



Research Article

Caring for the Carers: A Call to End Violence in Healthcare

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Abstract

Healthcare workers enter the profession with purpose, compassion, and a drive to heal—but too often, we are met with workplace violence (WPV). Nurses and other frontline staff are five times more likely to be injured on the job than workers in other fields, yet incidents remain underreported and inadequately addressed. Drawing on both lived experience and existing literature, this paper highlights the profound personal, professional, and systemic consequences of WPV. Evidence shows that while tools exist to assess patient violence risk, few mechanisms support the staff who endure it. Survivors are frequently met with silence, blame, or institutional gaslighting instead of trauma-informed support. I share my own experience as a psychiatric nurse practitioner and advocate alongside data demonstrating the human and economic costs of WPV, including burnout, turnover, and billions in financial losses. Real change requires believing healthcare workers when they report violence, providing trauma-informed interventions, and enacting policies that ensure accountability and safety. Preventing violence and supporting staff is not optional—it is essential for sustaining a healthy workforce and safe, high-quality patient care.

Keywords

Workplace Violence, Healthcare Worker Safety, Nursing, Trauma-Informed Care, Occupational Health, Mental Health, Policy, Burnout

1. Introduction

There are many reasons a person chooses to enter the healthcare field. For most of us, it begins with a heart full of joy and a desire to help others heal. We enter the profession with purpose, compassion, and a drive to make a difference. But the reality of working in healthcare often includes something far more sobering: a significantly higher risk of workplace violence (WPV). In the United States, healthcare workers are five times more likely to be injured on the job than those in any other profession. And yet, incidents of WPV remain chronically underreported. Too often, violence is minimized or dismissed as “part of the job”, forcing healthcare workers to endure verbal abuse—and in some cases, physical assault—without proper acknowledgment or support.

Positionality statement: As a board-certified psychiatric mental health nurse practitioner and former bedside nurse, I write this piece grounded in both lived experience and clinical practice. My perspective is shaped by years spent working in emergency and inpatient psychiatric settings, where I directly experienced workplace violence and the systemic failures that often follow. I approach this topic as a clinician, survivor, and advocate for healthcare worker safety. My aim is to elevate awareness, promote trauma-informed policy, and help create safer environments for both staff and patients.

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2. Workplace Violence in Healthcare

2.1. Prevalence and Trends

Since the COVID-19 pandemic, the issues have worsened. Many healthcare workers close to retirement left the profession, while others left due to vaccine mandates or health concerns. These departures, combined with public mistrust and misinformation, created widespread staffing shortages that persist today. The result was a rise in workplace violence—fueled by overburdened systems, staff burnout, and a lack of adequate preparation or protection [10]. During the height of the pandemic, some of us were viewed with fear—not because of who we were, but because of what we represented: the unknown.

A qualitative mixed-methods study conducted in Australia found that the healthcare industry is considered one of the most violent industries for employees, particularly in high-risk areas like intensive care units (ICU), mental health departments (MHD), and emergency departments (ED)—patterns similar to those seen in the United States [4]. In the study, Dafney and colleagues conducted focus group interviews with 23 nurses working in a regional Queensland hospital. They found that the primary source of support following WPV was other nurses. Institutional support was seen as lacking, and participants reported feeling isolated and unsupported after incidents of violence. This WPV pandemic is not confined to the United States; it is a global condition that desperately needs to be properly treated and addressed [11].

2.2. Consequences for Healthcare Workers

There are countless tools and models designed to assess the risk of violence posed by patients—such as the Brøet Violence Checklist, the Richmond Agitation-Sedation Scale, and others. Yet few tools exist to measure the impact of that violence on the healthcare workers who experience it. A healthy community depends on having enough well-supported healthcare professionals to deliver high-quality, evidence-based care. When a healthcare worker becomes the victim of violence, they face a profound, multifaceted trauma: the very person they were assigned to help has harmed them. And too frequently, these workers are met with silence or inadequate support from leadership, colleagues, and the systems meant to protect them.

It's time for that to change.

2.3. Systemic Failure and Gaps in Support

I've experienced firsthand the impact of workplace violence. Early in my nursing career, I was assaulted by a patient—an attack made possible by systemic failures: poor safety protocols, lack of training, and no clear follow-up process for injured staff. I returned to work disoriented and concussed, unsure where to turn.

Later, I was assaulted again while working alone in the psy-

chiatric rooms of the emergency department—another preventable situation. I begged for accommodations, but leadership offered little support. I was expected to return to the same environment, as if trauma was something I could simply leave at the door.

Eventually, with the help of a trauma-informed provider, I secured accommodations that kept me out of that area. But once those expired, I was forced back, despite the presence of serious risk factors—like concealed weapons the hospital failed to detect. Leadership refused to back me, and I had to leave my inpatient role for the sake of my own safety and recovery.

I tried continuing inpatient work at another hospital with better staffing and security. While I felt safer, I could no longer work alone with high-risk patients. My nervous system couldn't handle it. I still wanted to help, but I had to draw a line. Choosing safety shouldn't come at the cost of your calling—but too often in healthcare, it does.

And I'm far from the only one. I worked with a nurse who was attacked so severely that, despite trying her best, she was never able to return to work. Another colleague suffered a miscarriage after being kicked in the abdomen by a patient in the ED. Others have endured broken bones, head injuries, and repeated trauma. And the worst part is, these incidents are often followed not by support, but by silence, blame, or institutional gaslighting.

Too many of us healthcare workers are burned out—not from the work itself, but from the betrayal of systems that should protect us. We deserve better—and so do the people we care for. It's time for organizations to move beyond performative gestures and start engaging in meaningful action. It's time to meet us where we are and ask how they can support us: before, during, and after workplace violence. I dream of a day when WPV in healthcare is rare, when survivors are believed and protected, and when healing—not just productivity—is prioritized.

Now I work primarily remotely, seeing patients via telehealth—because no one can punch me through a screen. That may sound flippant, but it's the truth. I miss in-person care. I miss spending a shift with patients and really getting to know them. I miss the camaraderie of a team working side by side. But my own physical and mental health has improved since I could no longer work in the inpatient psychiatry level of care. I hope that one day, perhaps I'll be healed enough to return to that level of care, in a setting where safety is prioritized—not treated as optional.

3. Results (Literature and Lived Experiences)

3.1. Research Evidence

Studies have shown that adequate support following WPV can significantly reduce the long-term effects on affected staff [1]. Yet that support is still the exception, not the norm. The wheels of change in massive systems like global healthcare

take time to turn—and even longer to shift direction.

Zhang et al [8] conducted a qualitative systematic review of nurses' experiences with workplace violence and identified four major themes: "inevitable and unpredictable trauma in the career," "higher tolerance and understanding of unintentional violence," "positive learning or passive adjustment," and "struggle with the role and behavior conflict." These findings highlight the deep emotional and ethical toll that workplace violence takes on nurses—especially when they are expected to tolerate harm as part of their role. From the data, two primary types of support needs emerged: informal support, such as emotional validation and peer understanding, and formal support, including organizational policies, post-incident interventions, and leadership accountability. This study reinforces what so many of us have lived—when violence is treated as an expected part of the job and formal supports are inadequate or inaccessible, nurses are left to carry the trauma alone. Systems that recognize both the psychological impact and the practical needs following violent incidents are essential to retaining a healthy, empowered workforce [13].

3.2. Personal Experiences and Case Examples

So, what would real support look like? First, it means believing us when we report violence. It means trauma-informed debriefings, access to therapy, and clear, compassionate accommodations. It means leadership showing up—not with hollow words, but with meaningful action and accountability. Imagine if, instead of brushing it off, someone simply asked, "What do you need right now?"—and truly meant it. After my second assault, the nursing leadership team sent me a package of cookies and tea. What I truly needed was a leadership team that listened, advocated, and ensured I wouldn't be forced to continue working in the very space where my trauma occurred—especially without appropriate accommodations. I'm sure the people I worked with did the best they could with what they had. Hospitals are often so afraid of accepting liability that they forget a heartfelt apology and meaningful change can honor our humanity amid such agony. The safer and more emotionally supported a person feels, the more likely they are to process, reframe, and ultimately recover from a traumatic experience. I don't share this to blame individuals at the hospital where I worked, but to illustrate a broader systemic failure that continues to harm healthcare workers across the country [14].

This story may be activating for those who have experienced violence. Please take care of yourself and read with caution and self-compassion. The first time I was assaulted, one of my nursing colleagues asked me why I hadn't run away. The reason was simple: I couldn't.

I had been closing the door to one of my other patients' rooms while the unit had called for security to stand by. We were preparing to administer an intramuscular injection to a patient who had become agitated and threatening. As I turned back from closing that door, suddenly the agitated patient's

fist collided with my face. She grabbed my hair and punched me again, and again.

Anyone who has ever been punched knows that if you have long hair and your attacker grabs it, it is almost impossible to escape. I was kicked in the legs and punched in the face multiple times. I sustained a concussion, and my cheek was bloody and bleeding from the assault. I later found scratches not only on my face, my also on my neck.

The one valiant coworker with me came to my rescue. She was able to distract the patient and intercept the beating. But at that moment, I didn't realize the patient was not trying to hurt my colleague, so I didn't escape behind the nursing station. Instead, I stayed to try to help my coworker escort the patient—who had just beaten me to a bloody mess—back to their room.

The patient broke away from us. She grabbed me by my ponytail, and the next thing I knew, I was being dragged by my hair. My upper back was slammed into the corner of the nursing station, causing a thoracic injury that still flares up at times to this day, nearly seven years after that awful night.

Eventually, an incredibly vigilant security officer who had been monitoring cameras for the entire hospital noticed the violence unfolding. He called the main mental health unit and told them to get there immediately—we needed help.

By then, the patient and I were on the floor. She had a vice-like grip on my hair. Moments later, five more staff members arrived. I vaguely remember a kind coworker carefully untangling my scalp from the patient's grasp. I was finally able to stand, get behind the nursing station, and retreated into the medication room. I shut the door and began sobbing.

The thought that raced through my mind was, *what did I do wrong?* Survivors of WPV often inappropriately blame themselves for what happened, as is often seen with survivors of sexual assault.

My coworker looked at me and reassured me that I hadn't done anything to deserve what had happened. I reached up and gingerly touched my head. A large patch of hair was missing. Another coworker later told me they had been cleaning up blonde hair from the floor where I was attacked for some time the next day. I was also missing an earring.

A security officer drove me to the emergency department for evaluation. I remember staring at the full moon during the drive, my mind desperately dissociating from the pain I felt. They brought me into the room with the cameras. The knight in shining armor—the security officer who had witnessed the assault and sounded the alarm—showed me the replay of what had happened.

I didn't remember much. But watching my back slam into the corner of the nursing station helped me understand why it hurt so badly.

I was evaluated, and a police officer was called. He took photos of my injuries, jotted notes in his black Moleskine pad, and asked if I wanted to press charges. I told him yes. Not to be vindictive, but so there would be a record of what had happened to me. Even if charges were never filed by a district attorney, pressing charges

creates a paper trail. It documents the truth.

I sat alone in an emergency department room, numb, holding a bag of ice against my face. Security officers also took down my account of the incident.

I eventually made my way back to the unit, where I finished documenting the event and filed several safety alert reports. For reasons I still do not understand, the charge nurse on duty that night later added an addendum to my note in the chart. Even more troubling, the assault was logged in the unit's assault record as having happened to her, not to me. I did not notice this until quite some time after the assault, and I still wonder why those critical details were altered.

Later, as part of my own cognitive processing, I asked to watch the video of the assault again. The hospital initially refused. They eventually said I could view it, but only if my manager was present. That felt strange to me, so I did not pursue it further.

There was no clear process for what to do after an assault like this. There was no meaningful support. The hospital where I worked did not have a security officer stationed in the psychiatry unit—something I had advocated for repeatedly, until they finally implemented that safety measure years later. The unit also lacked alarm duress buttons, which were commonplace on the medical floors. That deeply troubled me.

Had either—or both—of those safety measures been in place, there is no doubt in my mind that the amount of time I spent being beaten would have been significantly reduced.

I was fortunate to have an incredible mentor who encouraged me to pursue my MSN and keep going when I was close to walking away from healthcare entirely. He listened to my story, helped me advocate for myself and others, and reminded me I wasn't alone. In a time when I felt like I was drowning, his guidance helped steer me back to shore.

The physical and psychological trauma I experienced was further compounded by organizational dismissal. Management offered little meaningful support, and when I required reasonable accommodations to continue working as a bedside nurse, they refused to advocate on my behalf. Instead, I was redirected to Human Resources and subsequently met with silence as calls went unanswered. Healthcare systems must evolve into structures that are not only patient-centered but also protective and supportive of the workforce. The well-being of healthcare workers must be valued with the same urgency as that of the patients they serve.

4. Discussion

4.1. What Real Support Looks Like

We must develop and implement comprehensive, trauma-informed policies and procedures for healthcare workers who experience WPV. That starts with data. Organizations must foster a culture in which every incident is reported—without fear of retaliation or shame [3]. Reporting should be seen not as a burden, but as an essential act of advocacy and protection.

Transparent reporting systems and organizational accountability are necessary first steps toward meaningful change [14].

From there, nursing researchers and workplace safety experts can use that data to build interventions and systems that truly support healing. Surveys capturing healthcare workers' experiences—and the presence or absence of support—can shed light on what's working and what urgently needs to improve. Healthcare leaders must be informed about the long-term repercussions of WPV, and they must be equipped with tools to support recovery and healing in their workforce [12].

As the saying goes, knowledge is power. But knowledge must be paired with action. A recent cross-sectional study in China found that 17.2% of nurses leave the profession due to workplace violence [9]. That number is likely a significant underestimation, as it does not include data on all healthcare workers, such as nursing assistants, respiratory therapists, patient transporters, patient safety companions, among others. A survey from National Nurses United in the USA showed that 82% of nurses had experienced at least one type of WPV in 2023 and a staggering 37.2% of nurses are considering leaving the profession because of it [5]. Many survivors of WPV are left unable to return to their roles, facing long-lasting personal and professional consequences. A trauma-informed system should provide the following after WPV:

- 1) Post-incident debriefing with trained personnel to facilitate emotional processing and ensure safety
- 2) Protected paid time off for recovery, without pressure to return prematurely and without punitive consequences
- 3) Peer support programs, utilizing colleagues' training to treat workplace trauma
- 4) Rapid access to evidence-based trauma treatments like trauma-focused therapy and EMDR
- 5) Clear, timely accommodation pathways with leadership accountability and transparent communication
- 6) Non-retaliation reporting policies that are highlighted and consistently upheld

Patient factors, including but not limited to delirium, acute psychosis, substance intoxication, or dementia, may contribute to violence, but these clinical realities do not absolve healthcare systems of their responsibility to anticipate risk, provide adequate staffing and security, and protect the workforce that is literally entrusted with care.

Workplace violence isn't just traumatic—it carries a steep economic toll. A 2025 report estimates U.S. hospitals spent more than \$18 billion in 2023 responding to assaults, compensating injured staff, training, and turnover costs [2]. The estimated costs of replacing a single bedside nurse average from \$56,000 to \$61,000, which translates to hospitals and other healthcare facilities losing millions each year as turnover spikes due to WPV. When we lose a healthcare worker, we lose years of training, lived experience, and relationships built on trust. We lose our ability to show up fully—for ourselves, our teams, our patients, and our loved ones.

4.2. Policy and Legislative Approaches

It is currently safer to drive a taxi in New York City than it is to work as a healthcare provider in Oregon—my home state. In NYC, assaulting a taxi driver is a felony punishable by up to 25 years in prison. In Oregon, if someone assaults a healthcare worker, there's a good chance they will never face criminal charges at all. The Oregon legislature recently passed Senate Bill 537, which I proudly provided testimony in support of [7]. The bill expands the definition of workplace violence, mandates annual prevention training, and establishes a flagging system to help alert staff when a person with a known history of violence presents for care [6]. However, to my knowledge, it does not include felony penalties for assaulting healthcare workers. This oversight sends a troubling message. Thirty-two other states have made it a felony to assault a healthcare worker—Oregon should, too. I invite the world to join me in demanding stronger protections and building systems that don't just prevent violence—but actively support healing and justice when harm does occur. These laws must also include safeguards to ensure that individuals with neurocognitive conditions, such as dementia, or psychiatric illnesses like schizophrenia, are not unfairly criminalized due to symptoms or altered mental states at the time of an incident.

4.3. The Human and Economic Costs

As a former member of the American Psychiatric Nursing Association's Council for Safe Environments, I support the principles outlined in *Pitfalls and Platforms in Workplace Violence Prevention* [3]. Though I do not speak on behalf of APNA or other council members, I believe strongly that organizations must move beyond top-down, compliance-driven models and instead adopt trauma-informed, relationship-centered, and recovery-oriented approaches. These strategies emphasize therapeutic engagement, conflict de-escalation, and post-incident support—not just containment. Nurses (all healthcare staff truly) should be viewed not only as employees to protect, but as trusted safety partners whose clinical insight and lived experience deserve to shape the systems in which we work. This isn't just a workplace issue. It's a human issue. It's about the stories we carry—the moments when our efforts to help were met with harm, and what happened next. It's about the nurses who show up anyway, despite the trauma, because they care so deeply. And it's about the ones who left—not because they didn't love their work, but because their workplaces failed to love them back.

5. Conclusion

Florence Nightingale once said, “*The very first requirement in a hospital is that it should do the sick no harm.*” I would expand her statement to include that a hospital—or any healthcare facility—*should do no harm to the sick or their carers.* It is not only an ethical obligation; it is what healthcare

organizations must do if they are to keep their facilities safely staffed and thriving. For if those who care for the ill are not safe from harm, how can they provide healing and quality care to their patients?

We cannot build a compassionate healthcare system on the backs of traumatized, injured healthcare workers. We are asking to be treated as human beings—with dignity, with care, and with the safety that every worker deserves. When healthcare systems invest in preventing WPV and supporting their staff, the returns on investment are profound: lower turnover, fewer injuries, improved patient outcomes, a more supported and happier workforce, and a significant return on investment. A safer environment for healthcare staff is a safer, more sustainable system for everyone.

It's time to care for the carers.

Conflicts of Interest

The author declares no conflicts of interest.

References

- [1] Andersen, L. P. S., Hogh, A., Andersen, J. H., & Biering, K. (2021). Depressive symptoms following work-related violence and threats and the modifying effect of organizational justice, social support, and safety perceptions. *Journal of Interpersonal Violence*, 36(15-16), 110-7135. <https://doi.org/10.1177/0886260519831386>
- [2] American Hospital Association. (2023). *Cost of community and workplace violence to hospitals and health systems*. <https://www.aha.org/system/files/media/file/2023/06/cost-of-community-and-workplace-violence-to-hospitals-and-health-systems.pdf>
- [3] Blair, E. W., Allen, D. E., Delaney, K. R., Polacek, M., Schneider, L., Lindvall, R., McGill, A., Sharp, D., & Weaver, T. (2025). Pitfalls and platforms in workplace violence prevention. *Journal of the American Psychiatric Nurses Association*, 0(0). <https://doi.org/10.1177/10783903251320377>
- [4] Occupational Safety and Health Administration. (2016). *Guidelines for preventing workplace violence for healthcare and social service workers*. U.S. Department of Labor.
- [5] Dafny, H. A., Chamberlain, D., Parry, Y. K., & Beccaria, G. (2022). Do nurses receive any support following incidents of workplace violence? A qualitative study. *Journal of Nursing Management*, 30(6), 1843-1851. <https://doi.org/10.1111/jonm.13695>
- [6] National Nurses United. (2024, February). *Assaulted and unheard: Workplace violence against nurses in 2023*. https://www.nationalnursesunited.org/sites/default/files/nnu-documents/0224_Workplace_Violence_Report.pdf
- [7] Oregon State Legislature. (2025). *Senate Bill 537: Relating to workplace safety in health care settings* (SB 537, 2025 Reg. Sess.). <https://olis.oregonlegislature.gov/liz/2025R1/Downloads/MeasureDocument/SB0537/A-Engrossed>

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- [8] Shi, L., Zhang, D., Zhou, C., Yang, L., Sun, T., Hao, T., Peng, X., & Gao, L. (2020). A cross-sectional study on the prevalence and factors associated with workplace violence against Chinese nurses. *BMJ Open*, 10(6), e038673. <https://doi.org/10.1136/bmjopen-2020-038673>
- [9] Zhang, J., Wang, A., Xie, X., Zhou, Y., & Li, J. (2020). Nurses' experiences and support needs following workplace violence: A qualitative systematic review. *Journal of Clinical Nursing*, 29(3-4), 387-403. <https://doi.org/10.1111/jocn.15108>
- [10] National Institute for Occupational Safety and Health. (2024). *Workplace violence in healthcare*. Centers for Disease Control and Prevention.
- [11] [World Health Organization. (2023). *Violence against health workers*. WHO.
- [12] American Nurses Association. (2023). *Workplace violence prevention*. ANA.
- [13] The Joint Commission. (2018). *Sentinel Event Alert 59: Physical and verbal violence against health care workers*.
- [14] Freyd, J. J., & Birrell, P. J. (2013). *Blind to betrayal: Why we fool ourselves we aren't being fooled*. Wiley.