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Violence in the daily work of healthcare professionals in an emergency care unit

Violência no cotidiano de trabalho dos profissionais de saúde de uma unidade de pronto atendimento

La violencia en el cotidiano laboral de los profesionales de salud en una unidad de urgencias

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ABSTRACT

Objective: To analyze the daily work of an Emergency Care Unit (ECU), with emphasis on the violence experienced by the multiprofessional healthcare team.

Method: Case study with a qualitative approach, conducted in na ECU in Minas Gerais, Brazil. The collection took place between August 2020 and January 2021, through observations, interviews and document review. Data were organized in MAXQDA 2020® and subjected to Content Analysis, based on Michel de Certeau's theoretical framework of everyday life.

Results: A total of 31 healthcare professionals participated. Violence against professionals was associated with the waiting time, the lack of beds for transfer and the restrictionson the entry of companions. The main aggressions were verbal, followed by physical aggression.

Final considerations: The daily life of the ECU was permeated by labor violence. Although it was governed by strategies aimed at organizing the assistance provided, professionals adopted tactics to cope with the adversity.

Descriptors: Workplace violence. Emergency medical services. Occupational health.

RESUMO

Objetivo: Analisar o cotidiano de trabalho de uma Unidade de Pronto Atendimento (UPA), com ênfase na violência vivenciada pela equipe multiprofissional de saúde.

Método: Estudo de caso com abordagem qualitativa, realizado em uma UPA de Minas Gerais, Brasil. A coleta ocorreu entre agosto de 2020 e janeiro de 2021, por meio de observações, entrevistas e consulta a documentos. Os dados foram organizados no MAXQDA2020® e submetidos à Análise de Conteúdo, com fundamentação no referencial teórico de cotidiano de Michel de Certeau.
Resultados: Participaram 31 profissionais de saúde. A violência contra os profissionais esteve relacionada ao tempo de espera, à falta de leitos para transferência e à limitação da entrada de acompanhantes. As principais agressões foram verbais, seguidas pelas físicas, praticada.
Considerações finais: O cotidiano da UPA era permeado pela violência laboral. Embora fosse regido pelas estratégias, que visavam organizar a assistência prestada, os profissionais adotavam táticas diante das adversidades.
Descritores: Violência no trabalho. Serviços médicos de emergência. Saúde ocupacional.

RESUMEN
Objetivo: Analizar el trabajo cotidiano de una Unidad de Atención de Emergencia (UPA), con énfasis en la violencia vivida por el equipo multidisciplinario de salud.
Método: Estudio de caso con abordaje cualitativo, realizado en una UPA de Minas Gerais, Brasil. La recolección se realizó entre agosto de 2020 y enero de 2021, a través de observaciones, entrevistas y consulta de documentos. Los datos fueron organizados en MAXQDA 2020® y sometidos a Análisis de Contenido, con base en el marco teórico diario de Michel de Certeau.
Resultados: Los principales hallazgos del estudio deben presentarse de manera concisa y clara, sin excesivos detalles. Los resultados deben estar alineados con la sección de resultados del artículo completo, proporcionando información más detallada sobre los análisis estadísticos realizados y los principales resultados encontrados.
Consideraciones finales: La vida cotidiana de la UPA estuvo permeada por la violencia laboral. Aunque se rigió por las estrategias, que tenían como objetivo organizar la asistencia prestada, los profesionales adoptaron tácticas frente a la adversidad.
Descriptores: Violencia laboral. Servicios médicos de urgencia. Salud laboral.

INTRODUCTION

The National Policy for Emergency Care (*Política Nacional de Atenção à Urgência* - PNAU) was established by Ordinance No. 1,863, of September 29, 2003, and structured the urgency and emergency care network, aiming to expand and improve access to emergency care services of the Unified Health System (*Sistema Único de Saúde* - SUS). For Emergency Care Units (ECUs), fixed components of pre-hospital emergency care, the objective was defined to decentralize care for less complex cases, thus preventing patients from being referred to hospitals and emergency rooms. Together with the Mobile Emergency Care Service (*Serviço de Atendimento Móvel de Urgência* - SAMU), they constitute the intermediate level of emergency care, between Basic Health Units (BHUs) and hospitals[1].

The ECUs are places where healthcare professionals often face challenges and unforeseen events, including violence. Almost a quarter of acts of workplace violence worldwide occur in urgent and emergency services and are generally committed by patients

and visitors, with psychological violence being more prevalent than physical violence[2]. Aggressors can be external to the service, such as users and companions, or internal, represented by the institution's own staff[3].

Some environmental conditions are risk factors for violence committed by users, such as overcrowding, shortage of staff members and resources, budget problems and lack of beds[4,5], in addition to the lack of security staff[2]. In Italy, workplace violence against healthcare professionals constitutes a "sentinel event", defined as a serious and potentially preventable adverse event, which can result in harm to professionals and lead to a loss of public confidence in the healthcare system. It represents a public health issue, which affects individuals and organizations[6].

Workplace violence increases the risk of occupational diseases, psychosocial issues and lack of interest by professionals in their work, and can result in a drop in the quality of care which, in turn, fosters the circle of violence by causing feelings of anxiety in users, frustration and loss of control[3]. It is noteworthy that violence in the daily work of urgent and emergency services is the main risk factor for occupational stress among healthcare professionals[7]and can be influenced by situations such as the recent COVID-19 pandemic.

The pandemic represented one of the most acute and severe health problems in recent decades and constituted a global public health emergency[8]. It challenged governments to carry out rapid, unprecedented structuring of healthcare services to assist the growing number of patients[9]. The ECU studied started to receive suspected or confirmed cases of the disease, which changed its daily work routine, both regarding the number of users and new care protocols.

On the front line of fighting the disease, professionals from an urgent and emergency service in Paraná, Brazil, found work overload, physical and mental distress and a lack of beds, materials and staff as the main triggering and intensifying factors for workplace violence during this period[10]. As violence in daily work leads to changes in professionals' practices, it is necessary to deepen studies on the theme to better understand it in the context of emergency services, from the perspective of the multiprofessional healthcare team. Addressing it is essential and indispensable to avoid negative repercussions on the work process, on the health of professionals and on the quality of care provided to the population.

The reason for developing this study is the relevance of workplace violence in emergency medical services. Its objective was to analyze the daily work of an Emergency Care Unit (ECU), focused on the violence experienced by the multiprofessional healthcare team.

METHOD

This is a case study with a qualitative approach, based on Michel de Certeau's theoretical framework of everyday life. Everyday life is what is given each day, puts pressure on it and can be understood as something more than a simple work scenario. It has the "arts of doing" and is the place of freedom and creativity, in which social practices are articulated. As the ways of doing things are creative, the invention of everyday life is unique and constitutes ruptures[11].

This theoretical framework allows an in-depth look at everyday life, where there is a diversity of practices, coexisting and articulated in strategies and tactics. Strategies are authorities that systematize and impose order. They can be institutions, laws, ordinances, guidelines, protocols, rituals, among others, organized by the postulate of authority and power that indicate stability[11,12], which, in this study, guide work at the ECU and organize the daily life of the unit.

Tactics are "ways of doing", small tricks that happen in the "minor" of everyday life. They supplant what is established by the strategy, they are blows upon the norm. They are improvised and unpredictable, depend on time and circumstances and arise to respond to needs that were not resolved through strategies, in the (re)invention of everyday life. It is from strategies that tactics occur, with new and inventive ways of doing things in everyday life[11]. Strategies break out from experienced situations, are subjective, transcend what is established and can be individual or collective. In this research, they are represented by the ways of facing the ECU strategies, adopted by professionals, with a view to deal with unpredictable situations, including violence.

The study was conducted in an ECU in the interior of Minas Gerais, Brazil, located in a health microregion made up of 20 cities, with an estimated population, in 2020, of 194,759 people[13].Between July 2019 and December 2020, 58,558 consultations were provided at the unit (monthly and daily averages of 3,253 and 108 consultations, respectively)[14].

It was considered an appropriate setting because it had been in operation for 10 years, therefore, it was consolidated as a reference in urgent and emergency care in the micro-region. The ECU was regulated by municipal regulations, aligned with the healthcare protocols established by the Ministry of Health, in addition to internal guidelines, specific to each sector, which governed and organized the work of healthcare professionals. It was easily accessible for the main researcher.

At the institution, there were 95 healthcare professionals employed. The target population was defined using the inclusion criteria: being a healthcare professional and working at the ECU for at least six months. The exclusion criteria were: being on leave or vacation during the data collection period. Three professionals on leave, five on vacation and two who participated in the pilot test were excluded.

The 80 eligible workers were verbally invited to the research, according to the work shift and professional categories, aiming to include all healthcare categories at the ECU - medicine, nursing (nurse and nursing technician), pharmacy, social work, radiology technician and pharmacy assistant. The technical nurse responsible and the clinical director were invited as key informants, as they have relevant knowledge regarding ECU management and organization, which is important for interpreting the findings. Three nursing technicians declined to participate without specifying the reason.

Data collection took place from August 2020 to January 2021, through unsystematic observations, semi-structured interviews, and review of UPA documents. The observations favored the researcher's insertion in the scenario, checking the interaction between professionals and between professionals and users, working conditions and the ECU functioning. Furthermore, they allowed workers to learn about the purpose for the research. Information was collected before, during and after the interviews and recorded in a field diary.

A pilot test of the semi-structured script was performed with two professionals and no adaptations were necessary. The interviews were conducted by the researcher, a doctorate-level postgraduate nurse, during working hours and in a private location. Participants read and signed the Informed Consent Form (ICF).

The convenience sample consisted of 31 participants. The number of interviewees was defined during the research, meeting the saturation criteria[15]. The audios were transcribed within 48 hours after the interviews and checked by two researchers. The total duration of the interviews was 9 hours and 46 minutes, with an average of 18 minutes. The transcripts were returned to the participants to check the content and no changes were requested. Alphanumeric codes P1, P2, [...] P31 were adopted to present excerpts from the participants' reports to preserve anonymity.

Documents were also analyzed, such as ECU service reports, routines, laws, ordinances and guidelines on the regulation of urgent and emergency care. The data were organized in the MAXQDA® software, version 2020, and subjected to thematic Content

Analysis, involving three phases: pre-analysis, material exploration, treatment of results and interpretation[16].

A systematic and meticulous reading of the transcribed material was conducted, guided by the research questions and theoretical directions outlined by Certeau. In the pre-analysis, floating reading was performed, and the material was prepared; in exploration phase, exhaustive reading and using the software, data-derived recording units were grouped based on thematic similarities. In the last phase, information was processed and interpreted, and inferences were drawn.

This article is an excerpt from a doctoral research[17], in which the category "Violence in the daily work of the ECU" will be analyzed, which emerged from the Content Analysis of the answers to the following questions in the interview script: 1) Considering work in urgent and emergency care, what causes stress in the ECU work? 2) How do you handle situations that cause stress at work? 3) What do UPA healthcare professionals do, collectively, to reduce stress during work?

The researcher complied with the rules established by Resolution No. 466/2012, from the National Health Council. The research was approved by the Research Ethics Committee of the *Universidade Federal de Minas Gerais* (COEP/UFMG), CAAE No. XXX.

RESULTS

Sample description

The convenience sample consisted of 31 healthcare professionals. The majority were female (64.5%), single (61.3%) and the mean age was 36 years old. Among the 16 graduates (51.6%), eight were physicians (25.8%), six were nurses (19.4%), one was a pharmacist (3.2%) and one was a social worker (3.2%). Among those who had complete high school (48.4%), 10 were nursing technicians (32.3%), three pharmacy assistants (9.7%) and two radiology technicians (6.5%).

On average, participants had worked in the health field for nine years and eight months and the average time working in the ECU was four years and eight months, varying from six months to 10 years. The average weekly working hours at the ECU was 36 hours and 50 minutes, varying from 12 to 44 hours. Most worked 12 x 36 hour shifts (58.1%) and during the dayshift (67.7%).

Violence in the daily work of the ECU

Relationships with users, whether patients or companions, were identified as a relevant occupational stressor in daily work at the ECU, in several reports from participants. For a nursing technician, it was the main stressor: “For me, 90% are users” (P10). It can be observed that relationships between professionals and users were permeated by violent behavior.

> *The patient already comes here at that extreme, right? He/she arrives, sometimes, screaming, crying. Because it is an emergency unit, open door, we take everything. This causes stress.* (P15)

The statements highlighted several types of violence to which ECU healthcare professionals were exposed in these relationships. They were often treated with hostility and, not infrequently, there were threats, insults and even attacks and damage to property.

> *A colleague was kicked, leaving a mark on her chest.* (P10)

> *Once, a man came here and he was going to throw a stool inside. They already broke the water cooler outside, chairs. They broke everything.* (P23)

The professionals, even at risk of violence, went to work out of necessity, as in the following statement: “But we need to work. What are we going to do? You have to tolerate it” (P10). These were common occurrences in daily work, to the point where a nursing technician stated: “I have suffered a lot of verbal aggression, me, and several people. Normal for a ECU” (P9).

> *Sometimes, you're working, calm and that stressed person arrives* [...] *ECU clients don't understand that we are working here. So sometimes they insult.* (P9)

> *He was having a breakdown. We have that here. Patients arrive here in a state of breakdown.* (P23)

> [...] *it is a public that we treat, that is more susceptible, that comes to the ECU because it is 100% SUS. It is a population that is already suffering, and the person gets sick, in need of help and then emotions arise and they become agitated.* (P24)

All professional categories reported cases of violence, especially members of the nursing team. To a lesser extent, physicians also suffered violent acts, but in a veiled way.

> *With the doctors they don't say anything. Then, they come up to us and we say: “Go talk to the doctor.” They don't. With the doctor, they are sweet, but they act with us*. (P10)

> *They have never directly mistreated me, but they are more demanding and want a medical certificate. Sometimes they threaten to sue*.(P24)

The professionals mentioned that most cases of violence were caused by less serious users, who tried to transgress the strategy that defined the flow of patients between public health services when seeking care at the ECU. In general, they complained about the waiting times. The ECU adopted the Manchester Protocol as anorganizational strategy for services and, since they were not prioritized, some of these users became angry with the waiting time.

> *The person comes and could have gone to a health center. They arrive here and want to be seen immediately. Then the husband and family come and fight. At the reception, with the nurse in screening and with us in medication. (P9)*

> *Their lack of patience don't let them understand that, sometimes, a physician or team is all in the red room and the person has to stay outside waiting, because it is classified as non-urgent. (P14)*

Between July 2019 and December 2020, 3,253 users were served per month, according to monthly service reports at the ECU. According to the risk classification, on average, each month, 1,953 users were classified as not very urgent (green) (60.01%), 835 as urgent (yellow) (25.67%), 249 as very urgent (orange) (7.65%), 199 as non-urgent (blue) (6.12%) and 18 were classified as emergent (red) (0.55%)[14]. It was observed that most of the users were precisely those who could be treated in other healthcare institutions, such as BHUs.

The strategy defined by the Ministry of Health was for the user to stay under observation at the ECU for up to 24 hours[18]. If it was necessary to be transferred to a reference hospital, they were registered with SUSFácil (software that regulates beds of medium and high complexity, urgency/emergency and elective hospitals, and outpatient clinics, accredited by the SUS, in Minas Gerais). Obtaining a rear bed was often time-consuming, which also generated stress among users. A doctor stated that they did everything they could and had to "pray for the vacancy to be available as quickly as possible" (P26).

> *What people don't understand is that patients are registered in SUSfácil and they think that shouting at the SUSfácil operator will get them a place faster, but it doesn't. It depends on other physicians, other places accepting it and shouting won't make it easier. It's a lack of knowledge.* (P12)

It was clear, in other reports, that some users already arrived at the ECU demanding certain procedures be performed, such as exams and medications, but medical conduct was defined by clinical protocols. Others had chronic illnesses who would need long-term follow-up, which was not offered at the location.

> *Our population is poor. Come here, if they haven't taken a serum, which is not necessary, haven't been medicated, they think they haven't been properly examined*. (P21)

> *They expect you to solve their problems in an emergency consultation, but most problems take months or years. It can't be resolved in one consultation. They don't understand and take their frustration out on you*. (P30)

> *Sometimes, a patient comes and wants something that isn't from here and wants to insist on it. Mistreating the team.*(P24)

> *Sometimes they arrive here wanting an orthopedist or pediatrician, which we don't have. We only have a clinic. This creates stress for the patient and the team because they demand, insulting: "I'm not leaving, I need this."* (P15)

It can also be observed that violence against professionals was not only practiced by patients, but also by companions, especially patients sent to the medication room (or green room). No companions were allowed due to the constant crowding and lack of space to accommodate more people. This limitation was a strategy employed by the UPA to organize the care at the facility.

> *Patients aged 18 to 59 years and 11 months do not have the right [to be accompanied] by law and are the ones who cause the most commotion. They are the ones who criticize and fight the most. We have a lot of difficulty with this.* (P5)

> *People don't understand, they want to pull rank and get in anyway. "I'm from the police, I want to get in." This is very humiliating.* (P14)

> *A companion already said he was going to hit me, you know? It's very stressful for us. They say that they pay our salaries.* (P10)

When the unit was "quiet", the professionals allowed companions to enter, even though they knew that the ECU strategy did not allow it. A nursing technician reported that if the patient "(...) demands greater attention and we have other patients and cannot provide that intensive care to them, we let them in" (P5). This was a tactic to avoid violence and, in some cases, rely on companions to help caring for the most weakened users.

> *When the unit is quiet, there are only one or two to medicate and we see that that family member is very desperate, wanting news, we let them in so they can be more at ease. Also, so that we no longer have a patient at reception fainting*. (P5)

Reports of cases of violence were common because the ECU is a public institution of the SUS. Some users would make complaints on social media, naming staff members. It's worth noting that, according to key informants, the ECU had strategies in place to address complaints.

> *It has happened that a companion wanted to take a photo and I said: "I don't accept it". Photo of the medical record, photo of the puncture...* (P19)

> *People think that in the SUS they have to be seen immediately and that doesn't exist. Here they think it's theirs. "This is mine, I have to be seen right away, I can't wait."* (P23)

> *When it comes to medication, they say they pay us and we don't do the job right, they use all names on us... There are patients who say they're going to sue. What kills us the most is saying that they pay our salary: "I pay your salary, I don't know how much." It's really humiliating, and there are quite a few who say that.* (P10)

When the situation got out of control, the strategy was to call security, who was at the ECU reception. Furthermore, nursing technicians called nurses and/or physicians to talk to users, seeking to resolve the situation through dialogue.

> *We call the security guard who comes running because, if we let, there are some who will come forward, even hit us. It has already happened that the technique gets hit in medication. When this happens, we call the nurse, because we can't talk to the patient.* [...] *They talk, but we can't.* (P10)

> *I try to stay calm, ask for permission, call the nurse or physician. Here, we have a lot of freedom with physicians, which is an advantage, it helps a lot. They come in with us to talk.* (P9)

In the unit, a common tactic mentioned by professionals to avoid clashes with users and reduce the violence risk was not to fight back. When there was no longer any possibility of dialogue, they remained silent and left the user talking alone.

> *A boy called me every name. He was dizzy, had stitches, and I remained silent. Later, he said: "Sir, I'm sorry for treating you badly. Can I give you a hug?" But I didn't respond, I stayed quiet, doing my work.*(P16)

> *With some people we can talk to, others we can't. They scream so much that you have to leave the room and let them talking because otherwise you will be attacked. If it's too aggressive, I leave.* (P10)

> *We stay away, because otherwise, we end up saying things we shouldn't. Whoever speaks is not offended, but the one who listens is.* (P5)

DISCUSSION

It was observed that the daily work of ECU healthcare professionals was permeated by verbal, psychological and physical violence by users, often as a result of the strategies that defined the functioning of the unit. It was related to the long waiting time, the delay in patient transfers and the limited entry of companions.

There was work standardized by strategies and the real work, with new meaning by individuals in their context of action. The standard provides guidelines, but it is not the absolute truth and depends on the creative know-how of individuals. Often, innovations are made to overcome healthcare system problems[12]. It is necessary to understand everyday life as battlefields, in which power, as a relationship of forces, is always being contested[19].

Worldwide emergency services have a high risk of workplace violence against healthcare professionals, which in most cases, involves patients and visitors as perpetrators[2], just like in the ECU studied. In these units, anxious patients due to fear of the unknown, insecurity in the face of death and concern about the health of loved ones[5], are frequently treated, which can generate tension and increase the risk of violence.

In India, violence against healthcare professionals and damage to healthcare facilities has become a debated issue at multiple levels. It is considered one of the biggest public health and patient care challenges[20]. At ECU, in addition to violence against professionals, there were reports of damage to public property, which harmed service.

The daily work of ECU professionals was guided by laws, programs, norms and routines, which correspond to what is pre-set, static and established by protocols that direct the actions to be conducted, which correspond to the strategies[11]. However, it is in this daily life that actions are transformed and redefined, according to the needs and possibilities of individuals. It is operated by creativity, invisibility, invention, assignment of new and different meanings to what is stated, with a validated and legitimized action[12].

The strategies are defined and it is assumed that they are accepted as desirable[11]. However, the ECU main organizational strategy, the risk classification using the Manchester Protocol, was a source of struggle with users. A predetermined program (strategy) was used, but users often did not understand its essence or did not accept it.

Many users with common or low-severity health complaints, sought care at the ECU, but, according to the strategies, it was not the appropriate place for their assistance. They sought medical care to immediately resolve their health complaints or undergo basic tests not available at the BHUs. These actions deviated from the control established by the strategies.

As they are classified as green (less urgent) and blue (non-urgent), care should take between 120 and 240 minutes, respectively, according to the protocol[21]. Delays in care, added with the fact that they are not prioritized, can lead to frustration and constitute a risk factor for violence against workers. Waiting times and the lack of understanding regarding the establishment of care priorities were also identified as causes of violence in other urgency and emergency services in Brazil and other countries[2-4,22].

Risk classification sectors are places with a high risk of violence. In 13 urgency and emergency services in Mato Grosso do Sul, Brazil, there were 212 episodes of verbal violence and 24 episodes of physical violence in one year, with the latter being more frequently brought to justice (35.7%) than the first (5.6%). Companions were the main perpetrators of verbal violence (43.7%) and patients were the main perpetrators of physical violence (58.3%). In most violence episodes, no prosecutions were initiated, but the police were called more often in cases of physical violence (1.6%) than verbal violence (28.6%)[23].

According to the ECU professionals, the strategy was to guide these users regarding the purpose of the unit, the profile of patients to be treated, and advise them to seek other services according to their needs. In this regard, a study indicated that the population's lack of knowledge about the services provided at UPAs constitutes another cause of acts of violence directed against professionals[22].

Another risk factor for workplace violence was the delay in patient transfers, due to a lack of backup beds. The orientation of the Ministry of Health is that users remain under observation at the ECU for up to 24 hours[18]. Otherwise, they should be registered with SUSFácil, to be admitted to a reference hospital in the unit. However, this procedure was also largely unknown by users, which increased the risk of violence due to the delay in transferring patients.

This strategy was important because it allowed the organization and prioritization of patient transfers between public healthcare services. However, it had become a limiting problem as it depended on factors external to the ECU. Physicians adopted some tactics to speed up the transfer of hospitalized patients, such as trying to contact known hospital professionals by phone. The same tactic was observed in a Brazilian study, in which the authors stated that good interpersonal relationships with professionals from different points of the urgency and emergency care network were considered facilitators for the user's access from one service to another[24].

The fact that the unit was a public service was another reason for healthcare professionals to suffer acts of violence from users, as they believed it was a poor quality service and that workers' salaries were paid by taxes[22].This finding was also verified at the ECU and caused professionals to fear to lose their jobs. Complaints were often public, via social media, although the ECU had strategies to receive complaints and the technical nurse responsible and director were identified as accessible to listen to users.

Psychological or verbal violence is more common than physical violence in urgent and emergency services[2,3] and has become routine. Patients and family members were responsible for most of the cases, which included insults, humiliation, death threats, embarrassment and attempts to discredit them. This finding aligns with what was observed at the ECU, where professionals suffered hostility, insults, offensive attitudes, humiliation and threats. Regarding physical violence, in some places, workers may suffer pushing, hair pulling, object throwing, among others[3].

The ECU studied also proved to be a high-risk environment for the nursing team. Violence is present in any area where nursing professionals work, but it is prevalent in emergency units, places with a greater patient flow and adverse working conditions. The underreporting of these occurrences creates an environment capable of accepting violent acts, making it difficult to prevent and fight them[3].

Nursing professionals from an emergency service in Bahia, Brazil, stated that the worsen of relationships with users can interfere with the performance of work, the qualification of the team and the construction of professional projects. This situation triggered feelings of worthlessness and identity crises, which could cause psychological harm and influence workers' mental health[5].

It is worth highlighting the gender of the victims. In ECUs, women tend to suffer more violence than men, as they are less respected and there is prejudice among the population regarding professional activities performed by women. A North American study showed that there was a difference between violent acts, with women being more prone to sexual abuse while men to physical violence[25]. Furthermore, the nursing category, the largest in the health field, is predominantly female, with women in constant contact with users, which can be a factor to greater exposure acts of violence[22,25].

The ECU physicians, although they also experienced situations of violence, were more veiled than other professionals, perhaps due to a gender issue, as the majority were male, or due to the social value attributed to the medical profession. They suffered threats of being sued and verbal attacks from users who demanded certain procedures. It should be noted that the clinical decision on the best procedure, case by case, based on clinical protocols, was an exclusive prerogative of physicians. However, some, to avoid the clash, gave in and carried out some procedures, sometimes unnecessarily, such as x-rays.

Not reacting to physical and verbal violence was the tactic most cited by Chilean workers to avoid violent occasions[4].They aim to listen and remain calm, establishing efficient communication, understanding people and putting themselves in the other person's

place[22]. At the ECU, this tactic was also used to avoid clashes with users. When faced with aggression, professionals adopt the tactic of silence and leave the rooms, leaving the user speaking alone.

Daily exposure to insult, lack of respect, humiliation or any type of violence practiced by patients, companions and/or coworkers causes damage to the mental and physical health of workers, and can cause occupational illnesses and psychosocial problems[3].It compromises the worker's self-esteem, reduces satisfaction and interest in work, harms the relationship with the patient, reduces the quality of care, and leads to absences and job withdrawals. It can lead to more violent behaviors, compromising patient safety and their rights[3,4].

Workplace violence is a relevant occupational stressor that, when chronic, increases the risk of stress, post-traumatic stress, Burnout Syndrome and can even be a risk factor for suicide. Victims express feelings of anguish, anxiety, fear and apprehension[7].At ECU, healthcare professionals pointed out violence as stressful. It drew attention due to its consequences in daily work, as it generated suffering and fear among workers in direct and continuous contact with users during shifts. Strategies for containing violent acts, by management, appeared to be incipient and punctual, which forced them to adopt individual and collective tactics to prevent them.

Violence in emergency rooms tends to be more severe, given the underreporting of cases, considering that some workers accept it as part of the job, which discourages reporting. Generally, they do not report it when they are not injured or by fear of the consequences [2,7]. The idea that violence is inherent to the work of physicians and nurses is not accurate and needs to be addressed as a way of ensuring the safety of professionals in the workplace. Failure to do so will worsen the care they must provide and will affect healthcare systems worldwide[26].

Professionals must recognize and report when they are victims, so that this problem has greater visibility and allows governments, professional associations, unions and managers of healthcare institutions to adopt measures for prevention and worker protection[3]. Key informants reported that they tried to guarantee the safety of professionals during work, including aligning with public security services, with a view to protecting these professionals. Furthermore, they sought to organize, together with the Municipal Health Department, the flow of users between healthcare services, with a view to reducing overcrowding at the ECU.

The limitation of this study is that it was conducted with “ECU healthcare professionals”, disregarding the heterogeneity of professional categories and the gender of workers. Furthermore, it was conducted during the pandemic, a singular moment in recent

history that certainly changed the daily life of the ECU and which, due to the tension it caused for both professionals and users, likely increased the risk of workplace violence.

Its findings have application for teaching, research and practice of healthcare professionals when addressing the daily life of an ECU, with an emphasis on the violence suffered by healthcare professionals. The results of this research were presented to the unit's managers, with the aim of reflecting on the problem and taking appropriate measures to avoid it, especially when trying, together with the Municipal Health Department, to correct problems with the flow of users between healthcare services. It is recommended that further research be conducted on the causes of violent acts, violence perpetrated by users in different healthcare services, as well as prevention measures.

FINAL CONSIDERATIONS

Daily work at the ECU was governed by strategies, such as the Manchester Protocol and referral via SUSFácil, which are often not accepted or understood by users. On the other hand, it was permeated by tactics adopted by professionals in the face of adversities that arose daily, such as attempts to expedite transfers to reference hospitals and the removal of users to avoid violence. Consequently, workers could develop occupational stress.

The reasons for the acts of violence, from the professionals' perspective, were the long waiting time for care, the lack of backup beds and the limitation of entry for companions. These facts were aggravated by the ECU overcrowding and were often made by less severe patients, whose waiting time could be up to 240 minutes, leading to dissatisfaction among patients and families.

The main acts of violence were verbal, but physical attacks also occurred. Most of the time, they were practiced by users and the main victims were the nursing staff. Overall, there seemed to be a certain “naturalization” of this situation by professionals, perhaps due to the high frequency in which it occurred in daily work. However, educational strategies should be implemented, and opportunities should be created to listen to and support the multiprofessional team.

Studies like this are important because they shed light on a problem that is often not identified in the daily life of ECUs, but that needs to be highlighted. They contribute to coping it and, ultimately, result in an improvement in the care provided to users.

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