the crime during their duties, physicians, and other persons who practice any branch of the art of healing may file a complaint (art. 287 CPP). Therefore, the medical director of the institution may file the complaint.
- Civil jurisdiction

Functions of civil liability
- Resarcitory: When the damage has already occurred, whoever caused the damage must restore the situation before the time of the tort.
- Preventive: It is intended to act before the damage occurs or is not aggravated.

Action for damages
- There is a generic duty not to harm another person, which applies to all persons. In the event of a breach of this duty (in this case, physical-verbal aggression to a health team member in the exercise of his functions), the right to claim compensation for the damage caused, for the mediate and immediate consequences, is enabled. Such a claim materializes through initiating a legal action, called damages, in the civil court.

What are the requirements/presumptions for the commencement of such action?
- Existence of damage: when a right or an interest not reprobated by the legal system is injured. It consists of the injury of a lawful interest, patrimonial or extra-patrimonial, that produces consequences in the spirit of the patrimony.
- Causal relationship: There must be an adequate causal link between the fact producing the damage and the damaging consequences. The causal relationship will determine the authorship and the extent of the compensation. In the first place, this element links the wrongful act with a particular result (an antecedent is elevated to the category of the legal cause of damage; for this, a judgment of probability is made, i.e., whether such action or omission of the alleged tortfeasor was suitable to produce, regularly or usually, a result). Secondly, the extent of compensation will include the foreseeable immediate and mediate consequences.
- Unlawful conduct: an action not justified in the legal system.
- Attribution factor: may be based on objective or subjective factors. In the present case, we will always speak of the latter, i.e., willful misconduct or negligence. The reparation of the damage must be complete, integral, and fair. The aim is to suppress the harmful effects of the damaging event as completely as possible and consists of restoring things to the state in which they were before the event. It may be in kind or cash equivalent.

Who can initiate the action?
- The direct injured party.
- If the victim suffered a significant disability or his death resulted, the ascendants, descendants, spouse, and those who live with the injured party receiving an ostensible familiar treatment can claim moral damages.
- What will the compensation include?
- Emerging damage: the loss/diminution of the victim's assets (including, by way of example, medical, pharmaceutical, transportation, and psychological treatment expenses).
- Loss of profit: the loss of the objective probability of obtaining an economic benefit. The damage is constituted by the deprivation of a profit that was not obtained. The victim must provide precise evidence of the objective probability of obtaining such economic benefit. This item includes the supervening incapacity.
- Loss of chance: the frustration of the current and specific possibility that the victim has of a future event occurring or not, without knowing whether or not the damage would occur if it did not occur. The deprivation of such chance may include the pecuniary or non-pecuniary aspect.
- Affectation of very personal rights: compensation for the consequences arising from the affectation of personal integrity, psycho-physical health, and interferences to the life project.
- Non-pecuniary consequences - moral damage: injury to a non-pecuniary interest of the victim with consequences of the exact nature. What is compensated is the invaluable modification of the spirit.

The proof
- Burden of proof: As a general principle, whoever alleges/claims to have received damage must prove/accredit the existence of the damage, the malice/culpability, and the causal relationship except in

those cases where the judge orders the reversal of the burden of proof (theory of dynamic burden of proof).
- Means of proof: documentary - informative - expert - testimonial. What is the time limit to initiate the action? In these cases, the claim for indemnity for damages derived from civil liability prescribes 3 years after the event. Note: In the Province of Buenos Aires, Law 13951 provides for mandatory mediation prior to the commencement of a lawsuit for damages as an alternative method of judicial conflict resolution.

Confluence of actions (Civil and Criminal)
- Autonomy: There is independence in exercising the civil and criminal actions resulting from the same fact. Option: The civil action may be brought jointly with the criminal action before the criminal court.
- Criminal pre-judiciality over the civil action: General principle: The judgment in the civil action is suspended until the conclusion of the criminal proceeding if the latter was initiated first in time or was attempted during the civil action.

Exceptions to the general principle:
Mediates causes of extinction of the criminal action.
If the delay of the criminal proceeding causes, in fact, a practical frustration of the right to be compensated.
- If the civil action for reparation of the damage is based on an objective liability factor.

Prevalence of criminal judgment in civil proceedings
Prevalence of the issues judged in the criminal court on:
- The existence of the central fact (qualification and its inherent circumstances).
- The fault of the convicted party. Both points are incontrovertible in civil court.

Occupational Risks Law 24557 and amendments (lrt) Law 26773

The cases of aggression (physical or verbal) towards the health team, produced on occasion or in the exercise of their functions, can be considered an occupational accident and, therefore, be a contingency covered by the national regulations on occupational hazards and enable the compensation regime provided therein. In this way, we reach a full recognition of the constitutional duty not to harm, in this case, within the framework of labor law.[23]

What is an accident at work (Art. 6 Inc. 1, Law 24557)?.[24]

It is an event:
- Sudden (rapid event, of brief origin) and violent (with the capacity to cause harm).
- It must occur by the fact (it is linked to the specific performance of the performance committed by the worker) or on the occasion of the work (it does not come from the specific performance of the labor obligation, but the occasion of the work is a relevant condition/nexus that surrounds the performance of the performance. The work impacts as a risk condition, e.g., the accident in itinere).

According to the above definition, external aggression in the healthcare field could fall within the scope of the occupational hazards regulations. However, it is disputed, both in the doctrine and national jurisprudence, whether an event occurring as a result of the actions of a third party outside the work environment is an accident at work.

Legitimized

Active parties

All workers in the public, national, provincial, and municipal sectors or the private sector are included in the scope of the occupational hazards law. Therefore, as direct victims, such workers are entitled to file a claim before their ART.

In case of the worker's death, benefits are granted in favor of the worker's beneficiaries.

Liabilities
- The labor risk insurance company is the direct debtor of the benefits.
- The employer may self-insure (subject to specific requirements), assuming the obligations established by the LRT.
- The employer not affiliated with an ART is directly liable to the beneficiary for the benefits.

What type of benefits are available?
- Benefits in kind: medical and pharmaceutical assistance, prosthesis and orthopedics, rehabilitation.

These are granted until complete cure or if the incapacitating symptoms persist. They also include professional requalification and funeral services. This catalog is illustrative and should be interpreted broadly.
- Cash benefits: The amount is determined by calculating the application of the age modules, percentage of disability, and base income.

Specific intervention tools from the legal point of view

Acceptable behavior agreement

Suppose a patient/family member's behavior is unacceptable to the health care institution (physical and verbal aggression). In that case, the healthcare team may decide to continue providing the service by establishing specific behavioral guidelines as a condition for continuing care.

Acceptable behavior agreements signed in the healthcare setting are written agreements between a patient/family member and the healthcare team in charge of his/her care.

They are an effective tool for modifying behaviors contrary to the institution's internal regulations and the national legal system, which violate individual and collective rights. They are a skillful alternative to conflict resolution.

Health mediation offices are an appropriate framework for addressing conflicts between users, between health team members, and between users and the health team. Therefore, these agreements on acceptable behavior can be signed within the framework of their work and as a result of the health mediation process (it should be remembered that the mediation tools explained in the previous section will be very useful in reaching such an agreement).

It is essential to clarify that the objective of health mediation is infinitely more significant than the signing of the present agreements.

When is it used?

When patients or their relatives commit acts of physical violence against members of the healthcare team; or shouting, insults, signs, gestures, words, or graphics that are capable of disturbing, intimidating, or psychologically undermining a member of the healthcare team; or acts of physical violence against healthcare property; or disturbing in any way the exercise of the healthcare service and other patients.

Confection process

- The patient/family should be formally summoned to a meeting to address the situation.
- The meeting is an opportunity to raise awareness and understanding of the impact on other people/systems of their behavior. Also, discuss the terms of the agreement. It should be conducted by a third party to ensure neutrality and impartiality.
- In the meeting(s) before reaching the agreement, mediation tools should/can be used, e.g., the rules of the reflective team. This generates the possibility that the parties' emotions may appear (we refer to the previous section).
- Ensuring that the patient/family member is competent at subscription time is essential.
- The principles of confidentiality should govern the meeting and should not be structured.
- Inform the patient/family that this agreement will be included in the medical record.
- It should not be signed without the agreement of all parties. It may take place in several meetings.

What should it include?

- The behaviors that are not tolerated/accepted should be clearly stated. E.g., shouting-threats-insults (the terms should not be numerous).
- The commitments assumed by all parties should be incorporated, as well as their obligations and rights (search for symmetry of the parties).
- The direct consequences of non-compliance should be included. E.g., discontinuing care with the attending physician, transferring the patient to another health care entity, and attending the facility always accompanied.
- Period of validity and revision of this.
- The wording should be in clear and straightforward language.
- Pre-form forms should not be used; the agreement should be adapted to the observed behavior.

Legal Validity

For our domestic legal system, they are private instruments. Their purpose is dissuasive; they do not necessarily form legally binding contracts. Therefore, they could not be subject to judicial enforcement upon breach.

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The consequences of non-compliance are immediately enforceable, subject to prior notice.

They can be used as background information evidence, evidence in a future judicial process derived from the aggression of the patient/family towards the healthcare team.

It is essential to mention that private mediation can be used.

Preventive action

In the event of non-compliance with the agreement, preventive action could be initiated. Preventive action is taken when the production or aggravation of the damage is foreseeable. The threat of production of damage is sufficient, and the existence of a particular risk of production of the same (art. 1711 et seq. CCyC).[25]

Models

You will find a model agreement of acceptable behavior in the annex to this guide.

International examples of the use of this tool:

- Australia.
- United Kingdom.
- Spain: Health mediation offices have been implemented in communities such as Barcelona and Valencia.

Aggravating remarks

The healthcare worker may be affected by such offenses, inaccurate/false or insulting information (related to the exercise of the healthcare service or as a consequence) issued through a press medium and reaching the general public.

What rights may be violated by such action? Right to image, honor, dignity, physical-psychic integrity, and privacy (personal human rights).

- In such a violation, the person directly affected has the right to rectify/ reply before the same organ of diffusion.
- Discontinuity of care
- When there are significant and specific problems for the safety of the healthcare team as a result of the behavior of a given patient or his/her family members (e.g., repeated acts of violence or the agreement of acceptable behavior have not produced any results), the discontinuation of the patient's healthcare may be considered.
- What rights are exercised?
- Right of admission: in the case of private healthcare institutions. The exercise of this right must be a reasonable measure and not cause irreparable harm. The causes must be expressed, and the health service must be guaranteed. Irregular exercise of the right is not allowed.
- Exercise of the liberal profession: In the case of a professional who works autonomously, due to his characteristics (without subordination - technical autonomy), he is not obliged to attend to all persons.
- Before deciding, and if necessary communicating, the cessation of care:
- Confirm that it is a decision agreed upon by the entire healthcare team, including the institution's management. Institutional support is essential.
- Analyze the patient's health situation. The existence of any particular risk to the patient's psychophysical health prevents the discontinuation of care.
- Analyze the risks for the rest of the healthcare team and other patients in case of continuing care.
- Analyze whether continuing the patient's care may imply a decrease in high-quality care for the rest.
- How to communicate the discontinuation:
- Personally (essential to consider how to approach the discussion and communicator training).
- Formal letter (explain the reasons for discontinuing care, ensure the exercise of the patient's right to care and information).
- Important reminders when exercising the discontinuance:
- Refer the patient to another appropriate healthcare facility for continuation of care. Alternatively, give the patient options to choose where to continue care.
- Advise the patient reliably of the importance of continuing his/her health care, as the case may be.
- Provide the patient with the prescriptions for temporary treatment and inform him/her about the care to be provided until he/she goes to another health care center.
- Give the patient his/her medical record or automatically send it to the health center to which he/she is referred.

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Analysis of research and theoretical background of the subject in the Argentine context

Violence in the workplace has become one of the main problems of our time, growing disproportionately in recent years, gaining ground with globalization, and having a global impact on occupational hazards, affecting all sectors and categories of workers, especially the health sector, which is at serious risk. Aggression in this sector may account for a quarter of all violence in the workplace.[20]

Violence against health professionals is causing growing alarm. Estimating its actual dimension is complex, given that most of these events go unrecorded, and even the most serious ones are often not reported to the authorities. Their frequency varies in the literature, partly because of the definitions of violence used and the populations evaluated.[26]

An analysis of assaults on health personnel in Spanish-speaking Latin American countries concludes that this is a frequent problem that generates emotional and occupational sequelae and causes a perception of insecurity in the workplace among health professionals. The problem is serious because it exposes thousands of people to be victims of aggression and violates fundamental safety rights in the workplace. Its consequences alter the quality of the service provided and thus affect the public health of the entire population.[27]

In Argentina, few studies allow us to evaluate and recognize the factors that determine the situations of aggression to which health professionals are exposed, even though it is recognized that a large population of health personnel has suffered from this problem. A total of 66,7 % reported aggression. Physical aggression accounted for 11,3 % of the aggressions. Of these, 73,4 % occurred in public institutions, mainly in emergency areas. In 16,9 % of the cases, sequelae were reported in the assaulted professionals, where physical aggressions were significantly associated with a higher risk of sequelae than verbal aggressions. They concluded that verbal or physical violence towards health personnel was frequent, resulting in occupational, psychological, and even physical sequelae.[27]

Algieri et al. studied a sample of 362 physicians (52,21 % men), where 91,99 % reported being assaulted during work; 8,01 % denied violence. This study concluded that aggression towards physicians, in all its variables, is a daily occurrence, usually goes unnoticed, and causes wear and tear on the health of professionals. It can generate adverse events that seriously compromise patient safety and, at the same time, increase health costs. Establishing and developing an organizational culture based on safety should be promoted. One of the substantive aspects is to develop the early identification of risks of aggression and violence and to act within the system to install barriers to prevent them from happening, thus preventing undesirable events for no one.[28]

Muñoz Pascual et al. analyzed the records of aggression to personnel in a health district and a hospital of public health institutions. They found that physicians reported the most aggressions with 34 %, followed by administrative assistants with 15,1 % and nurses with 13,2 %. Of the healthcare centers, the hospital accounted for 41,5 % of the violent acts. By type of aggression, 15,1 % used shouting and insults to achieve their goal, 13,2 % used insults and verbal threats, 11,3 % used shouting and verbal threats, 9,4 % used shouting, insults, and verbal threats, and finally 7,5 % used shouting, insults, verbal threats, and physical aggression. The same percentage is obtained with yelling, verbal threats, and mistreatment of the facilities. These authors consider that we are dealing with a hot topic, possibly due to the media pressure caused by the consequences it entails and the social alarm that this type of action generates.[19]

A specialty thesis presented by María Betiana Fornasari at the Universidad Nacional del Litoral analyzed the frequency with which 114 workers have suffered violence in health centers in Paraná. It showed that 57,9 % of those surveyed perceived situations of violence in the workplace. The most frequently recognized aggressors were the patients and senior staff, both in 52,6 %. In turn, the most frequent forms of Violence were shouting (84,2 %), followed by disrespect (68,4 %), and, finally, criticism (57,8 %) of the total obtained in the survey. The author concluded that the workers in the health institutions studied recognize the presence of Violence and that psychological Violence is the most frequent manifestation. Knowing this can have more significant repercussions than physical Violence, reducing the quality of life. The aim is to open up more possibilities for study and thus improve interpersonal relationships.[18]

In a study conducted in Cordoba with a sample of 321 healthcare workers, 62,9 % stated that Violence occurs in the institution. Among the violent behaviors, shouting stands out as the form of Violence that occurs in the institution with the highest percentage of response, 65,1 %, and 55,1 % stated that insults are another form of Violence present. The external aggressors most frequently recognized by the workers (50,7 %) were the patients' relatives and companions. Of the internal aggressors, 54,8 % of the workers with the highest hierarchy are recognized as the agents that generate violent situations. Among the main circumstances that lead to Violence are the lack of immediate response from the institution, the workload, the lack of shifts, and delays in care. Verbal and physical defense were found to be the most frequent form of action taken by workers when faced with an act of Violence. Among the consequences of Violence perceived by workers are defensiveness and exhaustion. Nurses are the most frequently recognized group among the groups recognized by the workers as vulnerable to Violence in health services. It was observed that various manifestations of

Violence in the workplace are frequently present in the health sector, affecting a significant number of workers and constituting an occupational risk of great relevance for those who work there, as well as affecting the quality of care in health services.[29]

A study of health personnel shows that 91,99 % received aggressions during work; 51,35 % were verbal, 35,74 % psychological, 12,91 % physical, and 40,24 % combined verbal and psychological attacks—28,45 % registered inconveniences during their work. A total of 28,45 % registered work-related inconveniences due to their sexual condition. Of those surveyed, 88,12 % felt that their work was a risk zone for their physical and psychological integrity, and 95,03 % recognized that their colleagues had been mistreated at work.[28,30]

An epidemiological survey of Violence against physicians in the work environment in Santa Fe, Argentina province, among 1134 respondents (62,7 % women). Of those surveyed, 70,2 % reported having suffered at least one Violence in the Workplace (VAL) episode.[31] The frequency of events described was 1 event in 15,1 %, between 2 and 5 events in 41,1 %, and more than 5 events in 14 %. The type of Violence described was only verbal in 63,6 % of the cases and physical in 6,5 %. The aggressor described as a patient's relative in 48,1 % of cases, an unknown patient in 35,9 %, the treated patient in 18 %, a medical colleague in 17,5 %, a non-medical coworker in 16,4 %, and other aggressors in 3,9 %. This study concluded that Violence against physicians in the workplace is a widespread problem with an increasing trend, the consequences of which are very significant for both the physician and the patient. It was observed that 7 out of 10 professionals suffered at least one episode of Violence in the last year; among the characteristics of the physicians surveyed, it was found that younger physicians, those with fewer years of graduation, and the female sex were associated with a higher risk of suffering an episode of Violence. About the place of work, it was found that the outpatient ward, regardless of whether it was a public or private facility, increased the risk of suffering an episode of Violence by 30 %.

CONCLUSIONS

The studies analyzed show that the effects of aggression are varied and will depend on the frequency and severity of the episodes and the vulnerability caused by the number of episodes, which cause deterioration in the quality of care, suffering, and illness of those involved, thus affecting not only the personnel involved but also having repercussions on their families and the environment outside the workplace. Therefore, it is essential to investigate and analyze the factors involved in the different situations that arise and thus be able to intervene promptly.

Statistics show that violence is more frequent the younger the staff is and more frequent in the case of women. It is also evident that not only age and sex are the factors that have the most significant impact on acts of violence, but other variants, such as nationality, place of work, and position held, influence the moment of being victims of aggression in the work environment.

It is essential to recognize that workplace violence is not only perpetrated by the patient; some statistics show that the patient's family member or companion is the primary external aggressor and that workers with greater hierarchical power are the primary internal aggressors.

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