Daniel Faggianelli, Sorin Burlacu, Cécile Carra (2018). Victimization of health professionals in Bucharest service relations and social work relationships. *Administratie si Management Public,* (30), pp. 109-126. DOI: 10.24818/amp/2018.30-08

Victimization of health professionals in Bucharest service relations and social work relationships

Daniel FAGGIANELLI[1], Sorin BURLACU[2], Cécile CARRA[3]

Abstract: *Workplace violence in the health sector has become an international social problem since the end of the 20th century. This concern is much more recent in Romania; few data are still available. This research aims to assess the extent of the phenomenon in this national context. The analysis is based on 207 questionnaires collected from doctors, nurses and care assistants from different departments and establishments in Bucharest, with an overrepresentation of the emergency department of public hospitals for its crystallization of conflicts. This research shows the prevalence of professional experience of victimization in the health sector (more than one respondent in two claims to have suffered violence at least once in the past year). This experience is massively built in the service relationship; the conflicts of perspective that manifest themselves there are experienced as violence when they undermine the exercise of the profession, as it is designed by the professionals. The results also show the significant role of the organization and its functioning in the expression victim. The more the organization is perceived negatively, the more often the expression victim is frequent. The service relationship is thus more than the question of the interactions between professionals and users and makes sense in the specificities of the context, which is itself crossed by fundamental reforms. This background helps to understand the importance of workplace conflict, accounting for more than one in five victimizations. More broadly, role conflicts, even if they are not all denounced as violence, contribute to shaping a lived experience, weighing on the victim expression of health professionals.*

Keywords**:** *Experience of violence, health professionals, Romania, victimization survey, profession, organization*

JEL: I18, I12, I19.
DOI: 10.24818/amp/2018.30-08

Introduction

The health care system is one of the main sectors of the European workforce, accounting for about 10 % of EU workers (EU-OSMA, 2007). The health and social care system reported the highest incidence of workplace violence

[1]Professor PhD ; Université de Bretagne Occidentale, CREAD EA 3875, France, daniel.faggianelli@espe-bretagne.fr
[2] Lecturer PhD; Bucharest University of Economic Studies, Romania, sburlacu@man.ase.ro
[3] Professor PhD ; Université d'Artois, LEM-UMR 9221, France, cecile.carra@univ-artois.fr

in the EU - 27 of about 15.2%. An overweight ratio has the incidence of intimidation and harassment. Also in this sector, the experience of actual physical violence or the threat of physical violence is 8 times higher than in the production sector (Parent-Thirion et al., 2007). According to the Danish project "Violence as a form of expression" (Pedersen, 2007), up to 32% of social workers in residential care units and medical staff in hospitals are exposed to violence. Currently, in most countries, there are laws covering all areas of activity, from constitutional laws, organic laws, ordinary laws, laws that provide protection to doctors and their patients (Gavurova et al. 2017; Panfiluk, Szymańska, 2017, Pranevičienė, Vasiliauskienė, 2018). Violence in healthcare facilities is made public and debated in various reports (Jeantet, 2003; Formankova et al. 2017).

In Romania to measure the impact of acts of aggression against work health workers, a challenge lies primarily in the absence of official information available public opinion due to the absence of a monitoring system but often the reluctance of victims to report incidents in certain situations. None cases of aggression or their consequences on health personnel were not recorded systematically. The World Health Organization (WHO) reported that global violence at work in this sector could be almost one quarter of all violence in the workplace and affects more than half of the medical staff. What about Romania? The first objective of the research presented here will thus be to determine the prevalence of violence in this national context. The second will be to seek explanations. In the face of the multiplicity of definitions of violence, it will be necessary first of all to present the object construction and the hypotheses chosen according to the chosen theoretical approach.

This presentation will be done in a first part, first exposing a state of the art (part 1). We will specify, in a second part, the methodological approach adopted in coherence with the theoretical approach, and the device of investigation (part 2). The results presented (part 3) and the following discussion (part 4) concern the Romanian part of a Franco-Romanian comparative survey (Carra, Burlacu and Faggianelli, 2016; Androniceanu, 2016), the French component being the subject of another presentation (Carra, Ridel, 2017; Androniceanu, 2017a). A final step will be to make the comparison between the two countries.

1. Literature review

Workplace violence has emerged as a social problem at the international level since the end of the 20th century (1.1). This concern has only recently emerged in Romania. It gives rise to some works of which we will expose the principal results (1.2.). These show the importance of relational and contextual factors in the production of violence. We want to deepen this double dimension, but in a theoretical light away from the dominant perspective (1.3.).

1.1 Internationalization of the social problem of workplace violence

In the growing movement of fears of violence in daily interactions at the end of the twentieth century, workplace violence has emerged as an international social problem: it is thus described as a "global fact of society" by Chapell and Di Martino (2000). On the one hand, very dynamic changes and increasing uncertainty in organizations promote the changes; on the other hand, they cause tensions and conflicts in relationships between employees, which often turn into mobbing and harassment. Often organizations, especially those declaring corporate social responsibility, use measures directed against harassment in employees' relationship into their policy, but mobbing remains a latent problem, which is accompanied by poor, insecure psychological climate, employees' injuries, diseases, absenteeism, or unfair dismissals (Vveinhardt, Sroka 2017). Moreover, sometimes this negative phenomenon is accompanying by prevalence of another negative aspect, i.e. nepotism and favouritism (Sroka, Vveinhardt 2018). Given these fact, since 2002, the WHO (2002) has made the fight against this violence "a global challenge". In the health and medico-social sector, taking into account violence - in particular those of users against professionals - is becoming a political, institutional and professional concern (Kumari and De, 2015). However, the issue of violence in this sector has remained largely marked by the rise of patients' rights (Stefko et al. 2016). Without the political interest for this angle has disappeared, as evidenced by campaigns to promote well-treatment, today the issue of violence is widely understood through the questioning of working conditions, what we see by example in the Parent-Thereon report, Fernandez Macias, Hurley, Vermeylen (Fourth European Working Conditions Survey, 2007; Zivcicová et al., 2017). This prism thus responds to a social demand impelled by the European choice of a social market economy, which, at the individual level, is broken down by taking into account the two figures of the modern individual: the moral individual (the which is realized in his personal, family and citizen life) and the rational individual (that of the market, performance, productivity) (Dubet, 1997; Konecki, 2017; Bilan et al., 2017). In both cases, the violence suffered, like other psycho-social, biological and chemical risks (Rippon, 2000), could hinder these two individual expressions, the consequences of which are expressed in terms of productivity, personal fulfilment and of work-life link. The consequence of this initial point of view is to focus the observation or analytical glance on the violence suffered by professionals according to an approach in terms of psychosocial risks. This approach is privileged in market logic, where it is a question of evaluating the impact of the violence on the functioning of the companies, and the productivity of the workers.

1.2 Health violence in Romania

This international concern about violence in the workplace is based on time-frames specific to each country. It has been sporadic in Romania until recently. However, we can note the promulgation in 2006 of the law no. 95/2006 on health reform guaranteeing protection for both health professionals (protection against hostile or violent behavior of patients) and patients (protection against abuse and misconduct).

Topic started to receive some attention in Romania only in the last five years and only on cases of physical abuse. Attacks on medical services personnel is brought to public attention only when incidents occur resulting in severe injury and unable to work or produce material losses related to supplies medical units. Studies on incidents of aggression at work in medical practice, however, are limited both in terms of research and public availability of data. The thematic reference found, being the work in 2011: The quality of professional life and the migration tendency of the personnel in the health care system. According to the authors, the aggressions have an impact on the health and safety of the medical staff and lead to the degradation of the quality of the medical care services, and the staff - and so insufficient in Romania - are abandoning their profession. According to a study by the European Federation of Public Services, about 3% of physicians and 5-10% of nurses in Romania emigrate every year 19, and exposure to aggression is an important factor for migrating physicians, along with economic and professional conditions, sometimes precarious (https://www.epsu.org/, 2018).

In 2015, the Bucharest College of Physicians Foundation organized a survey on violence in hospitals, to which 541 doctors responded, representing 39 medical specialties. Data processing revealed that 85% of respondents were confronted with verbal aggressions, 10.2% with physical aggression, and 14.2% of all respondents considered they did not have such incidents. Violence types identified following the collection of questionnaire information can be from both patients and physicians and are based on several causes. A first and very important cause is the stress that affects both partners in this relationship. The paper examines the relationship between physician and patient. Physicians have a loaded schedule, many tasks to accomplish and interact with different types of people. These things can be very stressful and can lead to violent situations of any kind. On the other hand, patients are stressed that they do not suffer, they have no money to treat or do not trust doctors and doctors and the entire health care system in Romania. A second cause is financial discontent. Doctors are very poorly paid for their workload, and the minimum wage in Romania for a potential patient is just as small. This can affect a person very hard, resulting in frustration, discontent, restlessness, depression, and therefore violence. Other causes for this phenomenon include poor education, lack of respect, indifference, rivalry, the busy schedule, the differences between generations, the pressure exerted at the workplace.

Earlier research already pointed to some of these elements in a broader search for factors that would increase the risk of aggressive behaviour in health facilities. For example, the Occupational Safety and Health Administration include

free movement of the public in health care settings; Prolonged waiting to benefit from services; The presence of patients and family members in stress conditions; Low levels of staff; Working with patients in isolation conditions; Lack of training to cope with bullying at work, and the quality of services provided (OSHA, 2004). Regarding the press releases in Romania the factors that play a role in the risk of aggression in health care units indicate firstly the sufficient staffing level and the length of the waiting time, but also the dissatisfaction with the consultation is frequently mentioned. Poor material conditions in some hospitals, in particular the lack of equipment, intervention materials and accommodation conditions may also predispose to aggression on doctors. Standard reporting systems for aggression incidents are also an exception at the level of medical units. Stress is recurrently mentioned in work as a factor - risk - of violence, - whether it is on the side of the patient or his family, or that of the practitioner - (Ghiorghievici, 2006; Prasetio et al., 2017; Štefko, et al., 2017). The same is true of lack of communication (Rujoiu, 2010). It is also the weight of poor working conditions, which is emphasized regularly, and poor conditions of reception and care of patients.Patients are referred to as the main perpetrators of violence. Some authors will then look for personality traits that may explain the violence. Dominant patients are labelled as self-confident, competitive, features of narcissistic personality. Dominant patients demonstrate a lack of empathy manifested in a wide variety of contexts. Paranoid patients are labelled "cold," serious, critical, reserved, and defensive, with features of paranoid and antisocial personality. For them, the world appears to be threatening and hostile. Obstructionist patients are labelled as hostile and unintended; Avoids patients are labelled as inhibited, uncertain, contain features of avoidant and obsessive-compulsive personality disorders.

Health professionals are also mentioned among the perpetrators of violence. One of the causes mentioned is the negligence of doctors who can bring to malpractice. Malpractice is the professional misconduct involved in the medical or pharmaceutical act generating harm to the patient, involving the civil liability of medical personnel and the provider of medical, sanitary and pharmaceutical products and services. The interrogation of the causes of the violence crosses the scientific disciplines until summoning the ethology when the violence is assimilated to the notion of aggressiveness.

Some research in health clinics in Bucharest indicates that the most important factors that determine the expectations of hospital management based on doctor and patient relationship are: the costs (usually quite high in private health clinics) the reputation of the clinic and the notoriety of doctors (Androniceanu, 2017b; Gavurová, et al., 2017; Krot & Rudawska, 2016).

1.3 For an apprehension of the experience of violence of health professionals

The definitions of violence are multiple, depending on the scientific field in which they occur and the theoretical approach used. However, we can see a predominance in the scientific and institutional literature of a definition that is

objective. The following definition fits in this last perspective: violence is the use of strength and constraint by an individual, group, social class in the exuberance of the others in both physical and psyche physical trauma. In this category, like threats of any kind, but also threats?

The approach in terms of psychosocial risks is based on an equally objective definition of violence. However, it departs at once by associating with violence, stress, violence being considered, in this perspective, as source or origin of stress at work. We have seen that stress appears repeatedly in the works cited above. It is even the most frequent cause of violence for some authors (as, for example, Ghiorghievici, 2006). This dimension refers to the subjectivity of the individual, committing to study his experience. So we chose to take note of the subjective dimension of violence by inscribing ourselves in a phenomenological perspective. It is then necessary to understand the meaning that individuals give to the situations in which they are involved, and to analyse the processes that lead to the qualification of violence in certain situations. We therefore define as violence what is qualified as such by the actors concerned. Defining violence by taking back the qualifications made by the actors makes it possible to integrate the socially constructed nature of violence (Carra, Faggianelli, 2011; Faggianelli, 2016). We will be able to characterize the forms that violence takes in the Romanian health system by anchoring it on the lived experience of the individuals.

Beyond this descriptive objective, we will seek to identify the factors by which the experience of violence of health professionals varies. The studies listed above report multifactor causes, and especially relational and contextual causes. This double level seems to us particularly relevant to deepen. We will interrogate him from a dimension little explored in his links with an indexation of professional situations on the register of violence, the relationship to the profession and professional standards.

2. Method and methodology

Self-reporting surveys provide a closer look at the violence perpetrated (2.1.). In addition, victimization surveys help to access victims' experiences. The construction of the questionnaire meets this dual objective (2.2.)

2.1 Self-reporting surveys to uncover the "black figure" of delinquency

Research in the field of delinquency and crime has established very early on that all the facts perpetrated are not recorded by the institutions. Durkheim chose to integrate this phenomenon into his very definition of crime by explaining that "We do not condemn it because it is a crime, but it is a crime because we disapprove it" (Durkheim, 1930: 48). The consequence was that the crime owed its identification to the social reaction and that the social reaction was observed through the institutional activity. However, the interest for the part of the facts that do not reach the attention of the dedicated institutions helped to animate the

research. Quantitative surveys have particularly developed around the measurement of the "black figure". The "black figure" designates beyond the criminal acts recorded by the various institutions in charge, the taking into account of the unregistered facts. It is actually a measure of the "real" delinquency that seeks to be achieved. This gap between two measures, recorded facts-total facts, that we try to emerge, allows us to question the implementation of the social reaction and thus reveals major scientific stakes. To approach real delinquency, surveys are carried out to overcome the bias of institutional records, by collecting data directly from the respondents. These self-declaration surveys, which are part of a long American tradition, were multiplying in Europe in the 1990s. The primary purpose of self-reported delinquency surveys is therefore primarily to improve the measurement of crime. These aim to take note of the limits of the institutions to record all the facts committed by addressing the actors themselves, that is to say the possible perpetrators of offenses. Initiated in the late 1940s in the United States, they were introduced in the United Kingdom and the Scandinavian countries in the 1960s. It involves questioning population samples on a series of deviant acts. It then becomes possible to compare the prevalence of delinquent behaviour (transgressive on legal grounds) - and more largely deviant (transgressive on regulatory and normative bases) - between social groups, by removing the bias of a measure of differential social reaction to offenses. That is, by reducing the effects of more or less active recording filters based on the social affiliation of the author or victim. These surveys were particularly used in the context of juvenile delinquency. The latter has been central to the security concerns of the late twentieth century (Mucchielli, 2001). Currently, Romania participates in several international surveys which are to be regularly renewed (Burlacu, 2015).

The integration of safety issues with health risks is old. This is the case for the ESPAD survey - European School Survey Project on Alcohol and Other Drugs in which Romania participates; it is conducted in about thirty European countries and the USA on the basis of a common methodology and questionnaire. Although focused on drugs (legal or illegal), the ESPAD survey incorporates a series of questions relating to other deviant behaviours such as "bodily violence", "predation" and "degradations", greatly expanding the field of this survey. The unit is building in the labelling of these behaviours as "risk behaviours". As a result, these surveys become exploitable for studies in the field of delinquency (Peretti-Wattel, 2001) or questioning the link between violence and consumption of psychotropic drugs (Lagrange, Legley, 2007; Zahars, Stivrenieks 2018, Kuril 2018). This creates a link between two fields: delinquency / violence and mental health.

In the field of expert reflection, the question of safety has therefore been closely associated with that of health (Acosta Price, 2017).. It has therefore echoed and contributed in return to a consequent development of the concern for health and safety at work in which the study of violence at work is dominant (Bereketeab, 2017). This development is particularly significant at the international level under the categorization of "workplace violence".

2.2 The victimization survey to access the victims' experience

The victimization survey pursues the heuristic intention of self-reported delinquency surveys. It aims to apprehend transgressions or offenses from the point of view of the victim. Focusing on the victim's point of view also gives access to important dimensions of victimization, such as the circumstances in which the facts occurred, the victims' reactions, and the physical, financial and psychological consequences of the act. Each of these dimensions brings together scientific interest and political concern. In the US, the various administrations and researchers have many years of data from victimization surveys at national or federal level: include, for example, the National Crime Victimization Survey (NCVS), the Department of Justice.

Our approach takes into account objectivist approaches to violence but aims to avoid the investigation bias inherent in the imposition of thought patterns borrowed from categories of common sense, as well as from institutional categories reformulated by the researcher's own judgments - which he considers violence, and more specifically, what is "good" or "bad violence", "the use of force" or "passage to violence", that is, to say of a legitimate or illegitimate action (Michaud, 1986-2012). To do this, our approach is an epistemological stance in support of the phenomenological tradition. Thus, the questioning of the victimization of the staff will not be elaborated on the basis of pre-determined categories of violence since it is to access the lived experience of the respondents. The questionnaire is built on a pivotal question: "For one year, in the course of the exercise of your function, do you consider that you have personally experienced violent situations (regardless of the form and persons involved)? ". The categorization will be performed retrospectively, excluding borrowing from the legal or institutional fields, from the description of the violent situation that has most marked the respondent during the past year. It is from this description and the logic that produces it that we can proceed to a categorization of violence anchored on the lived experiences of the respondents, or at least on their definitions of situation. The other questions allowing us to access the situations and the meaning given by the respondents, relate to the circumstances (category of protagonists, number, place of victimization), the respondent's reactions, his interpretation of the situation (on the basis of the question "How do you explain what happened?"). We also question the possible intervention of other people, such as the institutional and judicial suites. Finally, the consequences for the respondent of this victimization are questioned. Three sets of questions complete the interrogation of the victim's situation allowing us to relate these statements to elements of the near and far context of the action: that relating to the organization (service, unit or establishment) and its operation, that relating to the profession, industrial relations and conflicts at work, finally a series dealing with the users (patients and relatives). The last part of the questionnaire collects data on the socio-demographic characteristics of the respondents. The questionnaire is anonymous. The award was self-administered or conducted face-to-face. It has 42 questions including 12 open questions. These last ones aim at the collection of the verbatim allowing to build an analysis as close as

possible to the speech of the actors. 508 questionnaires were collected from institutions in the sanitary and medico-social sector of Bucharest. 207 questionnaires were used, only health professionals having been selected here. They are physicians (44.4% of the population of respondents), caregivers (42%) and nurses (13.5%). They come mostly from hospitals in the capital (77%), bringing together the largest number of health professionals in Romania, as in Europe ([European Agency for Health and Safety at Work (EU-OSMA), 2007a. Emergency services represent 40% of the total respondents, services that usually focus the most conflict.

Data analysis was performed using the software Sphinx IQ Quali. It will highlight the specific situations in which violence fall, the recurrence of forms they take, identifying the issues underlying such interactions. We do not pretend to account for the completeness of a reality or present a representative picture, but we give aim to highlight patterns in structuring a violent experience among health professionals practicing in Romania.

3. Results

3.1 Victimization as a significant dimension of work experience

Far from the anecdotal that enameled a career in health, the experience of violence is widespread among professionals.

3.1.1 More than 59% of respondents report victimizations

In fact, 59% of respondents report having experienced a violent situation at least once in the past year (see Table 1).

Table 1. Frequency of victimization during the past year

In the last year, in the exercise of your function, do you consider that you have personally experienced violent situations (regardless of the form and persons involved)?	Nb	% obs.
Never	62	40,8%
1 time	36	23,7%
Between 2 and 3 times	35	23,0%
More than 4 times	19	12,5%
Total	152	100,00%

Source: own processing

It can be noted that more than 12% of respondents report more than 4 victimizations, showing repeated exposure to violence Response rate: 73.4%, Mean = 2.93 Median = 3.00 SD = 1.07, Min = 1,00 Max = 4,00 **.**

3.1.2 A differential exposure to violence

To the extent that it is common, the victimization would be partly sensitive to characteristics attached to the respondent such as age and seniority, or gender and status. No correlation appears, however, with the first two variables; in other words, youth does not appear to be a risk factor for violence, and seniority associated with experience is not a protective factor (Popescu Ljungholm, 2017). On the other hand, the dependence between sex and victimization is very significant; However, although victimization is largely women (because of the constitution of the gender characteristics of health professionals), it appears to be an under-representation of women in victimization (Table 2): 57.8% of female victims while they constitute more than 67% of the sample against 42.2% of men whereas they represent only 32.9% of the sample. Despite the common representation that physical strength would protect against violence, physical strength associated with the male sex, this characteristic does not appear protective.

Table 2. Victimization by gender

sex / victim-non-victim

	Female		Male		Total	
	N	% cit.	N	% cit.	N	% cit.
Victim	52	57,80%	38	42,20%	90	100,00%
No victim	48	81,40%	11	18,60%	59	100,00%
Total	100	67,10%	49	32,90%	149	

p = 0,003 ; Khi2 = 8,98 ; ddl = 1 (TS)

Victimization would appear sensitive to the status of personnel, assuming a high status would be protective. According to our results, among the victims, caregivers are the most numerous with 53.3% of victims, then doctors (38.9%) and finally nurses (7.8%). These flat results relate primarily to the sample constitution in which the first two categories are the most numerous. However, the Chi2 test showed a significant relationship between victimization and status particularly on nursing. These are significantly under-represented among victims and overrepresented among non-victims (see Table 3).

Table 3. Victimization by status

	Care giver		**Doctor**		**Nurse**		**Total**	
	N	% cit.	N	% cit.	N	% cit.	N	% cit.
Victim	48	53,30%	35	38,90%	7	7,80%	90	100,00%
No victim	24	38,70%	23	37,10%	15	24,20%	62	100,00%
Total	72	47,40%	58	38,20%	22	14,50%	152	

p = 0,01 ; Khi2 = 8,52 ; ddl = 2 (S)

The relationship is significant We cannot identify exposure decrease in victimization based on the hierarchical position within the health system. This is the question of the distance to the patient (designated primary author of the violence, as the results show below) and professional tasks in a particular service context that must be asked in its correlation to victimization than that of statutory difference which would induce a form of protection or dependent exposure of the hierarchical level.

3.2. Service relations and victimization

3.2.1 An experience of violence crystallizing in the relationship with users

Health professionals reporting victimization massively attack users (57.8%). More broadly, laymen (users / patients and relatives) are designated as perpetrators of violence (Table 4).

Table 4. The perpetrators of violence [4]

In the situation you described above, who did you feel attacked?	Nb	% obs.
Staff	18	21,70%
User / patient	48	57,80%
caregivers	24	28,90%
Other	5	6,00%
Total	83	

Source: own processing

However, it is important to talk about a crystallization of the experience of violence in the relationship with users. Indeed, the share of personnel involved, although minority appears consistent 21.7% of the respondents, Response rate: 40.1%. The situations described mainly take place at the place of work, that is to say, the establishment or service. Outside the strict sense of the establishment is mentioned only three situations. And inside the establishment, places exponent appears more than others, as the waiting room, which centralizes alone nearly half of victimization narratives.

3.2.2 Low intensity violence

The stories of victimization often tend to mix description of the facts and attribution of the causes / responsibilities, even to be sufficient in the attribution of the responsibilities as shows this answer of a professional to the request for narrative of a victimization (Popescu, 2017). “These are patients who do not understand that some emergencies are more serious than their own and these

[4] Total percentages exceed 100%, with multiple responses.

should be given priority "(obs. *They will also more or less respond to a first classification work by the respondent himself. It operates on categories of common sense, such as the respondent's unique mention of "verbal abuse". Victimization stories may also denounce an attitude more than a gesture or words, as in this excerpt: "The lack of understanding of patients or their relatives"* (obs 23). Finally, attending an altercation, being a spectator may victimize some respondents, showing that the victimization can be indirect.

Table 5 resulting from a recording of the question thus formulated: "Describe the violent situation that has impressed you the most and which took place during this period," reflects these different logics. Although the response rate was low (23.7%), however, it can identify trends in "making violence" for professionals: verbal violence in the lead (24.5% of responses), followed by workplace conflict (22.4%). Physical violence is mentioned only in 3 cases.

Table 5. Qualification of Violence

	Nb	**% obs.**
Verbal abuse	12	24,50%
Labor disputes	11	22,40%
Aggressiveness	8	16,30%
Other	6	12,20%
user requirements	6	12,20%
Indirect victimization	6	12,20%
refusal to leave the hospital	5	10,20%
Physical violence	3	6,10%
Threat	3	6,10%
Total	**49**	

Source: own processing

Only a little over a quarter of reported victimization have been legal suites and over 55% experienced no result. Over 53% of respondents felt that there were no personal consequences to victimization. Finally, the quality of the relations with the users is finally little affected (Figure 2).

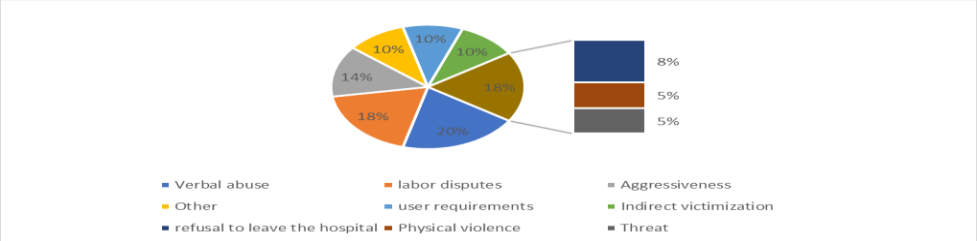

Figure 2. Victimization reported

Source: own processing

The correlation between victimization and the quality of the relationship with users is indeed insignificant (Table 6). Only 17% of professionals describe these relationships as rather difficult.

Table 6. Victimization and quality of relations with users
user relationship, victimization

	Rather difficult	% cit.	Very good	% cit.	Rather good	% cit.	Total	% cit.
Never	9	15,30%	20	33,90%	30	50,80%	59	100,00%
1 time	7	19,40%	17	47,20%	12	33,30%	36	100,00%
Between 2 and 3 times	5	14,30%	6	17,10%	24	68,60%	35	100,00%
More than 4 times	4	22,20%	3	16,70%	11	61,10%	18	100,00%
Total	25	16,90%	46	31,10%	77	52,00%	148	

p = 0,07 ; Khi2 = 11,80 ; ddl = 6 (PS)

Source: own processing

The relationship is not significant.

3.3 Organization and victimization

If the assessment of the quality of relations with users is somewhat correlated with victimization, the correlation between the first variable and the organization appears very significant contrast (Table 7). More work organization is evaluated positively, the better the perception of the quality of relationships with users (Pera, 2017).

Table 7. Quality of relations with users and organization of work
user relationship, work organization

	Difficult relationships % cit.		Good relations % cit.		Very Good relationships % cit.		Total	% cit.
Very good organization	5	9,30%	22	40,70%	27	50,00%	54	100,00%
Good organisation	13	11,80%	66	60,00%	31	28,20%	110	100,00%
Poor organisation	20	64,50%	7	22,60%	4	12,90%	31	100,00%
Total	38	19,50%	95	48,70%	62	31,80%	195	

p = <0,01 ; Khi2 = 55,96 ; ddl = 4 (TS)

The relationship is very significant.

Modalities have been groupedMap: Factorial Analysis of Matches on the Cross Table

Source: own processing

Moreover, victimization is significantly correlated to the evaluation of the quality of work organization (Table 8).

Table 8. Victimization and organization of work
p = 0,9% ; F = 6,97 (TS)

	Organization work
No victim	3,28
Victim	2,99

Source: own processing

The relationship is very significant.
Valuation of steps: from 4 (very good) to 1 (very bad)

This is assessed negatively; more victimization statements increase. It is also significantly correlated with the assessment by health professionals the ability of the labour organization to manage conflicts and tensions (Table 9).

Table 9. Victimization and the role of work organization on conflict
p = 1,9% ; F = 5,53 (S)

	Organization and conflict
Victim	2,05
No victim	1,7

Source: own calculation

The relationship is significant Valuation of steps: 3 (Often); 2(Sometimes); 1 (Rarely); (Do not know / Not applicable)

4. Conclusion

We chose to understand the violence in the health sector from, not pre-defined categories, but the experience of the individual, in this case here, the health professionals in Bucharest. Our objective was to analyse their experience of violence, according to a phenomenological perspective, reregistering it lived, at one level, in situations in which they appraising, those service relationships; and at a second level, in the organizations in which they register. Thus constructed, this analysis takes into account the double dimension, subjective and objective, of this experience. Consistent with this theoretical approach, we collected data from victimization surveys, asking respondents what they had experienced such violence. 207 questionnaires were operated, which provides interesting results. However, one should be cautious about interpretation, not being particularly numerous responses to the open questions. This is particularly the case for violence in the form of workplace conflict. Should we see a kind of code of silence?

Anyway, we can return to some solid results and identifiable trends. The first major result is that the significance of the experience of victimization (more than one in two and claims to have suffered violence at least once during the past year). This experience massively built in the service relationship; the prospect of conflicts that manifest themselves there are experienced as violence when they

undermine the exercise of the profession, such as the design professionals. We can thus validate the first hypothesis. The results also show the significant role of the organization and its functioning in the expression victim. The more the organization is perceived negatively, the more often the expression victim is frequent. We can validate our second hypothesis. The service relationship is thus more than the question of the interactions between professionals and users and makes sense in the specificities of the context, which is itself crossed by fundamental reforms. This background helps to understand the importance of workplace conflict, accounting for more than one in five victimizations. More broadly, role conflicts, even if they are not all denounced as violence, contribute to shaping an experience in situations that weigh on the victim expression of health professionals. If this research is not given as a first intention - by its construction of object itself - to identify "good practices" in what could raise in terms of victimization of the identification of the limiting criteria the exposure to the risks however, it shows the importance of acting on the organization and re-definition of professions, roles and missions of each, in a context of restructuring of the Romanian health system.

References

Acosta Price, O. (2017). Strategies to encourage long-term sustainability of school-based health centers. *American Journal of Medical Research*, *4*(1), pp. 61-83.

Androniceanu, A. (2017a). Hospital management based on the relationship between doctors and patients. *Administratie si Management Public*, 29, pp. 41-53.

Androniceanu, A. (2017b). Improving citizens' satisfaction concerning the social welfare services at urban level. *Theoretical and Empirical Researches in Urban Management, 12*(4), pp. 67-82.

Androniceanu, A. (2016). The quality of the urban transport in Bucharest and how to improve it in accordance with the expectations of the citizens, *Theoretical and Empirical Researches in Urban Management*, *11*(1); pp. 5-18.

Bereketeab, R. (2017). The role of the international community in the Eritrean refugee crisis. *Geopolitics, History, and International Relations*, *9*(1), pp. 68-82.

Bilan, Y., Mishchuk, H., & Dzhyhar, T. (2017). Human capital factors and remuneration: Analysis of relations, modelling of influence. *Business: Theory and Practice*, 18, pp. 208-214.

Burlacu, S. (2015). Violence in the Health Sector and Social Organizations in Romania. in *Proceedings of Administration and Public Management International Conference* , 11(1), pp. 69-83. Research Centre in Public Administration and Public Services, Bucharest, Romania.

Carra, C., Faggianelli, D. (2011). *Les violences à l'école.* Paris: PUF.

Carra, C. & Ridel, D. (2017). L'expérience de violence des professionnels de santé. *Déviance et société*, 3, pp. 447-479.

Carra, C., Burlacu, S., Faggianelli, D. (2016). Violence within organizations in the health and medico-social sectors, comparative analysis France-Romania. *Administratie si Management Public*, 27, pp. 123-142.

Chapell, D., Di Martino, V. (2000). La violence au travail. Genève : Bureau International du Travail.

Dubet, F. (dir.), (1997-2003). *Ecoles, familles: le malentendu*. Paris: Textuel.

Durkheim, E. (1991-1930). *De la division du travail social*. Paris: PUF.

EU-OSMA (2007). European Agency for Health and Safety at Work

Faggianelli, D. (2016). Victimations et rapports au métier des professeurs des écoles, *Spirale, Petite enfance et politique inclusive : quelle prise en compte du handicap ? 57,* 135-154.

Formánková, S., Hrdličková, A., Kučerová, R., Skýpalová, R. (2017), Evaluation of the applicability of CSR standards in the praxis of tertiary education institutions, *Forum Scientiae Oeconomia* 5(1), pp. 95-103.

Gavurova, B., Kocisova, K., Sopko, J. (2017). An analysis of health spending: Trends in selected countries. *International Journal of Applied Business and Economic Research, 15*(9), pp. 1-12.

Ghiorghievici, (2006), Combaterea stresului la locul de muncă, Bucureşti, Editura Universitară;

Jeantet, A. (2003). À votre service ! La relation de service comme rapport social, *Sociologie du travail*, 45, pp.191-209.

Konecki, K. T. (2017). Contemplation for economists. Towards a social economy based on empathy and compassion. *Economics & Sociology*, *10*(3), pp. 11-24.

Krot, K., & Rudawska, I. (2016). The role of trust in doctor-patient relationship: qualitative evaluation of online feedback from Polish patients. *Economics & Sociology*, 9(3), pp.76-88.

Kumari, S. S. M. H., De, A. C. A. (2015). The nursing shortage impact on job outcome (The Case in Sri Lanka). *Journal of Competitiveness*, *7*(3), pp. 75-94. https://doi.org/10.7441/joc.2015.03.06

Kuril, J. (2018). Public administration for safe and secure environment: case of Slovak Republic, *Entrepreneurship and Sustainability Issues, 5*(3), pp. 493-501. https://doi.org/10.9770/jesi.2018.5.3(6)

Lagrange, H., Legleye, S. (2007). Violence, alcool, cannabis et dépression chez les adolescents français, *Déviance et Société, 31*(3), pp. 331-360.

Michaud, Y. (1986-2012). *La violence*. Paris : PUF.

Mucchielli, L. (2001). Violences et insécurité. Fantasmes et réalités dans le débat Français. Paris: La Découverte.

OSHA (2004), Occupational Safety and Health Administration

Panfiluk, E.; Szymańska, E. (2017). The measurement of the innovativeness of health tourism services using an adequacy matrix title of the

article, *Entrepreneurship and Sustainability Issues, 4*(4), 400-420. https://doi.org/10.9770/jesi.2017.4.4(1)

Parent-Thirion, A., Fernandez Macias, E., Hurley, J., Vermeylen, G. (2007). Quatrième enquête européenne sur les conditions de travail, European Foundation for the Improvement of Living and Working Conditions. Luxembourg: Office for Official Publications of the European Communities.

Pera, A. (2017). The prevalence and cost of deviant behavior in the workplace to both organizations and employees. *Contemporary Readings in Law and Social Justice*, *9*(1), pp. 139–145.

Peretti-Wattel, P. (2001). Théories de la déviance et délinquance auto-reportée en milieu scolaire, *Déviance et Société*, *25*(3), 235-256.

Popescu, G. H. (2017). Does medical malpractice tort reform have a Constructive effect on the health care bottom line? *American Journal of Medical Research*, *4*(1), pp. 141-147.

Popescu Ljungholm, D. (2017). Feminist institutionalism revisited: The gendered features of the norms, rules, and routines operating within institutions. *Journal of Research in Gender Studies*, *7*(1), pp. 248-254.

Pranevičienė, B.; Vasiliauskienė, V. (2018). Security in crisis situations: the problems of the limits of the human rights. *Journal of Security and Sustainability Issues*, 7(3), pp. 439-448. https://doi.org/10.9770/ jssi.2018.7.3(6)

Prasetio, A.P., Yuniarsih, T., Ahman, E. (2017). The direct and indirect effect of three dimension of work-life interface towards organizational citizenship behaviour, *Polish Journal of Management Studies*, 15 (1), 174-184. DOI: 10.17512/pjms.2017.15.1.17

Rippon, T. (2000). Aggression and violence in health care professions, *J.A.N.*, *31*(2), 452-460.

Rujoiu O., (2010). Cultura violenţei şi emoţiile sociale, Bucharest, ASE Publishing.

Sroka, W., Vveinhardt, J. (2018), Nepotism and favouritism in the steel industry: a case study analysis, *Forum Scientiae Oeconomia 6*(1), pp. 31-45.

Stefko, R., Gavurova, B., Korony, S. (2016). Efficiency measurement in healthcare work management using malmquist indices. [Pomiar efektywności w zarządzaniu pracą w opiece zdrowotnej przy użyciu indeksu produktywności malmquista]. *Polish Journal of Management Studies*, 13(1), pp. 168-180. DOI: 10.17512/pjms.2016.13.1.16.

Štefko, R., Jenčová, S., Litavcová, E., Vašaničová, P. (2017). Management and funding of the healthcare system *Polish Journal of Management Studies*, *16* (2), pp.266-277. DOI: 10.17512/pjms.2017.16.2.23

Vveinhardt, J., Sroka, W. (2017), Mobbing and harassment in the steel enterprises, *Metalurgija*, 56(1-2*)*, pp.275-278.

Zahars, V., Stivrenieks, M. 2018. Security, surveillance and re-socialization aspects in center for drug addicts of Olaine city prison in Latvia, *Journal of*

Security and Sustainability Issues, 7(4) https://doi.org/10.9770/jssi .2018.7.4(3)

Zivcicová, E., Bulková, K., Masárová, T. (2017). Comparison of the selected indicators of work life balance in European Union countries. *Economics & Sociology, 10*(1), pp. 222-231.

WHO (2002), World Health Organization and Public Services International: Framework Guidelines for Addressing Workplace Violence in the Health Sector. Geneva, International Labour Office,